A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation into
'The influence of client facial appearance on therapists as mediated by therapists’ self perceptions: a qualitative investigation into the views of trainee psychologists'

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Submitted to the University of Surrey in partial fulfilment of the degree of Practitioner Doctorate (PsychD) in Psychotherapeutic and Counselling Psychology.

July 2005
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Statement of Anonymity

Throughout the compilation of this portfolio all client and research participant names have been altered to ensure their anonymity. Where reference is made to clients, research participants and/or practice settings every effort has been taken to ensure that any identifying details have been eliminated, altered or kept as general as possible to ensure confidentiality is maintained.
Acknowledgements

I would like to thank Dr. Adrian Coyle and Dr. Martin Milton, Course Directors, as well as the entire course team for their ongoing support and help throughout my studies. I am also indebted to Dr. Evanthia Lyons for her invaluable guidance and encouragement in my research pursuits, and to the secretarial staff Kay Hambleton, Marion Steed and Sarah Church for all their efforts that allowed the course to run so smoothly. Additionally, I would like to express my gratitude to my fellow trainees for making the learning process such a rewarding one, and to all those that took the time and energy to participate in my research projects. I am very grateful to all of my placement supervisors and to all of the staff in each placement who made my placements such a positive experience. Lastly, I would like to thank my parents, Ron and Iris, for their love and support, my friends for their patience and understanding, and my wife Katherine who quite frankly has had to put up with a lot over the past few years and is probably happier than I that this process draws to an end.
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Introduction to the Portfolio

Introduction
This portfolio contains a selection of academic, therapeutic practice and research work carried out during the three years of my doctoral training in Psychotherapeutic and Counselling Psychology. While each piece of work could be seen as context dependent, relating to my relative position in the progress of my training, in reflecting on the portfolio as a whole I feel it gives scope to my interests and pursuits, as well as my continued development over the past three years.

It will become apparent during the reading of my portfolio that at times I orientate the reader to background factors, previous to my training, that proved influential in the pursuits in which I engaged and indeed the process of my training itself (most notably my Final Clinical Paper and my research interests). While such issues are flagged up as necessary I feel it would be useful at this stage to broadly outline my previous experience and route to Counselling Psychology. It is hoped that this will allow for a fuller understanding of how I have come to engage in the process of training and how that engagement has impacted on me at a number of levels.

Finding Counselling Psychology
My journey to the profession of Counselling Psychology has not been a direct one - and I suspect few are. My first degree was in Social Science which I studied at South Bank Polytechnic/University (it changed its designation in my third year). While I generally enjoyed this course, revelling in the ‘freedom’ of the further education learning modality which contrasted starkly with the didactic nature of my private Roman Catholic education previous, the components that most interested me were those that were Psychology based. After graduating I gained employment with a Jewish charity working with people with learning disabilities. Whilst I was initially hesitant as to my abilities (I was thrown in at the deep-end if you like, running education programmes and managing challenging behaviour with little training), as I persevered with the work I came to appreciate the power of the relationships I was forging with clients, the result of which encouraged me to take on keyworker and advocacy duties which I feel gave me a respectful appreciation of ‘difference’.
During this period of employment I followed up my interest in the field of Psychology completing the BPS conversion diploma in Psychology with the Open University which allowed for GBR. With the completion of this course came an eligibility to apply for 'mainstream' Assistant Psychologist posts etc, and I applied for a Rehabilitation Assistant post at the Royal Hospital for Neuro-disability working with people with acquired head injury and neurodegenerative disease. From my family life I had first hand experience of the impact of neurodegenerative disease and in many ways I feel I was drawn to this post to build on this experience but also to make sense of it. The work in which I engaged was very rewarding. While most Rehabilitation Assistant's stayed a year to enhance their CVs, I stayed six gaining promotion and becoming involved in employee inductions and training. During this employment I completed a Masters degree in Clinical Neuroscience at Roehampton Institute and decided that I would pursue a career in Neuroscience and research having been enthused by the research component of this course. I secured a Research position in the Research Department of the same Hospital and there decided with my supervisor's support to embark on a PhD in Medical Research Methods, run between St. Georges Hospital and Kingston University. The Year that followed was not what I had envisaged. While I enjoyed aspects of the research project in which I was involved, I really missed the client contact I had previous. It seemed that through the 'helping relationship' (predominantly with clients but also with staff) I in some way gained a sense of professional validation, and the absence of such relationships in the research department had a significant impact on my mood. As the research work continued colleagues I had worked with previously commented on how I seemed disengaged and downbeat, and as I came closer to PhD application (it was set to take place after six months once I had passed through my employment probation) I became more despondent and unsure of the path I had chosen.

While it may not be right to call it 'luck' there is a certain amount of serendipity in what happened next. I was involved in a road traffic accident in which I was knocked off of my motorcycle sustaining a crush injury to my foot. I was 'bed bound' for three weeks and while I recuperated at home, as if by chance, one day to relieve the boredom I flipped through some copies of The Psychologist (which I rarely read - they were kept on the toilet cistern for guests to avail themselves of) and happened
upon an advert for Counselling Psychology at Surrey. I decided to send off for an
information pack and on its reading decided to change my career path.

It seemed a number of themes in my life were drawn together all at once. My interest
in psychological theory, my desire to be involved in research and my
acknowledgement of the power of client relationships not only seemed validated but
prioritised. The ethos of the course seemed to gel with me at a core level, and, if I’m
honest, since applying I have not looked back. I have truly relished my time on the
course and while the workload has been heavy, I feel the attention paid to both group
process issues and one’s individual process has had a fundamental impact on my
development not only as a Counselling Psychologist but as a Person.

My individual therapy, in which I engaged in my first year of training with an
integrative Psychologist, was a significant experience. I learnt for the first time what
it felt like being in the ‘client’s chair’ and immediately became aware of process
issues that had bearing for my own practice (such as the power of gesture and my
sensitivity to misplaced words - factors to which I had hitherto paid little attention).
Indeed I feel the personal exploration that was facilitated by my therapist, as well as
my enhanced self-awareness through placement supervision and process
considerations, has had a considerable influence not only on how I choose to relate
with the world but also on how I comprehend options for relating. I believe the course
has allowed me to engage with my own process in a way that is far removed from my
self-judgemental and often punitive nature of old (possibly a remnant of my Roman
Catholic upbringing), enabling me to venture towards a ‘way of being’ that would
seem a more natural vantage point from which to experience. While I recognise that
my personal journey is ongoing, I do feel aspects of it are echoed in the portfolio
before you (sometimes explicitly and sometimes implicitly), and I hope that you
enjoy reading it.

Given this broad background as to my journey both in career and self up to this point,
I would now like to take this opportunity to reflect on the contents of each of my
portfolio dossiers, looking specifically at what drew me to the pieces of work
contained therein.
Academic Dossier

My Academic Dossier contains three essays, one selected from each of my three years of training. My first essay explores issues of client engagement in Cognitive Behavioural Therapy (CBT) for depression. I was drawn to this topic for three reasons. Firstly, as a Rehabilitation Assistant the service model in which I worked was predominantly Cognitive-Behavioural. I was aware of the feel of the model but had not received any formal training in this post as to its application. The essay topic thus granted me the opportunity to explore this area in a more theoretical manner learning from and building upon my previous experience. Secondly, I was captured by a lecture on the primacy of client engagement, without which the therapeutic aspect of any relationship is likely to be absent. I was aware of how CBT’s stance to building a ‘working alliance’ was criticised by some in this regard and wished to explore this aspect further. Thirdly, as many of my clients reported feelings of depression, I felt such an essay would provide me with an opportunity to inform my practice with possible direct benefit to my clients.

My second essay, entitled ‘The language of silence: considerations for the therapeutic relationship’, stemmed from my own practice experience of the power of silence in the therapeutic relationship. Working as I was in a psychodynamic placement at the time, the ‘hidden’ communication of silence was very present in my mind. This essay gave me the opportunity to investigate at a more theoretical level the processes of silence in therapy, allowing some conceptual framework to be given to my thinking, which again I feel enhanced my practice. It is interesting that in this essay I refer to the clinical population as patients rather than clients, which is the term of reference I use in all my other pieces of work. I feel this reflects both the literature I encountered on the subject matter (largely coming as it did from a psychodynamic perspective), as well as the orientation of the CMHT placement I was on at the time. I flag this up as an issue of note and recognise my personal preference for the term client.

The focus of my third essay was directed by the course with the set title: ‘In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice’. In many ways the orientation I took in this essay reflected a number of processes that were occurring in me at the time. I was becoming more confident in my identity as a
Counselling Psychologist (entering as I was the final semester of my training), and I was applying a freedom to my thought and narrative I hadn’t previously. I feel this essay captures the essence of a number of issues/questions with which I was engaged at the time (from how post-modernist conceptions might be applied to therapy, to how I ‘own’ my practice as a therapist), and it is the one that I most enjoy re-reading sensing a congruent engagement of me in its narrative.

Therapeutic Practice Dossier
This dossier relates to my therapeutic practice during my training and includes an overview of my clinical placements and the client groups with which I have worked. It also contains my Final Clinical Paper, which discusses how I conceptualise and approach the integration of theory, research and practice as a consequence of my training. I feel the preparation for this paper allowed me to explore aspects of my own practice and orientation, in a broad and holistic manner, which itself enhanced my practice as a result.

Research Dossier
The Research Dossier contains my first year literature review entitled ‘Counselling Psychology and the Conceptualisation of Facial Disfigurement’; my second year qualitative research report, ‘The influence of client facial appearance on therapists as mediated by therapists’ self perceptions: a qualitative investigation into the views of trainee psychologists’; and my third year quantitative research report, ‘Therapists’ reactions to client facial appearance: the influence of therapists’ perceptions of their own relative facial appearance’.

While I orientate the reader at the appropriate time as to my motivations for the focus of each of these pieces of work, stemming as they do from my own experience of facial scarring and my considerations as to the practice implications of facial appearance, I would like to take this opportunity to point out two things in relation to this dossier. First, in each piece of work I have integrated the ‘use of self’ component into the narrative. In the literature review this is done at such an intrinsic level I have chosen not separate it from the narrative itself, however in the subsequent research reports I have chosen to bracket it (in square brackets). I feel such bracketing aids the
reading of these reports, allowing my self-reflections/use of self a certain independence from the narrative - the end result I feel is more engaging. Second, in devising my research orientation over the three years, it was envisaged that the design of the research reports would in many ways complement each other. Consequently, I feel all three pieces of work are best read with that complementary relationship in mind, building from each other as they do, an approach I am presently developing in their write-up for publication.

Conclusion
I feel my three years of training have had a profound impact on my life and have granted me a foundation on which to build both professionally and personally. I am aware of the distance I have travelled and in many ways have come to appreciate that the journey is at least as important as the end destination, this portfolio being my most significant 'ticket check' to date.
Academic Dossier
Issues of client engagement in Cognitive Behavioural Therapy (CBT) for depression

Willingness, by both client and therapist, to take-part or engage in psychotherapy would seem a necessary precursor of any meaningful therapeutic interaction. It is this willingness that lays the foundation of the therapeutic relationship, which many stress is the active ingredient in the beneficial progression of therapy (Frank, 1982; Gaston, 1990). However, what is meant by engagement in therapy may not be as clear-cut as one might at first assume. In the field of Counselling Psychology the concept of engagement in therapy can have a diversity of meanings depending upon the philosophical underpinnings, theoretical conceptualisations and practice modalities of the model of psychological understanding subscribed to.

In this essay I will explore the Cognitive-Behavioural (C-B) conceptualisation of engagement in psychotherapy, and discuss its application with regards to working with those with a diagnosis of depression. It is recognised that 'a diagnosis of depression' raises a number of questions regarding measurement and labelling of psychological phenomena, which have deep philosophical roots, however, it is not my intention here to get embroiled in such debate. In the context of this essay depression is positioned in terms of the standard psychiatric classificatory scheme of DSM-IV, Axis I classification of depressive disorders, and while this may dispose one to a particular conceptualisation it is felt the most applicable to the approach of CBT.

Engagement in CBT

In conceptualising the C-B approach to engagement it must first be understood that despite efforts aimed at the 'manualisation' or 'standardisation' of its procedures (Young & Beck, 1980), CBT cannot be seen as a homogeneous theoretical tradition and treatment modality. Within the field of CBT, as with all other psychotherapeutic traditions, there is great variability, both in terms of theoretical understanding and treatment protocols, and it must be said that being aligned to a CBT approach does not necessarily negate influence from other theoretical models (Safran, 1990). As a consequence when it comes to understanding how CBT conceptualises client engagement in psychotherapy there would seem inherent difficulty in representing
this diversity in any meaningful manner. However, a possible aid to this could be the use of Spinelli's delineation of the tendency of psychotherapists to "stress either the 'doing' or the 'being' elements" of the therapeutic relationship (Spinelli, 1996, p.189). Here the therapeutic relationship can be seen as a function of engagement as without engagement in the process of therapy the relationship would not exist. Through use of this delineation it would seem possible to understand more clearly aspects of engagement in CBT, and possibly address any misconceptions.

It has been pointed out that therapists in CBT have often been portrayed as being colder, more mechanical and superficial in their contact with clients than therapists from other psychotherapy orientations (Keijsers et al., 2000). This stereotype seems to stem from the idea that the therapeutic relationship is one of 'collaborative empiricism' where the focus is on the 'doing' aspects of the relationship and in the 'scientific' exploration of thought processes which are at the heart of therapeutic technique. Here engagement in therapy is termed in relation to the ability of a client to form a good 'working alliance' with their therapist, which is seen as a prerequisite to positive response (Segal et al., 1995), and the ability to engage in a collaborative manner is suggested to be an important factor in the initial selection of clients suitable for CBT treatment (Safran et al., 1993). While this stereotype may be an extreme representation it does point to a number of themes relevant to CBT in general. In CBT client engagement is often represented as a one-way process, where by the client engages with the therapist and theoretical model, and there is little attention paid to a therapist's personal dynamics. Therapists are seen as 'scientist investigators' working with clients, teaching them skills and directing their progress, and in this way they develop a working alliance. The working alliance is seen as the point of engagement in therapy and essential to its progress, it is collaborative in nature, being dependent on the client's willingness to 'do' therapy, and is often portrayed as the central relationship focus of CBT practitioners (Clarkson, 1995).

This portrayal seems to exemplify the 'doing' aspects in the conceptualisation of engagement in CBT and while it may bear some resemblance to the application of therapeutic technique (Leahy & Holland, 2000), it seems far removed from the relationship and engagement skills commonly employed by CBT practitioners (Keijsers et al., 2000). Aaron T. Beck, who is thought of as one of the principle
founders of the C-B perspective, emphasised the centrality of the therapeutic relationship to the therapeutic process. In his discussions of the characteristics of the therapist he highlighted the provision of a warm, empathic, genuine environment in which a client could engage with a therapist and the therapist "begins to enter the patient's world" (A. Beck et al., 1979, p.48). In this therapeutic interaction Beck pointed to the 'positive transference' of basic trust by the client in the progress of therapy and the centrality of building rapport between client and therapist. Beck explains:

"The term rapport, in general, refers to harmonious accord between people. In the therapeutic relationship, rapport consists of a combination of emotional and intellectual components. When this type of relationship is established, the patient perceives the therapist as someone (a) who is tuned in to his feelings and attitudes, (b) who is sympathetic, empathetic, and understanding, (c) who is accepting of him with all his "faults", (d) with whom he can communicate without having to spell out his feelings and attitudes in detail or to qualify what he says. When rapport is optimal, the patient and therapist feel secure and reasonably comfortable with each other. Neither is defensive, overly cautious, tentative, or inhibited" (A. Beck et al., 1979, p.51).

These thoughts by Beck seem more congruent with Rogarian core principles and conditions of therapeutic change (Rogers, 1957) than any cold, scientific stereotypes of CBT application. Beck seems to recognise both the transferential nature of the therapeutic relationship and also the person to person aspects of human encounter, both identified by Clarkson as relationship typologies not commonly associated with CBT (Clarkson, 1995).

If we return to Spinelli's delineation, the conceptualisation by Beck seems to recognise the 'being' qualities of engagement in the therapeutic relationship, although possibly not to the same degree as the existential-phenomenological paradigm, and thus begs the question where CBT actually stands in the 'doing/being' dichotomy. To answer this question it is important to make clear that while the dichotomy may be useful in conceptualising engagement processes, it is a dichotomy of emphasis rather
than of strict differentiation (Spinelli, 1996). It would seem that all therapeutic approaches, at least tacitly, recognise the link between ‘being’ aspects of the human condition and ‘doing’ aspects required by that same condition, and thus each falls at some point on the continuum of ‘doing/being’. It would therefore seem that while CBT may have a technique closer to the ‘doing’ end of the continuum it does not negate the ‘being’ qualities of the therapist in the promotion of client engagement in the therapeutic process. With this said I will now look at the C-B model of depression.

The C-B model of depression

CBT is founded on the premise that an individual’s emotions and behaviours are a consequence of how life events and situations are construed rather than the actual events or situations themselves (A. Beck, 1964). The focus of psychotherapy is therefore on how people think, their construal processes, and any maladaptive thought patterns they may exhibit. The point of therapeutic entry is an individual’s current thinking patterns as these are seen as triggering current symptoms, either behavioural, motivational, affective, cognitive, somatic or any combination thereof. Through the exploration of these thinking patterns and their cognitive origins the C-B approach believes psychological understanding is possible and strategies can be employed to ‘unlearn’ dysfunctional thought processes (Hollon & Jacobson, 1985). If we take a generalised example of someone who reports feeling depressed, the symptoms they display may include social withdrawal, loss of interest in hobbies, feelings of sadness and sleep disturbance. CBT would conceptualise these current symptoms as stemming from negative thoughts such as ‘I am a failure’ or ‘I am unlovable’, which it postulates are automatic in nature and part of an individual’s general stream of thought consciousness. It’s aim would be to challenge the link between these thoughts and symptoms by exploring the history of the individual’s thought processes looking for any critical incidents, such as relationship difficulties, that generate current thinking; any dysfunctional assumptions that may have been triggered by the incident such as thoughts of being inferior; and any early life experiences that may have informed dysfunctional assumptions or negative core beliefs, such as being the ‘unfavoured’ twin. CBT would seek to understand the cognitive processes at work and employ an array of behavioural and cognitive techniques in teaching an individual to identify and challenge their own dysfunctional thinking process and thus eradicate
their current symptoms (A. Beck et al., 1979). As mentioned above the CBT technique requires clients to actively engage in the ‘doing’ of therapy, which in turn necessitates their commitment to explore and work towards changing their thinking patterns, feeding-back and collaborating on enhancing therapeutic technique, and committing to a structured and directive treatment programme usually aimed at shorter term work, possibly 12-18 sessions (J. Beck, 1995). Given this brief cognitive conceptualisation, with its focus on active client engagement in therapy, I will now turn to issues of engaging clients with the diagnosis of depression in CBT.

**CBT for depression and issues of engagement**

At the start of any therapeutic process the focus is likely to be on relationship elements of the therapy. Clients are likely to want a ‘safe’, hospitable environment where they can explore their difficulties with the hope of getting assistance. They will be assessing a therapist’s ability to provide such a facilitative environment and are likely to adjust their level of engagement accordingly. Therapists are likely to want to promote client engagement and thus will employ their therapeutic skills in building a supportive and trusting environment where clients feel free to discuss their issues. However, clients suffering from depression may have difficulty engaging with therapy at this initial stage. They may have reduced cognitive and behavioural activity levels, reduced motivation, and poor concentration. They can demonstrate despondency in taking part; reluctance to question their own thinking patterns; difficulties in forming ‘relationships’ due to disruption of interpersonal operations; and hypersensitivity to and dislike of being challenged (A. Beck et al., 1979, p.28).

Engagement in an active, directive, and time-limited course of CBT would then seem to pose a number of problems for such clients, however, CBT has much clinically based evidence to suggest its effectiveness and is often taken as the treatment of choice with this client group (Cornwall & Scott, 1997; Dobson, 1989). It is my endeavour here to consider how the C-B approach to engagement might be related to this effectiveness and how this might be seen in the light of other factors involved in the therapeutic relationship.

It has been pointed out that clients with depression often do not respond well to unstructured approaches to the treatment of their symptoms (Scott et al., 1991), and while different approaches may vary in conceptualising symptoms, symptom
reduction is often seen as the focus of psychotherapeutic intervention and the point of outcome measurement (Leahy & Holland, 2000). The CBT approach to depression would then seem to have a number of merits with regard to its structured technique. It provides clients with a clear psychological model of their experiences and a diagnostic framework within which they can conceptualise their difficulties. It is argued that the provision of a diagnosis may be reassuring (Scott, 1998), and with CBT diagnosis is provided with clear, logically sequenced, problem orientated plans for bringing about change (Padesky & Greenberger, 1996; Scott, 1998). Of course a client is unlikely to even get to the stage of model introduction if they feel misunderstood and unsupported by the therapist, and there is evidence that CBT practitioners may come across as more supportive and reassuring than psychotherapists from other orientations (Brunink & Schroeder, 1979; Hardy & Shapiro, 1986). This may be due to an emphasis on the therapist’s direction of sessions, where frequent coaching and feedback may be given in an encouraging and reassuring manner. CBT’s structured problem orientated approach might then allow depressed clients to focus in on specific aspects of their depression rather than treating it as an overwhelming whole, and thus encourage gradual and sequential engagement in the therapeutic process.

It would seem that a therapist’s ability to combine the ‘being’ skills of empathising with and understanding a client’s current difficulties, with the provision of a diagnostic framework (from which clients can start to objectively conceptualise their condition), is at the heart of founding therapeutic rapport and the ‘working alliance’ vital for the ‘doing’ aspects of C-B treatment. In CBT clients are often encouraged to take part in role-play and imagery techniques in eliciting their thought processes; to employ ‘Socratic questioning’ and behavioural experiments in evaluating their thoughts and assumptions; and to participate in weekly ‘homework’ assignments to monitor their activities and practice the techniques learnt in sessions (J. Beck, 1995). Therapists often provide support and encouragement for task completion and the emphasis is on setting short-term achievable goals that clients might gain satisfaction in completing. Furthermore, therapists often encourage feedback during and after sessions, and this may serve to emphasise the value of the client’s opinions in therapy; the collaborative nature of therapy; and also help identify any problems with the process of therapy, allowing for strategy adaptation to suit the individual client. It
has been suggested that through such ‘doing’ aspects of therapy, in a supportive and facilitative environment, a depressed client’s sense of self-efficacy and ability to cope might gradually be raised (Scott, 1998), which in turn might raise their motivation to participate and do more. It may therefore be the emphasis on the doing aspects of therapy and the active engagement in process, facilitated by the cognitive conceptualisation of depression, that at least in part leads to CBT’s effectiveness in symptom reduction and positive outcome (DeRubeis & Feely, 1990).

However, the link between the ‘doing’ aspects of therapy and outcome is in need of further consideration. There is much support for the general assumption that non-specific, common relationship factors, as exemplified by Rogarian core conditions for therapeutic change (Rogers, 1957), are intrinsically linked to therapeutic outcome (Barber et al., 2000; Gaston, 1990). That is, the ‘being’ aspects of therapy in Spinelli’s delineation. In this conceptualisation ‘doing’ aspects are only likely to enhance outcome with regard to the dynamics of the particular population to which they are applied. It would therefore seem necessary to set the findings for the effectiveness of CBT in the treatment of depression in the context of the assessment criteria it applies to such a population. That is to say, suitability for CBT may be assessed on a number of issues, of which active engagement and alliance potential, as well as severity of symptoms and likely outcome, would appear to be significant factors (Safran et al., 1993). It would then appear that such selection may actually predispose positive outcome findings, which may be useful in treatment planning, but potentially biases findings of effectiveness especially in comparisons between treatment modalities. Discussions as to the effectiveness of CBT for depression, and the role of the ‘doing’ aspects of engagement, need then to be considered in this light, and caution taken in assuming the link between a condition and a technique without emphasising the importance of individual client dynamics to treatment outcome.

**Conclusion**

In drawing together the different aspects of engagement in the therapeutic process and their potential links to the therapeutic relationship and outcome, Barber points out that the nature of any links are likely to be more complex than is often assumed, with intertwined and interrelated elements that require a more sophisticated approach to research in this field (Barber et al., 2000). This point seems further endorsed by
recent research which has suggested that a client’s expectation of treatment outcome influences their level of engagement, which in turn influences treatment outcome (Meyer et al., 2002). Thus if a client thinks a treatment will work it is more likely to. This finding appears to relate to the transtheoretical model of change proposed by Prochaska and DiClemente (1983) where a client’s stage of readiness for change anticipates their engagement levels and likely therapeutic outcome. Here depending on their stage of readiness, which may be at the pre-contemplation, contemplation, action, or maintenance level, so different techniques to promote engagement may be indicated. Thus if we return to Spinelli’s delineation, ‘being’ aspects of engagement may be more the focus in pre-contemplation and contemplation stages, while ‘doing’ aspect more appropriate for action and maintenance stages. It would therefore appear that the interconnectedness of aspects of engagement, across the process of therapy, should be emphasised, rather than any focus taken by a particular theoretical tradition. Thus, a therapist’s ability to integrate engagement techniques according to a client’s needs, at that time, would seem to lay at the heart of building a good therapeutic relationship and creating the conditions for positive outcome, and it is this integrative ability that would seem to be the appropriate focus for future research.
References


The language of silence: considerations for the therapeutic relationship

It is widely accepted that the therapeutic relationship is a key factor influencing the process and outcome of psychotherapy (Horvath & Symonds, 1991; Krupnick et al., 1996; Price & Jones, 1998). A good therapeutic relationship between patient and therapist is suggested as a necessary condition for effective therapy and thus of central importance to which psychotherapists should attend (Barber et al., 2000; Frank, 1982; Gaston, 1990). Many studies have looked at different aspects of the therapeutic relationship trying to pinpoint crucial factors for therapists' consideration. These have ranged in focus from non-specific common relationship factors (Barber et al., 2000; Gaston, 1990) to specific therapist characteristics and therapeutic techniques (Ackerman & Hilsenroth, 2001). While such studies draw attention to the importance of communicating warm empathic understanding to patients in the facilitation of therapy, there is a tendency to focus mainly on aspects of verbal communication in the therapeutic setting. While this might be expected in 'talking therapies', my own clinical experience has pointed to the importance of another communicative aspect of therapy, that of the occurrence of silence, which is also likely to have important implications for the therapeutic relationship. The following essay will look at different aspects of silence as it may occur in therapy and ask how it may itself hold a rich, if unspoken, language.

What is silence?

Silence has been defined as a period of five seconds or more when neither patient nor therapist speaks (Cook, 1964; Goodman & Dooley, 1976). While such a definition allows for the differentiation of silence from normal short pauses which might occur as part of regular speech, it seems to focus on speech and silence as opposites i.e. one either speaks or is silent. While this might physically be true in the production of sound, it has been argued that such a polar view misses the important point that both speech and silence are forms of communication (Lane et al., 2002; Reik, 1968), and as such there is a relational aspect to silence which needs to be understood both interpersonally as well as intra-psychically (Pugh, 1997). In attempting to illuminate such an understanding I shall now examine some theoretical approaches to silence.
Theories of silence

While different theoretical models have recognised the importance of silence in therapy, most notably Carl Rogers' Client Centred Therapy (Rogers, 1951), by far the most in-depth analysis of inter-personal as well as intra-psychic aspects of silence has come from psychodynamic models.

Traditionally psychoanalysis viewed silence in therapy somewhat negatively as emanating from patient resistance to transference thoughts (Freud, 1958). The therapist's role was seen as helping the patient overcome their silence so they could verbalise their thoughts and fantasies and thus work through their inhibitions, resistance and ego regression (Shafii, 1973). However, this view of silence began to change in the second half of the twentieth century with theorists and practitioners also recognising the importance of silence as communication and its consequent relevance to the therapeutic relationship (Lane et al., 2002). Furthermore, the previous focus solely on patient silence broadened to incorporate considerations of therapist silence and consequent implications for practice, and it is to a consideration of each of these perspectives that I now turn.

Patient silence

Patient silence has been conceptualised in a number of different ways. Sabbadini (1991) saw silence as originating from unconscious fantasies and the result of psychic conflict. Here silence serves to transform unconscious anxiety resultant from inner conflict into more manageable anxiety that can be experienced consciously in the analytic relationship. Silence then can be a form of defence or self-censorship to curtail the exposure of a patient's internal world which might lead to their rejection and alienation (Coltart, 1991). Silence could communicate the fear and anxiety of the patient about opening up to the therapist, as well as their possible desire to regress to a safer place without words such as their pre-verbal childhood or ultimately their mother's womb.

Also working from the idea of silence as conflict/regression, Busch and Arbor (1978) have outlined how silence might represent a patient's past inability to separate from the primary object (mother). That is, as the development of speech involves a clear recognition that self and other are separate, and language development coincides with
loss of infant egocentricism (Piaget, 1937), so there is a corresponding growth in self-differentiation. Silence then could be seen as communicating a desire to rejoin union with the primary object which words separate one from. Here problems in relating to others might be highlighted, Kohut’s (1971) concept of language as enabling relational contact through the process of transmuting internalisation would seem to suggest that in silence potential rewarding interactions are lost which may represent earlier difficulties in the mother-child relationship (Eveloff, 1971).

Pugh (1997) has suggested that silence might be considered as the reappearance in the transference of pre-verbal forms of object relations. Working from Balint’s (1968) concept of pre-oedipal regression as signifying a more ‘basic fault’, Pugh argues that adult language might be insufficient in approaching difficulties that occurred at a pre-verbal age and thus the working through of silence is necessary. Here silence as communication of ‘basic fault’ could be seen as highlighting the failure of the mother to provide a holding environment for the child, resulting in the weakening of ego structure and necessitating the construction of a false self (Winnicott, 1965). Pugh (1997) suggests that in order to overcome this maladaptive method of coping the therapist needs to understand the patient’s communication of silence and work to allow them to regress to silence, whilst themselves functioning as an auxiliary ego providing a holding environment for the patient. It is argued that when patients have returned to operate at the level of basic fault so they might develop more adaptive strategies to maintain ego structure and thus reach a ‘new beginning’ (Balint, 1968), where their ‘true self’ might emerge (Winnicott, 1965) and they can ‘self-experience’ (Khan, 1974).

Other writers have also highlighted the need to understand silence as a transferenceal phenomena pointing out how the process of therapy might cause, if not necessitate, its occurrence. It has been pointed out that silence could communicate anger or annoyance at the therapist, being used to punish the therapist through eliciting awkward counter-transference (Lane et al., 2002). While this type of silence might provide the therapist with much to work with, it has been cautioned that patient silence requires a therapist’s particular attention in order to attune themselves to the patient’s inner processes as well as their own counter-transference (Mander, 2000).
Benjamin (1981) alternatively has moved away from strict ideas of silence as an expression of conflict/transference suggesting that silence in patients might communicate a state of confusion or disorder and thus a need for quiet space in which to organise thoughts. Coltart (1991) along these lines highlights the way in which silence might allow for assimilation and incorporation into the psyche of previously unprocessed material. Thus patient silence can be seen as a nurturing time that communicates development rather than conflict. Such adaptive silence has been suggested as a therapeutic goal (Shafii, 1973) which, similar to the meditative construction of ‘inner-peace’ and ‘harmony’, allows for “dense internal experiencing” (Bollas, 1996, p.13), in the presence of the other (Winnicott, 1965).

**Therapist silence**

Langs (1988) suggests that therapist silence is an important technique for therapists to learn. He suggests that it can be employed in a number of ways from providing a holding and containing environment in which patients might experience themselves whilst ‘being with’ the therapist, to communicating warmth and acceptance to the patient and thus maintaining the integrity of the therapeutic relationship. He argues that therapist silence in response to patient silence can give the patient responsibility for structuring sessions and imply a responsibility to make behavioural adaptations which might reinforce ego strength and advance their ability to maintain mature object relationships (Langs, 1976). In essence Langs sees therapist silence as a technique in facilitating the therapeutic process, patients are given space in which they can explore their internal worlds and consequently make sense of themselves while in therapeutic contact.

While this facilitative therapist silence would seem the ideal it is recognised that as a skill it may be relatively hard to acquire. There is little literature in basic texts on its use and there has been much controversy surrounding examples of its misuse (Hill *et al.*, 2003). Indeed while silence might be seen in terms of a positive intervention by some (Langs, 1988) others point to the need for it to be used more cautiously. It has been suggested that therapist silence in response to patient silence can raise patient anxiety and exert pressure on patients to verbalise leading to feelings of being misunderstood or abandoned by a critical and uncaring therapist (Hill & O'Brien, 1999). Such reactions are obviously likely to be detrimental to the therapeutic
relationship and, indeed, some studies have linked therapist silence in some instances with negative therapeutic outcome (Davis, 1977; Saunders, 1999).

In recognising that therapist silence could have many different impacts depending on the timing and patient need, it is of primary importance that therapists attend to how their interventions with silence are experienced by patients. It has been pointed out that therapist use of silence might progress incrementally, gradually ensuring patients are able to tolerate longer silences during the course of therapy. It is suggested that such progression might prevent the sudden impact of ‘being alone’ in a room with another which might be experienced as punitive and overwhelming (Elson, 2001). Furthermore, it has been pointed out that there are different types of silent intervention that might be employed depending on patient appropriateness. Ogden (1994) suggests ‘interpretative action’ as a silent method of communicating to patients that the therapist should not be thought of as a question answerer, rather that they the patient could work through their own material without reference to the therapist, and thus progress therapy independent of transference and counter-transference phenomena. Blumenson (1993) has suggested the ‘silent mirroring’ of a patient’s body movements as allowing therapists access into the patient’s inner chaotic and preverbal world through patient self-recognition and emotional connectedness. While these techniques seem novel and inventive they each come with the proviso that patients be assessed as suitable prior to their use through therapeutic engagement.

Pugh (1997) in reflecting on how therapists use of silence needs to be done so cautiously, also recognising the potential for its use in negative counter-transference as a display of therapist anger and a desire to punish or withdraw from the patient (Langs, 1973), suggests the value of meta-communication. That is, rather than intervening by interpreting the silence, therapists might stay with the silence and communicate about the communication of silence. In this sense it is suggested that the therapist and patient step outside of the silence and allow themselves space to reflect on it without necessarily breaking it (into it) as a consequence. It is suggested this would allow both to remain with the facilitative aspect of silence while also exploring its meaning, as well as allowing the expression of therapist understanding and attunement to the patient.
**Overview of theory and practice considerations**

Given the outline above of some of the theoretical approaches to silence it would seem clear that the occurrence of silence in therapy is a multifaceted phenomenon potentially serving multiple functions for both patient and therapist. Silence can be seen as a two-way communication that occurs between therapist and patient without words. In this type of communication normal language structure may become redundant (Pugh, 1997) as the ‘language’ and meaning of silence is likely to be uniquely constructed between therapist and patient along ever-changing and fluid lines, possibly echoing a preverbal chaotic psychic structure (Blumenson, 1993).

Given that the potentially rich language of silence is interpersonally constructed in a unique way in therapy, the question then comes to mind not as to how the language of silence might be understood per se, which might be guided by theoretical approaches such as those outlined above, but as to how as therapists we might set the conditions for it to be spoken.

In essence the therapeutic relationship is the setting of any communication between patient and therapist. It is the container in which we meet the other, work in alliance and eventually from which we separate. The nature of the therapeutic relationship will impact on the types of communication that occur therein, and in-turn the outcome of such communications i.e. how they are received and responded to, will impact on the nature of the therapeutic relationship. Communication, whether verbal or silent, becomes intertwined with the relationship, and it has been reasonably suggested that without one the other ceases to exist (Laing, 1967). With this said there are a number of further points in relation to the facilitation and occurrence of silence in therapy that might be of value for therapists to consider with regard to the conduct of therapy and the therapeutic relationship.

In working with patients who communicate through silence therapists may have a range of reactions which are likely to reflect their experience of such patients (Pugh, 1997). It has been pointed out that patient silence can cause many emotions in therapists such as feelings of being put on the spot, discomfort, disempowerment, and extreme anxiety (Brown, 1987). Although such reactions might be more prevalent in less experienced therapists, silence as communication should alert all level of therapist to that being communicated. While different techniques, such as meta-
communication (Pugh, 1997) might be employed, in dealing with such silence, it has been suggested that therapists at this time need to pay particular attention to what they communicate to patients in the silence (Elson, 2001). It is argued that therapists need to convey an ability to tolerate silence, to ‘be with’ the patient (Coltart, 1991). That is they need to work through their own counter-transferential feelings and avail themselves to the patient’s silent communication, being comfortable within it (Rogers, 1951). In this, silence should not be seen as a passive stance but as an active role (Walker, 2001) in which the therapist’s ‘evenly hovering attention’ can absorb a myriad of non-verbal communications ranging from body language and facial expression to silent utterings and gestures in their immersion in the other (Kohut, 1988). In this active role a therapist’s own transferences might be reflected upon, asking what they might communicate about the patient and therapist and what the implications might be for the therapeutic relationship.

Furthermore, in considering the experience of patient silence, therapist’s need also to recognise how cultural and gender issues might influence patterns of communication. In the literature I reviewed in the course of preparing for this essay there was no mention of cultural or gender variables that might affect the employment of silence. While it would seem possible that patterns of communication might be influenced by such variables, and thus a potential avenue for future research, such considerations also raise the issue of how the power dynamic in therapy might influence types of communication. Given that language can be seen as a powerful tool in the construction of self in relation to the other, a construction that is likely to be socially influenced (Burr, 1995). The occurrence of silence may be precipitated by a shift in the ‘socially prescribed’ power structure. That is, a male patient may not wish to talk to a female therapist, a white patient to a black therapist. Although it is not my intention here to be prescriptive of interpersonal interactions, it would seem that therapist consideration of such dynamics would be fruitful in understanding and facilitating patient communication, whether silent or not, and ultimately lead to greater awareness of their potential impact on the therapeutic relationship.

**Conclusion**

The occurrence of silence in therapy is the occurrence of communication. Such communication may have a myriad of causes, meanings and purposes, all of which
are deserving of therapist attention in the exploration of a patient’s inner world. The manner of this exploration will undoubtedly impact on the therapeutic relationship, and it is the therapist’s skill with which they can work with and in silence, recognising its ‘language’, that is likely to not only anticipate the use of this communication style but also the nature of the therapeutic relationship. Furthermore, it has been suggested that for a strong verbal relationship to exist in therapy there needs to exist a correspondingly strong non-verbal one (Nacht, 1964). Ultimately the nature of the therapeutic relationship becomes the sounding tool through which therapists can monitor the impact of their strategies and thus inform their practice, and this would seem especially true with regard to the complex skill of communicating with silence.
References


In cognitive therapy, how would the therapist understand and work with difficulties that arise in the therapeutic relationship?

Illustrate with examples from your own practice.

When I first read the above essay title I thought “that seems simple enough”. I followed my usual steps of conducting a literature review, accumulating the material I deemed relevant, and planning time to pore through that which I had gathered in order to write an essay. However, when I started reading the literature on Cognitive Therapy and how it conceptualised the therapeutic relationship (literature I was familiar with to some degree from my doctoral placements and previous work experience) my initial thought of “that seems simple enough” began to dissipate. As I read it seemed increasingly apparent that there was some sort of schism in the portrayal of the therapeutic relationship in Cognitive Therapy. Some authors argued that Cognitive Therapy needed to refine its ideas as to the relational aspects of therapy and pay more importance to interpersonal factors in the therapeutic relationship (Safran, 1990), while others felt it necessary to ‘defend’ Cognitive Therapy from any accusations that it undervalued such factors or indeed the value of the therapeutic relationship itself (Gluhoski, 1994). While I recognise the power of interpretative difference between individuals, I was left pondering if such authors were in fact talking about the same Cognitive Therapy. Indeed I am often aware how the terms Cognitive Therapy and Cognitive-Behavioural Therapy are used interchangeably in a single context without any explanation, and at this point I was again conscious (an earlier piece of course work had drawn attention to this point) that Cognitive Therapy might not be as homogeneous a modality as often assumed. While I recognise the focus of this essay is not on teasing out the array of differing perspectives as to how Cognitive Therapy might be encountered and understood, I do feel that some recognition of such difference is necessary if the Cognitive Therapy from the perspective of this essay is to be adequately operationalised.

A brief history of Cognitive Therapy and the therapeutic relationship
While its roots can be traced back to Greek Stoic philosophy, Aaron Beck is generally attributed as the founding father of what has come to be called Cognitive Therapy, a
theory of personality which argues that one’s thoughts largely determine how one feels and behaves (Beck et al., 1979). Beck’s earlier work emphasised Cognitive Therapy as “a collaborative enterprise between the patient and the therapist to explore dysfunctional interpretations and try to modify them when the therapist finds them unrealistic or unreasonable” (Beck & Weishaar, 1989, p.286). In this context phrases such as collaborative empiricism and guided discovery were coined to epitomise an active therapeutic relationship that while recognising the importance of the general therapeutic characteristics of warmth, accurate empathy and genuineness, did not hold that they were sufficient in themselves for “optimal therapeutic effect” (Beck et al., 1979, p.45). Instead it was the amalgamation of such therapist qualities with clearly evidenced and rational therapeutic technique, as applied through the skill of the therapist, that produced optimal change. The therapist’s role was one of assessor of distress and clarifier of goals; guide to and organiser of thoughts; as well as provider of ‘reason’ and promoter of ‘corrective’ experiences (Beck & Weishaar, 1989), all conducted, with appropriate regard to client ‘collaboration’, in an air of confidence and a certainty of approach derived from a secure modernist context.

The growth of postmodernist ideas in the last decades of the twentieth-century was profound. As I went through my teens and early twenties I was warned against writers such as Will Self who promoted an ‘anything goes’ attitude and the Turner Prize was contemptuously denigrated by the ‘powers-that-be’ as vulgar low art and a sign of an increasingly amoral and depraved society... how could Elephant dung be art? I was hooked! As constructivist conceptions slowly infused into the more ‘receptive’ quarters of society, including that of psychotherapy, personhood was increasingly discussed as a transient, moment-by-moment narrative through which we could define ourselves in relation to others (Burr, 1995), and in this context Cognitive Therapy changed, or at least some of its practitioners did. While at this point one could explode into the compatibility of postmodern conceptualisations of the person with any one of the multiple therapeutic understandings of ‘the self’ (Gergen, 2002), including that of Cognitive Therapy, I particularly like Caro’s (2004) diplomatic return to the clinical context stating a simple ‘truism’, “therapists face a human who changes but maintains some degree of consistency” (Caro, 2004). In its staggering simplicity I find I can amalgamate my ‘postmodern’ leanings with my sympathies for Cognitive Therapy’s conceptualisation of ‘the self’ as an information processor.

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interpreting events and creating meanings (Beck & Weishaar, 1989). Cognitive Therapy in this context does not offer a rational guide to the discovery of reality, after all there is no reality, rather an opportunity to disrupt and manipulate meanings, interpretations, and beliefs according to a client's subtexts, not the therapist's (i.e. "when the therapist finds them unrealistic or unreasonable", Beck & Weishaar, 1989, p.286), as in the modernist orientation. With this said the therapeutic relationship is not entirely different from that previous; warmth, respect, empathy are all therapeutic qualities still recognised (Overholser & Silverman, 1998). However, the need for therapist flexibility and collaboration in generating and understanding a client's narratives from the client's perspective is more acutely recognised from an egalitarian power perspective (Caro, 2004), and the interpersonal characteristics of the relationship receive greater emphasis (Rudd & Joiner, 1997).

Given a recognition of this brief history, my original ponderings as to the homogeneity of Cognitive Therapy seems understandable. While I have painted a rather abrupt and clumsy caricature of the modernist and postmodernist orientations (in actuality boundaries of thought are often far less delineated), I feel the schism I noticed between authors whilst reading for this essay might in some way reflect their various perspectives and orientations with this regard, a point also evidenced by Caro (2004). Furthermore, the fact that such authors use the same language (that passed down from Cognitive Therapy's initial conceptualisations) such as that of 'collaboration', but attach different meanings according to their conceptual underpinnings, only serves to confuse an already complex relationship between language and meaning (Burr, 1995).

With no intention of being obtuse, if Cognitive Therapy cannot be seen as homogeneous, rather reliant on the perspective taken by individual practitioners (within certain bounds of course), then one can only own one's own perspective. As the essay question asks for illustrations from my own practice, the remainder of this essay will focus on how I understand and work with difficulties that arise in the therapeutic relationship from my own experience as a practitioner of Cognitive Therapy. With this said it is not my intention to launch into some relativistic discourse in which all arguments and practices are equally valid. Rather, I aim to
ground my conceptualisations and practice discussions within clear theoretical guidelines taken from the broad discourse of Cognitive Therapy.

**Difficulties in the therapeutic relationship – understanding and working with**

In his earlier work Aaron Beck suggested that the development and maintenance of a good therapeutic relationship was grounded in trust, rapport and collaboration between client and therapist. If any one of these components was lacking then therapeutic effect was likely to be inhibited (Beck et al., 1979). The relationship was seen as an interactional process between client and therapist, breakdown in which could be attributed to one or other party (or indeed both). However, in his later work Beck also seemed to give greater credence to a third influence, that of the environment, at play in the interactional process, which could mitigate relationship difficulties and ruptures (Beck et al., 1993). It is my intention to use such perspectives to frame the discussion that follows.

**Difficulties with trust**

From a client’s perspective the establishment of trust in a therapist and indeed a therapeutic process is likely to take some time. Clients are likely to want to ‘test the water’, check out boundaries, and gather a sense of the therapist in whom they are ‘expected’ to confide. In fact the piecemeal development of trust can be seen as an adaptive process, the client who is immediately forthcoming with trust might set the therapist wondering as to the nature of other interpersonal contacts and their potential implications. With this said the therapist has the task of establishing an atmosphere in which a client’s trust might develop. Beck et al. (1979, 1993) stress how a therapist’s display of professionalism, honesty and well-meaning action, as well as commitment to the client is paramount if trust in the therapist is to be established. Difficulties in the establishment of trust could then be seen as residing in either a client’s cognitive or interpersonal features (severely depressed clients may have the belief that they are so unlovable that no one can genuinely commit to them (Beck & Weishaar, 1989)), or a therapist’s ability to facilitate an appropriately trusting atmosphere; both elements which a competent cognitive therapist would be expected to be able to work with examining both the client’s and their own ‘rupturing’ thought processes and behaviours (Bannan & Malone, 2002; J. Beck, 1995). However, from my own
practice I can directly relate to the third influence, that of the environment, in the development of trust in the therapeutic relationship.

For some time now I have been on placement in a substance misuse service. Clients are generally referred to me by their substance misuse keyworkers due to problems with ‘compliance’ with a methadone maintenance/reduction programme. My role as ‘Psychologist’ (in training) is to assess the difficulties they may be having with such a programme and work with them in the development of strategies and cognitive operations that might help them achieve their stated service aim of substance control and/or withdrawal. In this environment the establishment of trust can be particularly difficult. In my experience clients have seen therapy as something they have to ‘pass through’ rather than ‘engage in’ as they have rarely initiated their referral themselves. They have seen me as part of ‘the system’ making numerous assumptions about my motives and likely reactions and/or judgements as to their ‘criminal activities’ (indeed early into the placement a number of my own beliefs and assumptions about working with this population did indeed need to be examined). Furthermore, many of my clients are ‘old hands’ in such services, they have seen keyworkers and therapists come and go, why should they ‘invest’ in me? How then do I work with such potential obstacles? In truth it’s not as hard as it might seem. How I see it is, it’s not ultimately what I do that instils trust but how I am. I do not sense that I have to balance the competing forces of client autonomy against the need for structure; my dependability and responsiveness against the need to set limits; and my being ‘real’ against my being ‘objective’ (Beck et al., 1979), all these make sense to me, but at some implicit level of technique. Rather I see my genuineness as a competently ‘flawed’ therapist; my ability to work (without judgement), both between and within my own and the client’s cognitive conceptualisations of their material; and my commitment to respecting a client’s narrative even if we might be engaged in a joint process of exploring possible alternative narratives (Biever, et al., 1998), as the key ingredients to establishing both trust in me and the process of therapy. While I have found my ambitions towards such an approach reap positive returns in my current placement, I also find it is completely compatible with Beck et al.’s later conceptualisations of trust building (Beck et al., 1993, p.63).
Difficulties with rapport

Beck says of rapport:

"The term *rapport*, in general, refers to harmonious accord between people. In the therapeutic relationship, rapport consists of a combination of emotional and intellectual components. When this type of relationship is established, the patient perceives the therapist as someone (a) who is tuned in to his feelings and attitudes, (b) who is sympathetic, empathetic, and understanding, (c) who is accepting of him with all his "faults", (d) with whom he can communicate without having to spell out his feelings and attitudes in detail or to qualify what he says. When rapport is optimal, the patient and therapist feel secure and reasonably comfortable with each other. Neither is defensive, overly cautious, tentative, or inhibited" (Beck *et al.*, 1979, p.51).

While our discussion on the establishment of trust would seem of direct relevance to many of the components for the establishment of rapport, indeed one might argue there can be no true rapport without trust, it is the interpersonal quality of Beck’s conceptualisation that most strikes me. Problems with establishing rapport in therapy could in many ways be seen as reflecting the interpersonal patterns of clients (and indeed therapists) outside of the therapeutic context. Clients may be prone to negative interpersonal evaluations; cognitive distortions of and selective attention to the language and ‘meanings’ of others; as well as more pervasive cognitive interpersonal ‘deficits’ leading to ‘maladaptive’ interpersonal behaviour (Beck & Weishaar, 1989). While all such features could be seen as suitable for open and reflective cognitive evaluation within a warm and respectful therapeutic atmosphere (Beck *et al.* 1979; Beck *et al.* 1993), my own experience has informed me of how particular attention needs to be paid to ‘counter-transferential’ reactions in rapport ‘building’.

At times I find working with people who abuse substances, say they want to stop, but don’t, incredibly frustrating. My own cognitive patterns allow me, for good or bad, a relatively clear framework from which behavioural options are evaluated and decisions subsequently made. I am generally clear of purpose and quite determined (I think one has to be to set about and complete a doctorate). The frustration I can feel when in a room with a client who has completed an advantages/disadvantages
analysis highlighting the overwhelming disadvantages as to continued substance use; recognises the 'dire' health implications of continued abuse; but 'scored' at the weekend acting on the thought "one won't hurt", leaves me open to numerous negative reactions regarding my abilities and the use/'waste' of my time (interestingly not my client's). In working with such feelings, which could have obvious consequences for the establishment of any true rapport, I have found their overt recognition in supervision (as well as by others in the literature e.g. Overholser & Silverman, 1998) both helpful and reassuring. Furthermore, through supervision I have learnt the use of a simple adjustment in focus. As I become aware of my frustrations I allow my 'internal supervisor' to gently direct me away from a client's presenting automatic thoughts, which might be triggering frustration, towards an acknowledgment of their underlying belief systems. It is through the narrative of such belief systems (obviously previously encountered at some level with clients), be them of unloveliability or worthlessness, dysfunctionality or inadequacy, that I find a place in which I can resonate, empathise with and receive a client's immediate narrative and try to make 'meaning' from it, from their perspective, within the interpersonal space that Beck describes as rapport (Beck et al., 1979).

Difficulties with collaboration
Of central importance to any cognitive conceptualisation of the therapeutic relationship is the idea of client and therapist collaboration. Like trust and rapport, Beck et al. (1979) did not see collaboration as a therapeutic given, rather as something that has to be built and maintained, taking into account a client's individual features which are likely to influence how this is best undertaken. While we have already drawn attention to how collaboration might be seen differently by modernist and postmodernist practitioners, I feel in many ways both are likely to face certain similar difficulties in establishing a collaborative relationship. Cognitive therapy is an 'active' therapy, both clients and therapists need to engage in the elicitation of the 'raw' therapeutic material; be ready to manipulate and investigate such material; and play an active role in the exploration and development of meanings (Beck & Weishaar, 1989; Biever et al., 1998). However, such activity may not always be easy to generate.
In both my current placement and previous experience I have found that the development of an active/collaborative relationship poses numerous challenges. I often find clients’ beliefs about psychotherapy need immediate attention. While the literature recognises that clients require ‘education’ as to the nature and procedures of Cognitive Therapy (Beck et al., 1993), I have found it can take a number of sessions before I feel clients truly ‘taste’ what I’m getting at, and even then if I ask them to think of a cognitive conceptualisation for their material they sometimes recoil at the thought. I have learnt that in many ways ‘education’ is best achieved through *doing therapy*, then together reflecting on the learning gained, and that this is an ongoing process throughout therapy. While I see such an orientation as completely in line with that of Beck et al. (1979; 1993), I find that such an approach works best when geared to a client’s pace rather than to my ‘therapeutic timetable’. With such ‘gearing’ I find any beliefs that clients might hold that I am ‘the expert’, in the presence of whom they are best to stay cognitively passive, can be experientially dispelled, and their participation is enhanced.

The setting up and conduct of cognitive and behavioural experiments in and out (homework) of sessions is seen as integral to an atmosphere of collaboration (Beck et al., 1979), and much attention has been given to explorations as to why clients ‘don’t do their homework’ (Marsh, 1997). From my experience a major difficulty clients often have (at least initially) is seeing what goes on in therapy as relevant to their lives out of therapy. It is only when the two worlds collide and clients become ‘thirsty’ to explore the connections further that I sense they are truly engaged in the therapeutic process. Bringing these worlds together is not simple and while technical suggestions as to increasing a client’s involvement in the formulation and evaluation of the homework task are important to bear in mind (Beck et al., 1979), in my practice I find what is fundamental is to get the client interested in themselves. I’m a Psychologist (in training), I chose this path because I am interested in how humans ‘work’, why should we assume this of clients! I find getting clients interested in themselves at a psychological level the key to developing active collaboration and indeed in many ways the key to therapy itself. While I can suggest no formula for the generation of such interest (though the ‘transference’ of my own enthusiasm for a client’s material can often set the foundations), without becoming too animated, I feel that if a client is suitably interested in themselves, and is reasonably confident that
their therapist is also suitably interested in them, then trust, rapport and collaboration, all vital elements of the therapeutic relationship (Beck et al., 1979), are off to a good start. Furthermore, as therapy continues and difficulties in the therapeutic relationship are encountered, if such interest can be maintained and used to reflect on such difficulties (be them located in the client, therapist or the environment) then ruptures might more easily be ‘repaired’ in the knowledge that both client and therapist are engaged in a joint therapeutic process of discovering more viable ways of ‘knowing’ (Caro, 2004), a process likely to impact profoundly on them both.

**Conclusion**

In many ways this essay did not turn out as I originally expected. The narrative both espoused from and developed my thought. While it was my intention to ‘own’ and speak from my own perspective as a practitioner of Cognitive Therapy, on numerous occasions my narrative left me questioning my authority as a trainee to speak ‘my thoughts’, especially when contrasted to the ‘expert’ of all ‘experts’ Aaron Beck! Indeed, writing in such a way has raised one profound question in me, what are my own thoughts? As Newton recognised he ‘stood on the shoulders of giants’ (and I do not in any way mean to compare myself to Newton!), so I must recognise that in ‘owning my own perspective’ I do not in any way suggest that it is an original (nor superior) perspective. While I have made every attempt to reference the material ‘used’ in this essay, I recognise that my train of thought is likely to have had numerous influences, at both conscious and unconscious levels, that I make no mention of.
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Therapeutic Practice Dossier
Description of Clinical Placements

First Year Placement – Primary Care (January 2003 - August 2003)

My first year placement was in a primary care setting (General Practice surgery) situated in an urban area of London, part of a Primary Care Trust. The large GP service, set in a new purpose built premises, provided access to an in house Psychological Therapies service available to adult individuals (and occasionally couples/families), who had been referred by their GPs, due to a variety of presenting difficulties. These difficulties included: depression, anxiety, problems with interpersonal functioning, low self-esteem and difficulties managing anger. Clients came from a mix of social, economic and ethnic backgrounds, though there were a large number of young families with small children in the GP service's catchment area and less than 10% of its client population was older than 65 years of age.

The psychology team, which comprised of three Chartered Psychologists as well as myself, was supported by a full-time Medical Secretary who was available for appointment scheduling as well as administrative and typing support.

Following referral, clients were seen for assessment, and if deemed suitable for treatment within the remit of the Psychological Therapies service, they were then placed on a therapies waiting list of approximately 2-3 months duration. As a trainee I was responsible for the conduct of assessments and the management of my own client caseload.

While the orientation of the Psychological Therapies service was towards Cognitive Behavioural Therapy (CBT), my supervisor endorsed a Cognitive-Behavioural/Humanistic approach to client work and encouraged my efforts to integrate such modalities. With this regard I was responsible for contracting up to 18 sessions with clients, discussing and developing my rational for a particular therapeutic approach in weekly supervision sessions.
Second Year Placement – Secondary care (September 2003 - July 2004)

In my second year of training I worked as part of a Psychological Therapies service providing psychological input for a large locality Community Mental Health Team (CMHT), which had a catchment area covering parts of London. The CMHT had nearly 30 members (though not all were required to attend the weekly Multidisciplinary Clinical Team Meetings) including: Psychiatrists, Care Managers, Community Psychiatric Nurses, an Occupational Therapist and a Housing Liaison Officer, Support Workers, Chartered Psychologists and a Team Manager (Social Worker).

The CMHT served a large and diverse population from a mix of social, economic and ethnic backgrounds (18.3% were from ethnic minorities). This population also consisted of a large number of asylum seekers who had special needs including the provision of interpreters and appropriate liaison with government agencies. The Psychological Therapies service received referrals from the CMHT as well as GPs within the CMHT’s catchment area. Referrals were varied in nature often relating to the more severe and enduring difficulties associated with anxiety, depression, self-harm and suicidal intention, interpersonal problems and personality disorders.

Whilst on placement I was responsible for scheduling my own appointments with clients and ensuring an appropriate consultation room was booked. Despite access to secretarial support such support was stretched across a number of disciplines and I choose to do my own typing and administration.

The placement had a psychodynamic orientation and I was encouraged to contract, with suitable clients, weekly sessions for the duration of my placement. I had weekly supervision in which I presented verbatim extracts from client sessions for exploration and review with my psychodynamic supervisor. These meetings provided a rich and often intense learning environment in which I felt both supported and challenged, both in terms of my therapeutic reasoning and my self-insight.
In my third year of training I was on a split placement working as part of the Psychological Therapy provision for both a specialist Alcohol Treatment Service and a specialist Substance Misuse Service within the same large NHS Mental Health Trust with a catchment area covering parts of London. The Psychological Therapy provision within both teams had a Cognitive-Behavioural orientation, and while this was partly aimed at assisting clients with a variety of issues underlying their substance misuse or alcohol dependency, clients were often referred due to motivational issues relating to their engagement with substance/alcohol reduction programmes setup by their keyworkers.

The Alcohol Treatment Service
The Alcohol Treatment Team had 10 members including a Consultant Psychiatrist and a Senior House Officer, Nurse Specialist Alcohol Keyworkers, Occupational Therapists, Chartered Psychologists and one Team Manager (Nurse Specialist). The team was situated in premises which were previously part of a hospital and had been converted to provide suitable office space, filing areas and consultation rooms. As part of the Mental Health Trust the Alcohol Treatment Service served a large and diverse population from a mix of social, economic and ethnic backgrounds, as well as a large transient homeless population.

Substance Misuse Service
The Substance Misuse Treatment Team had 14 members including a Consultant Psychiatrist and Specialist Registrars, Nurse Specialist Substance Misuse Keyworkers, an Occupational Therapist, Pharmacists, a Chartered Psychologist and a Team Manager (Nurse Specialist). The team was situated in temporary premises which had been refurbished to provide suitable office space, filing areas and consultation rooms. Again as part of the Mental Health Trust the Substance Misuse Treatment Service served a large and diverse population from a mix of social, economic and ethnic backgrounds, as well as a large transient homeless population.

Whilst on placement I was responsible for managing my own client caseload and despite its Cognitive-Behavioural orientation the service was flexible as to client contract duration recognising the difficulties with this often dually diagnosed client
group. While my supervisor initially encouraged a ‘purist’ CBT approach to client work, as the placement developed he supported me in adopting a more integrative stance to my therapeutic approach, the orientation he himself took, supervision providing a valuable learning arena with this regard.

**Other Professional Activities**

During my first placement I liaised with my supervisor, the General Practice Manager and the IT department in developing protocols for more reliable and accurate documentation of DNA’s for the Psychological Therapies service. It was hoped that through better access to information on DNA levels these levels might be reduced (a service wide initiative) through the implementation of a number of strategies. These strategies eventually included requests for at least 24hr notice prior to appointment cancellation (to deter ‘sunny day’ absenteeism) and notices on patient notice-boards stating DNA levels and the implications for practice resources. I left the service prior to any audit/assessment of the impact of these strategies.
Final Clinical Paper: How I approach the integration of theory, research and practice.

As will be apparent from the title the aim of this essay is to give you an idea of how I approach the integration of theory and research into my clinical practice. In setting about this task I have come to realise how the task itself has both informed and modified my thinking and in many ways I view what follows as an opening communication about my current position rather than a conclusive or definitive stance on it. Before I begin I would like to acknowledge a couple of things. First, my language, I will endeavour to convey my ideas in my own language though as is protocol I will make numerous reference to the ideas and language of others. As much as possible I will try to contextualise such references to show how I understand them but given the space constraints I may assume a level of knowledge in you the reader that might mitigate a certain brevity. Second, I acknowledge that you are part of my story, that is, I don’t see this paper as simply an academic course requirement, a hurdle to be jumped or felled, it is a communication to you. I have constructed you in my mind, you are a qualified experienced psychologist, you are my judge/examiner, you have ‘power’ over me which has influenced how I convey to you. I have been second guessing your response and editing my narrative accordingly. You have been part of my battle between conformity and creativity, and while it has provoked an anxiety in me as to how I might be received, I have tried throughout to convey myself in a true and honest way. I believe this will give you a better sense of me; of how I am as a person; of how it might be being with me as a Counselling Psychologist; and ultimately a more natural position from which to have a discussion should we meet.

Coming to Counselling Psychology

In February 2001 I was involved in a road traffic accident, my leg was in plaster for six weeks and I was ‘bed bound’ for three. I had been receiving The Psychologist since graduating a conversion diploma in Psychology five years earlier, I rarely read it. During my recuperation I flicked through some articles and saw an advert for the Surrey course in Psychotherapeutic and Counselling Psychology, I hadn’t heard of it. Clinical Psychology was the mainstay of my employment setting through which I
was preparing to enrol on a PhD in Medical Research Methods. I sent off for an information pack and on reading it I decided to change my career path.

Counselling Psychology has been defined as “the application of psychological knowledge to the practice of counselling” (Woolfe, 1996, p.4), while I consider this to be generally accurate, if rather brief, I prefer the words of Clarkson (1998, p.xv):

“I think of the discipline of counselling psychology as the professional application of the integration of psychological research and supervised practice in the amelioration of distress and the improvement of quality of life for individuals, groups, families and organisations within the relevant historical and cultural contexts”.

Firstly, I really like the bit about “the amelioration of distress and the improvement of quality of life”. My mother was a social worker and my father a policeman. I have an engrained sense of the ‘helping’ qualities of being human. Finding a profession where such qualities are explicitly recognised through its humanistic value base and emphasis on the interpersonal nature of being (Woolfe, 1996) is affirming of both my personal and family philosophy. I also like the stance of “the professional application of the integration of psychological research and supervised practice”. While much of this paper is concerned with this aspect I feel it is important to highlight that the blend between research and practice holds special sway for me. Prior to this course I worked for several years as a Rehabilitation Assistant at a Transitional Living Unit for people with acquired head injury. Alongside this I complete a Masters degree in Clinical Neuroscience. The mix of academic study, client contact and my interest in the furtherance of knowledge through research was most rewarding. I enjoy research and I enjoy client contact, Applied Psychology such as Counselling Psychology with its acknowledgement of the scientist-practitioner model (though caveats for this will be discussed later) allows for both, it fits with me. The final thing I like about Clarkson’s description is “within the relevant historical and cultural contexts”. My first degree was in Social Science, the individual as I see it can never be taken out of their circumstance. I could be classified as white, middleclass, educated and male, though such categories make little sense to my everyday lived experience, others may use them to assess my opinions, my shopping/voting habits or even my value. The
explicit recognition of such components in the phenomenological ‘ethos’ of Counselling Psychology, as well as, what I sense to be a growing appreciation of social-constructionist conceptions within the field, has made my continual ‘becoming’ (in the word of Bion (1975)) as a Counselling Psychologist, a profound process of fulfilment as well as one of labour.

The word that most sticks out for me in Clarkson’s description is “integration”, whilst she highlights the integration of psychological research and supervised practice, I also find myself drawn to Fear and Woolfe’s (1996; 2000) emphasis on the integration of the professional and personal self. I see the concept of integration as one which explicitly takes into consideration aspects of the ‘self’. The ‘self’ as I see it is the component part through which integration is made possible. While there is no scope in this paper to expand my conception on the ‘self’, suffice it to say that I believe humans to be ‘constructors’ of internal models of the world (Kelly, 1955) and that such construction occurs through relationship at intra-psychic (between internal-objects); inter-personal and societal levels. Once the ‘self’ is recognised as the point of integration in this manner then a number of acknowledgements need to be made. First, as all people are unique so will be all integration. Second, integration becomes a process of being, unavoidable, it is therefore how one engages with that process that ‘determines’ ones outcome. Third, awareness of ‘self’ and one’s process becomes ‘the holy grail’. Counselling Psychology’s fundamental recognition of this through the value it attaches to the ‘use of self’ and self-reflection, for me is the thing that has driven me to embrace the profession so wholly. I agree with Duffy (1990) here, he argues that it is not what Counselling Psychologists do that makes them different from other related professionals (and I do not mean better) but how they are. If you like it is a way of being with your ‘self’ in the world.

With this said it is my way of being, at this place in time, as the point of integration of my experience of theory, research and practice that I want to get across to you in this paper. This is no small task and I have struggled with finding an appropriate structure for the past few weeks. I have a tendency to try to do too much (an insight gained from my personal therapy) and at times it can be tiring managing my enthusiasm to show you what ‘I know’. I have decided on a thematic structure rather than one tied into my ‘linear’ development. In essence I will try to give you a taste of how I work
and think about my work now, contextualising this in how I have come to this position. Throughout I will make reference to clinical examples and you should note that as this will be a public document forming part of my portfolio all identifiable information on clients has been changed.

**Ethical practice**

Throughout my training and in previous employment I believe I have operated within a clear ethical framework. While this framework could be seen as part of my Judaeo-Christian heritage, I feel the Professional Practice Guidelines for the Division of Counselling Psychology (British Psychological Society, 2001) have given me a practical yardstick with which to measure my conduct. The most significant elements for me during my training are outlined below.

**Competence**

While I acknowledge that practitioners should not practice beyond their competence, I am aware of how as a trainee I have often developed my competence through practice. That is, as a necessary part of training (and advisably beyond) one could be seen as operating on the fine edge between pushing ones own competence and working within it. When I have recognised that I might be getting too close to this edge (often triggered by an internal disquiet, feelings of anxiety, or sense of being on insecure ground) I have sought guidance. I have no problem in asking for assistance and regard myself as appropriately 'un-self-sufficient' (a stance my personal therapy has helped me internalise, recognising my own relational ways of being). Early in my first year, as my first supervisor and I discussed my previous experience and the 'type' of client she thought it would be appropriate for me to start with I was able to reflect on my own need for a gradual beginning. Feeling 'thrown in at the deep end' as others in my cohort reported, was not something I wanted to experience. In expressing this I was anxious that it would be received that I was not up to scratch, that I was stand-back-ish, it wasn’t. My supervisor acknowledged and validated my feelings, she buffered me from the service demands of a long waiting list and supported my gradual growth in competence and confidence as my knowledge and skill base advanced through the course training and my engagement with theoretical and research literature relevant to my clients. I raise this point because I feel this experience has allowed me to acknowledge my limits more freely, both to myself and
others, and as a consequence I have been better placed to engage in the training experience, feeling comfortable with my growing ‘conscious competence’ (Clarkson, 1996).

Respect for autonomy
Which ever perspective I have found my client work orientating from, be it Humanistic, Psychodynamic or Cognitive-Behavioural, I have always been aware that a core value of my practice has been the primacy of a client’s autonomy. I do not seek to tell clients what to do, nor what not to do. Rather, I seek to understand a client’s perspective, what has led them to their situation and what they want to change about it. It is their aspirations that determine how I am with them not mine. Of course I may engage in operations aimed at clarifying a client’s aspirations, for instance the procedures and ethos of Motivational Interviewing (Miller & Rollnick, 2002) have been helpful with my current client group (in a substance misuse service) in getting to a shared point of understanding their desire to change. I feel it is through a sharing of perspectives that clients are better able to make decisions for themselves, and I see it as in my nature to respect those decisions even if they seem erroneous to me. I also recognise that through being part of this ‘sharing’ process I have learnt much about my own experiences and ways of being, therapy is a two-way process.

Professional and societal obligations
As a trainee Counselling Psychologist I believe my conduct is an important communication to other professionals about the profession I have chosen. In both my first and second year placements I was acutely aware of the power imbalance between Clinical and Counselling Psychology, while this may be bemoaned as unjust, I believe it is only through demonstrating one’s own professionalism and engaging with other professionals (if you like ‘educating’ them as to what I do, how I think and why) that I feel the profession I have chosen will receive the recognition it deserves in health and other settings. I believe the profession (a function of the professionals contained therein) has an obligation to promote itself as a valuable entity throughout all service contexts, and to recognise its potential value at a more macro socio-political level. While this may take some time given its relative ‘infancy’, I believe the current process of change it is undergoing will aid its development.
Theoretical integration

As mentioned earlier I believe the elements of theory, research and practice are integrated through one’s ‘self’ creating the unique blend of how one interfaces and exists in the world as a Counselling Psychologist. However, within this framework another type of integration has to be acknowledged, that of theoretical integration, and it is to how I approach this that I now turn.

Why integrate?

Learning the fundamentals of three theoretical paradigms was one of the attractions of the Surrey course. It seemed intuitive to me to have multiple viewpoints from which one might work depending on a client’s needs/presentation, and the lack of evidence for the application of a single approach across client presentations (Norcross & Goldfried, 1992) seems a strong case for eclectic/integrative approaches which are growing in evidential base (Clarkson, 1996). While I feel the eclecticism versus integration debate is rather academic and not one I wish to enter into here, given my broader views on integration it is probably not entirely surprising that I have been drawn to describe my practice in a more ‘integrative’ manner, though in truth this may at times have a certain ‘eclectic’ feel to me.

How to integrate?

The question then becomes one of how one goes about integration. Clarkson (1996) has identified numerous routes towards integrating theory and in recent years there has been a proliferation of models of integration (O’Brien & Houston, 2000). While debate continues as to the relative merits of different classifications of integrative models: technical eclecticism; common factors; and theoretical integration ‘proper’ (Arkowitz, 1989; Castonguay & Goldfried, 1994), and indeed whether such classifications are at all valid (Hollanders, 2000), as mentioned above it is not my aim to join the debate. Instead I wish to give you a picture of how I work (as a developing practitioner) with differing theoretical models both in thought and in practice. I feel that such an approach will give you a better grasp of me in actuality rather than an espoused academic construction of my orientation.
How I integrate theory in practice – Humanistic/Cognitive-Behavioural traditions

The first theoretical tradition to which I was formally introduced, and one that has had a profound impact on my thinking and practice, was the Humanistic tradition, most notable the work of Carl Rogers (while there is no scope in this essay to outline the features of each tradition, and I assume you are familiar with them, I will endeavour to draw out those aspects that have been most relevant for me in my practice development). Rogers (1951; 1957) recognition of the primacy of empathic understanding, therapist congruence and unconditional positive regard for the client (three of the six ‘core conditions’ Rogers felt necessary and sufficient for therapeutic change to occur) in the development of any therapeutic relationship offered a valuable base from which I started to conceptualise my practice. Given that my first year placement supervisor, working in a primary care setting, endorsed a Cognitive-Behavioural/Humanistic orientation, I was immediately thrown into the complexities of integration. Cognitive-Behavioural approaches (which I recognise to be heterogeneous) whilst recognising Roger’s ‘core conditions’ generally stand in contrast suggesting such conditions are not sufficient in themselves for therapeutic change (Gelso & Carter, 1994). They argue that the application of technique such as behavioural modification strategies or cognitive restructuring strategies is optimal in the facilitation of change (Beck et al., 1979). Indeed it was the potential conflict between ‘being’ and ‘doing’ aspects of therapy that occupied much of my thought at this time and partly informed the focus of my first year Theoretical Models of Therapy Essay (seen earlier in this portfolio). For me the point through which I came to integrate Humanistic and Cognitive-Behavioural conceptualisations (and the one to which I have found myself returning throughout the course both in practice and academic work) was in my reading of the following passage by Beck et al. (1979) on the importance of rapport to the therapeutic relationship:

“The term rapport, in general, refers to harmonious accord between people. In the therapeutic relationship, rapport consists of a combination of emotional and intellectual components. When this type of relationship is established, the patient perceives the therapist as someone (a) who is tuned in to his feelings and attitudes, (b) who is sympathetic, empathetic, and understanding, (c) who is accepting of him with all his “faults”, (d) with whom he can communicate without having to spell out his feelings and attitudes in detail or to qualify
what he says. When rapport is optimal, the patient and therapist feel secure and reasonably comfortable with each other. Neither is defensive, overly cautious, tentative, or inhibited” (Beck et al., 1979, p.51).

For me these words allow for a theoretical/practice based alignment between Cognitive-Behavioural approaches and Rogerian core conditions with regard to the centrality of the therapeutic relationship. Cognitive-Behavioural approaches then lose their cold technical veneer (unless applied in that manner) as often portrayed (Keijsers et al., 2000), and allow for a more integrative stance. My stance is simple, while the therapeutic relationship (with an emphasis on rapport building through attention to the ‘core conditions’) is fundamental, for some clients this will in itself be the primary vehicle for change while for others change, in accordance with their aspirations, might best be facilitated through application of additional ‘technique’. ‘Being with’ is essential while the ‘doing’ aspects of therapy is a function of client need. How this might translate into practice can best be illustrated by example.

In my first year I worked with Ms A, a single parent in her twenties referred to the primary care Psychology Service by her GP due to bouts of depression since a relationship breakdown some years earlier. While my initial focus was to engage Ms A in the therapeutic relationship, during our early sessions I came to believe her predominant attention to how she thought about her feelings of depression indicated a more cognitive element to her internal world and to her therapy. It seemed Ms A was stuck in a number of ‘distorted’ aspects of her self-worth due to the interpretations she made of a past relationship breakdown. It appeared her thinking style made her prone to negative evaluations of her abilities and to consequent feelings of failure and depression. In this presentation the employment of Cognitive-Behavioural techniques, aimed at thought evaluation and the exploration of the meaning/interpretations Ms A ascribed to her relationship breakdown, seemed particularly relevant. However, the ‘application’ of such techniques was not straightforward. Though my supervisor had ‘modelled’ some examples of the cognitive techniques ascribed to in Judith Beck’s (1995) book Cognitive Therapy: Basics and Beyond, I found the way such techniques interfaced with Ms A problematic. She didn’t do her homework! Ms A seemed happy to work with her cognitions in the therapeutic context but out of therapy, in real life settings, she didn’t complete ‘thought records’ as she was “too busy” or “forgot”.
While this had me musing on Ms A’s resistance and motivation to change as well as my own frustrations in supervision, it was primarily through a colleague in group supervision that I decided to, in his words, “return to basics”. I went back to the therapeutic relationship, I asked myself what had I not heard, I ‘returned’ to unconditional positive regard (it had ebbed slightly due to Ms A’s ‘non-compliance’) and listened with a more empathic ear. I then heard her speaking from what I understand currently, after a year’s psychodynamic supervision, as a transferential position, but then saw as a manifestation/repetition of her core-belief of failure, the homework allowing for this. If I knew then what I have come to ‘know’ now I would have probably focused more on transferential aspects of our relationship, I didn’t. With guidance from my supervisor I went back to the core conditions and ‘shored-up’ the therapeutic relationship, I emphasised the creation of a secure relationship feeling that it was Ms A’s uncertainty/insecurity in relation to me that was causing her ‘resistance’ to homework. Again I can now recognise how I came to this stance partly through my own ‘counter-transferential’ feelings of uncertainty regarding my abilities as a first year trainee. It seems to me that while such feelings were explicitly acknowledged in supervision at the time, their impact has only really become apparent to me through aspects of my later training and experience, thus leaving a gap between how I thought then and why, and how I think now and why (I have decided in this essay to acknowledge this gap rather than try to bridge it, the later seeming rather fabricated). In the secure relationship I had placed greater emphasis on building I found the qualities of congruence and genuineness key facets to understanding Ms A’s world view. It seemed to me and my supervisor that in our stronger relationship aspects of CBT could be integrated at Ms A’s pace, with due regard to her need to be accepted and valued. This was how therapy progressed with some sessions orientating to Ms A’s expression of her current feelings while others orientated more to her cognitions and thinking patterns. As Ms A changed from week-to-week in relation to her material so did the therapy, it was flexible and responsive. On ending Ms A reported feeling less prone to bouts of depression and better able to cope when such feelings emerged due to the insights/techniques she had gained/learnt. Furthermore, her pre/post therapy Beck Depression Inventory II score (used by the service as an outcome measure) had dropped significantly.
While I have tried to highlight how I might approach Ms A’s presentation differently given my later training/experiences, I feel her ‘case’ allows for a taste of how I might approach the integration of Humanistic/Cognitive-Behavioural traditions to this day, through a client’s presentation.

Within Psychodynamic traditions
From this early integrative experience my second year was more purist. I was on placement in a Community Mental Health Team (CMHT) and while my supervisor expected me to work from a solely psychodynamic tradition she did encourage a more active therapeutic stance in line with brief therapy models (Mander, 2000). While this stance gave me the opportunity to integrate theoretically within the psychodynamic tradition, I found myself mainly working from a deficit/relational model perspective, the model ‘modelled’ by my supervisor and one which seemed to fit with my own world view of the importance of relational aspects of being. Such a perspective focuses on how we come to see the world through the ‘internal structures’ created through relationships with others. I predominantly conceptualised cases using the ideas of Winnicott (1958; 1969) regarding relational aspects of the mothering experience (the ‘good enough mother’) and the development of a true/false self position; as well as those of Alexander and French (1946) regarding the facilitation in therapy of a ‘corrective emotional experience’. It is not my intention at this stage to give you an example of how I approached theoretical integration within the psychodynamic tradition. I feel that since my second year placement I have developed new insights into psychodynamic work, mainly regarding the work of Kohut (1977), and consequently my practice position has changed. A case illustration would thus be of ‘archaic’ interest rather than current practice relevance. Instead, I would like to take a little time in outlining my current approach to integrating all of the three theoretical traditions mentioned above from my third year perspective.

Integration now
My third year placement is split between a Substance Misuse Service and an Alcohol Treatment Service. While my supervisor encouraged a purist Cognitive-Behavioural approach at the start of my placement (to give me a taste of what pure CBT might feel like), he now encourages me in supervision to integrate and I have come to appreciate
the experience he has facilitated. I believe the way I have come to integrate theory and practice in my third year might best be illustrated through reference to Ms B.

Ms B, a woman in her fifties, was referred to the Psychological Therapies provision of the Alcohol Treatment Service by her keyworker due to episodes of binge drinking which her keyworker felt were triggered by feelings of high anxiety regarding past life events. I have met Ms B once, and we plan to meet again next week to continue the assessment. I have chosen to refer to such a ‘new’ client as a case in point of how for me integration starts from the initial point of contact.

During the first assessment appointment Ms B was given space to discuss aspects of her current situation and background factors she felt relevant. At this stage I place great emphasis on building the therapeutic relationship and engaging the client, Rogers’s (1951; 1957) core conditions are a central feature of my approach. As I have developed as a practitioner over the past years such a way of ‘being with’ clients has become more naturalised and my ‘mind space’ is freed up to observe other elements of our meeting. With Ms B I was aware of how her level of anxiety in the room with me did not seem to dissipate as she relayed her situation. I have come to appreciate through clinical experience and my own personal therapy how initial meetings and the start of later meetings might necessarily involve elevated anxiety, and while my ‘internal supervisor’ (Casement, 1985) was paying due attention to the impact of my own anxiety in the room, I felt that Ms B’s was not following the ‘normal’ path to reduction. In the moment it was apparent to me that Ms B was getting lost in her anxiety as was the coherence of her narrative, that talking about her past experiences to a stranger was being interrupted by something, some ‘internal working model’ (Bowlby, 1988) or automatic thinking pattern (J. Beck, 1995), possibly a consequence of our gender difference and her reports of a punitive/violent husband. I decided to focus on our relationship rather than the ‘assessment timetable’ I loosely carry in my head. I acknowledged her feelings of anxiety in the room and while a part of me was reciting the research evidence for CBT in anxiety management (Wells, 1997), I stayed with Ms B as she acknowledged that her anxiety was escalating as she recalled her thoughts about past events to me (I curbed my immediate curiosity as to what it might be about me, feeling this could be too challenging at this time). It seemed that once her anxiety in the room was explicitly acknowledged Ms B felt ‘permitted’ to relax
more. I began to conceptualise that Ms B’s attempts to manage her anxiety started a cycle of escalation as she increasingly became conscious of her inability to maintain control, the overt recognition of this in therapy permitted the decommissioning of her defence or coping response and allowed her in the moment to become more attuned with her ‘true-self’ (Winnicott, 1958; 1969) or ‘actualised self’ (Maslow, 1954) (I refer to two models here as this relates to the ‘multilingual language’ in which I sometimes find myself thinking, a language promoted by Messer (1987) as beneficial in integrative conceptualisation). We continued for the remainder of the session reflecting on past events with recourse to here and now thoughts/feelings and at the end of the session Ms B spontaneously fed back that she found the session difficult but helpful, saying she had initially been very pensive in meeting me but was happy to organise a further appointment to continue with the assessment.

While this might be seen as an example of ‘in situ’ integration, with me coming to interface with Ms B’s presentation through the medium of a flexible and responsive therapeutic relationship informed by a diversity of theoretical traditions, how I might develop this to inform my conceptual approach to a client is also in need of mention.

Through my appreciation of the transferential relationship I am aware of how what happens out of sessions is likely to be repeated in sessions (Malan, 1979), and given Ms B’s seemingly positive response to the recognition of the dynamic between us (even if the reasons underlying this thus far remain unexplored), I feel that attention is best placed initially on the ‘transferential’ aspect of Ms B’s presentation. I am of the mind that such attention to Ms B’s here and now thoughts/feelings and process might become the vehicle through which more cognitive aspects of Ms B’s presentation might be explored. It appeared from our first meeting that Ms B was a person who thought much about the impact of her drinking (her relationship with her children had been severely effected as a consequence) and was prone to very punitive negative self-evaluations which seemed to feed her anxieties as to how others might receive her. While such thinking patterns might naturally be seen as the domain of Cognitive-Behavioural approaches, I feel that given Ms B’s presentation in the room such approaches might best be translated through an empathic acknowledgement of Ms B’s interpersonal nature, a translation informed by the transferential or self-object relationship (Kohut, 1977), allowing for the facilitation of a ‘corrective emotional
experience' (Alexander & French, 1946) through the therapeutic relationship (a necessary part of the therapeutic encounter recognised in the recent Cognitive/Integrative model of Schema Therapy (Young et al., 2003)). While such a therapeutic approach is of course tentative and flexible given the early stage of our relationship, and one I am keen to enhance further through supervision, I do feel it gives a flavour of how I might currently approach 'theoretical integration' in a practice setting.

**Research integration**

This is concerned with an aspect of why I do what I do. While there is a growing body of research for the effectiveness of integrative approaches (Clarkson, 1996; O'Brien & Houston, 2000; Palmer & Woolfe, 2000) I recognise that in the case examples above there was an urge in me to refer to the research 'evidence' supporting aspects of my approach e.g. Cognitive-Behavioural approaches for Depression (Cornwall & Scott, 1997; see Dobson (1989) for a review) and Anxiety (Wells, 1997). I mostly resisted because I wanted to be very clear as to how I approach the integration of research into my practice. I believe a good practitioner should, as far as possible, keep abreast of the current research in an area that relates to a client's issues. However, research evidence does not equal practice. As the paper of Safran et al. (1993) highlights, CBT might be 'indicated' for depression but in some instances clients will not be 'indicated' for CBT. Research has to be translated through an individual's uniqueness to have practical meaning, and I believe as an Applied Psychologist I have a duty to be able to translate such research. However, it must be recognised that the conduct of research and therefore the generation of 'evidence' is not equally spread across theoretical traditions (Roth & Fonagy, 1996) and in recognising this I am again drawn to the stance of Clarkson. Clarkson (1998) suggests that what constitutes research needs to be broadened and that through an appreciation of new and insightful methods of research a research base from which all Counselling Psychology practitioners might draw might become more attainable. In this conception 'positivist' based research such as that which normally underpins evidence for Cognitive-Behavioural approaches becomes only one of an array of modalities from which one might inform their practice. As my course has progressed I have found myself appreciating a number of different evidential arenas from both quantitative and qualitative methodological orientations including those based on
randomised control trials; survey material; individualised case study; Interpretative-Phenomenological reports; social constructionist discourse accounts and ‘anecdotal’ accounts both in the literature and from colleagues. I see myself as a Scientist-Practitioner exploring the evidence and informing my practice, for me what constitutes ‘evidence’ is dynamic and broad and I fully align myself with Barkham’s (1990) endorsement of ‘methodological pluralism’ for the field.

Another aspect of my Scientist-Practitioner stance is the importance I place on evaluating my effectiveness and informing my practice accordingly. In evaluating one’s practice I believe once again one should draw on a range of formats rather than just one. I have used numerous psychometric measures such as the Beck Depression Inventory II; the Beck Hopelessness Scale; CORE; and the General Health Questionnaire. I also draw from client self-reports (as well as considerations of what they don’t report); the reports of others that might be in contact with a client; as well as my own intuitive sense of how a client is progressing according to their presentation and aspired goals.

Finally, in recognition of the need for the field of Counselling Psychology to expand its research base, I have enjoyed engaging in the conduct of three formal research studies during my training. I believe practitioners in any field and especially new ones, best serve that field and ultimately themselves through the dissemination of knowledge about what they do and why, and I am committed to continue to engage in research after my academic training is complete.

**Concluding comment**

While I feel the narrative above and in particular my reference to clinical material should give you an idea of how I go about integrating differing theoretical traditions and research into practice, I would like to add that to me integration is an ongoing process rather than a point of completion. As such my approach is liable to be adapted over the coming months and years according to the theoretical encounters I have, and in many ways the acknowledgement to myself that I am ‘in-process’ is a fundamental feature of how I have come to face many of the challenges, and anxieties elicited in me, encountered during the course of my training.
References


Research Dossier
Abstract
The present review sought to explore the question of how the current literature on facial disfigurement might be applied to the relatively new field of Counselling Psychology. It found that while there was little literature stemming directly from a Counselling Psychology perspective, other approaches to facial disfigurement, drawing more from socio-evolutionary or social psychological perspectives, were of relevance. Such approaches shed light on the origins of the face; possible reasons for the importance of facial appearance; the potential impact of a facial disfigurement; and social models in conceptualising facial disfigurement, including theories of stigma as well as approaches exploring the perspective of those that are stigmatised themselves. While such approaches were informative and seem to have influenced traditional counselling practice, this review also sought to explore other approaches, stemming from psychological theory, that seem particularly relevant to the practice of Counselling Psychology in the field of facial disfigurement. These approaches include theories on the formation and function of negative attitudes to those with facial disfigurements as well as methods indicated in the changing of such attitudes. Within this context the application of Counselling Psychology was considered and the relevance of Identity Process Theory, to this field, suggested. The review concludes by suggesting a number of research questions, that emerged as a consequence of the review, which would seem in need of further exploration.
Introduction

At the age of 9 months whilst mobilising in my toddling chair I was up-ended by the bottom lip of a doorframe and projected through a glass door. The lacerations caused by the broken glass extended from my left temple to the bottom of my jaw and, I am informed by my parents, required 23 stitches. I first remember really becoming aware of my scars at primary school at around the age of 8 when other children would ask how they were acquired. At this age they were mostly pink though towards the bottom of the jaw, where I am told they could not get the skin to stitch together that well due to my jaw movements as I cried, they had an orange complexion. I don’t remember being teased or bullied due to them, instead rather liking the attention they brought. As I progressed through secondary school and into adolescence the stories I told of the scars acquisition became ever embellished, sometimes incorporating tales of bravado if sustained in ‘heroic fights’ or victim-hood in cases of boating or railway ‘catastrophes’. The scars became part of my developing identity, an identity that was reflexive to differing social requirements, and used to my advantage. At the age of 26 I wrote a short story that was published by the hospital where I worked in their in-house magazine, it was called ‘How I got my scar’ and was a parody of previous embellished stories. A few days after publication a colleague commented on the article asking what had inspired such a ‘great literary work’, slightly bemused I traced my scar with my finger, to which she replied “Oh, I hadn’t noticed”. It was true my scars had mostly faded. I had been increasingly aware of this over the previous years but had not until this point incorporated such fading into my ‘scarred’ identity. I could no longer talk of my scars or embellish stories or use them in my humour, my identity had changed and I could no longer genuinely pass as scarred.

This personal experience of facial scarring is what brought me to the literature on facial appearance and disfigurement. I was initially surprised at how my own experience was very different to that which most of the literature covers on the negative impact of facial difference (Bull & Rumsey, 1988). To this end it was almost a search for ‘what could have been’ that drove the present literature review, though throughout I was aware that my personal experience needed to be held separate to, though not completely devoid of informing the review. In what follows I seek to explore the question of how the current literature on facial disfigurement might be applied to the field of Counselling Psychology.
Counselling Psychology is a relatively new discipline, only being granted professional status by the British Psychological Society in 1994. It has been defined as “the application of psychological knowledge to the profession of counselling” (Woolfe, 1996, p. 4), and draws from a clear humanistic value system acknowledging the primacy of the therapeutic relationship (Woolfe, 1996). Given its ‘youth’ it is recognised that its application is somewhat incomplete, something I found whilst reviewing the field of facial disfigurement.

People with a facial disfigurement (and those close to them) may present a Counselling Psychologist with a number of issues related to disfigurement including low self-esteem, depression, social phobia and isolation, emotional and behavioural disturbance, relationship difficulties, panic attacks and fears as to the future (Clarke, 1999; Nordlicht, 1979), as well as, it must be said, issues that are not related to disfigurement. With this said there would seem a number of factors that might affect the therapeutic process (Bull & Rumsey, 1988). Judging an appropriate level of eye contact in sessions, without being perceived as staring, may cause anxiety to both the Counselling Psychologist and a facially disfigured client. Given the influence of social process that might lead to the stigmatisation and discrimination of those with disfigurements, either at a conscious or unconscious level, establishing empathy, unconditional positive regard and congruence, ‘core conditions’ (Rogers, 1957) in the practice of Counselling Psychology, may at least to some degree be hindered. Furthermore, Counselling Psychologists will not be immune from society’s increasing obsession with physicality and appearance, where images of attractiveness serve to marginalize anyone that can’t meet the rising standards (Bull & Rumsey, 1988). In this context it would seem psychologists need to be aware of their own dispositions and subscriptions to society’s values, both in terms of their belief systems and the possible effects their own appearance may have on clients (Lewis & Walsh, 1978).

Given the potential then for a facial disfigurement to impact both at an overt and covert level in therapy sessions, I was surprised by the lack of literature that pertained to this specific issue and the profession of Counselling Psychology in general. It would seem that the literature tends to stem from a social psychological perspective, focusing on broader aspects of facial appearance as well as the impact of facial
disfigurement, and through this perspective traditional approaches to counselling would seem to have been informed. I therefore set out to review this literature, before considering its application to the profession of Counselling Psychology.

**Origins of face**

The first question that occurred to me is what is a face and where does it come from. In his book, ‘About Face’, Jonathan Cole (1998) explores the evolution of the human face from the single sheet of muscle covering the head of fish (our very distant ancestors), to the complex multi-sensory communication centre at the front of our heads that allows for conceptions of ‘self’ in humans today. Cole (1998) suggests that not only did our faces evolve in complexity due to the increasing need to communicate effectively in ever developing complex social groups, but also that through the facial display of affective internal states and the consequent impact of these on the responses of others so humans were able to develop a theory of mind, which itself allowed for increasing social complexity. Faces then are suggested as central to who we are and how we understand ourselves and others in the world. This socio-evolutionary status of face, which Cole himself recognises as possibly being overstated (Cole, 2001), would seem a good grounding point that could go some way to explaining why facial appearance is so important (Bull & Rumsey, 1988), however there have been a number of other approaches to this issue.

**The importance of facial appearance**

It has been estimated that the UK facial cosmetic industry is worth £1 billion pounds per annum (WBIMR, 2003). Lipsticks, blusher and mascara are common facial products, but other products such as jewellery and glasses, or styles of hair or beard, all affect facial appearance and seem to draw the attention of others. Psychologists have suggested a number of reasons why this particular aspect of our appearance exerts such a profound influence. Kleck and Rubenstein (1975) suggest that facial information is usually the first available to a perceiver and one that usually remains available throughout social interactions, possibly explaining why some people say they don’t like talking on the phone or in e-chat-rooms. Maruyama and Miller (1981) suggest that facial appearance offers the first and simplest dimension by which we can evaluate others, and thus may be of primary use as a point of reference on which
to base our judgements and adjust our behaviour. Others such as Bernstein (1976) seem particularly in line with Cole’s (1998) emphasis on the face as a communication centre. He emphasises the face as the most important non-verbal instrument of communication, and thus suggests it would naturally be the primary visual focus. In fact this visual attention to others’ faces seems to develop from a very early age. It has been argued that neonates have a genetic disposition to focus on faces (Fantz, 1961), but while this predisposition for ‘faceness’ has been questioned (Dannemiller & Stephens, 1988), it is accepted that infants at three months can make subtle discriminations among the internal features of faces (Barrera & Maurer, 1981) and by five months can recognise faces in different contexts (Fagan, 1976). It is argued that the development of facial perception that allows the infant to recognise and respond to the expressive behaviours of others, such as with a smile response, also allows for the beginnings of social interaction and the formation of the earliest social relationships (Berk, 1991).

Given then the importance of face and facial perception to early social interactions, the question is raised as to how perceptions of facial appearance might influence later interactions. Research has highlighted the importance of facial appearance in a number of contexts, and drawn attention to the possible negative influence an ‘unattractive’ facial appearance can have on liking, dating and marriage (Miller, 1970); employment chances (Heilman & Stopeck, 1985; Stevenage & McKay, 1999) education prospects (Cline, Proto, Raval & Di Paolo, 1998; Landy & Sigall, 1974); as well as the workings of the criminal justice system (Stewart, 1980). In their comprehensive review Bull and Rumsey state, “the profound social significance of the face, taken together with society’s prejudices towards those who have an untypical appearance, can mean that an unattractive facial appearance could be a severe social handicap” (Bull & Rumsey, 1988, p.179).

Implicit in this statement is the suggestion that a facial disfigurement could have broad and far reaching consequences for an individual, which would seem of clear relevance to the profession of Counselling Psychology, and it is to an evaluation of such consequences that I now turn.
The impact of facial disfigurement

It is estimated that 250,000 people in the UK have a severe facial disfigurement with 1 in 500 hundred children (under 16 years) having a disfigurement that significantly affects their ability to lead a ‘normal’ life (OPCS, 1988). More recent figures have taken account of less severe disfigurement, estimating that a further 400,000 people (Lansdown, Rumsey, Bradbury, Carr & Partridge, 1997), and 1 in 100 children (Frances, 2000), may have a minor disfigurement that could impact on their lives. In looking at the likely impact of a condition it has been suggested that the relationship often assumed between the severity of a condition and the impact it has on life may not necessarily apply to those with a facial disfigurement, with minor disfigurements being equally if not more distressing due to the increased unpredictability of other people’s reactions (Robinson, Clarke & Cooper, 1996). While there are numerous types and causes of disfigurement, including congenital birthmarks, cancers of the face as well as acquired facial burns or scars from accidents, disfigurements that affect the facial triangle (the area between eyes, nose and mouth) seem to cause the strongest reactions in others (Kish & Lansdown, 2000). However, in attempting to classify disfigurements it must be noted that there is a subjective element that needs to be taken into account. There is no measurable organic scale of what constitutes a facial disfigurement (Bull & Rumsey, 1988), an adolescent with ‘spots’ may deem themselves disfigured, while an individual who has remnants of facial scarring due to surgery may not. Those with facial disfigurements clearly could not be said to form a homogeneous group. However, with this said, research into the social context of disfigurement has shown that a facial disfigurement is likely to affect the treatment of an individual by others at all life stages.

The birth of a facially disfigured baby may cause initial shock, anger and feelings of despair (Lansdown, 1981), which may give way to over-protectiveness and sheltering by a family (Easson, 1966). A lessening of physical contact and expressive communication may limit the quality of infant-parent attachment (Walters, 1997) with parents taking less pride in their child (Kapp, 1979). Children with facial disfigurement are less likely to receive positive communications, leading to lower responsiveness and reduced self-learning (Adams, 1977a, b). Kapp (1979) found that children aged five to eight years with cleft lip/palate demonstrated disturbance in the emotional and social aspects of their self-concept, with parents being more anxious
and negative about their child’s personality and intellectual development.

In school, the abilities of the facially disfigured may be underestimated by their teachers (Richman & Harper, 1978) with less consequently being expected of them; they tend to be less popular (Leonard, Brust, Abrahams & Sielaff, 1991) engaging in reciprocal play less (Kapp, 1979) which may impact on social skills and heighten risk of teasing and bullying (Bradbury, 1996). They usually have smaller peer groups (Walters, 1997), which can lead to social isolation and increased behavioural, cognitive and emotional problems, a finding surprisingly consistent across types of facial disfigurement (Kish & Lansdown, 2000).

In adolescence, a time when identity is particularly prone to ‘confusion’ (Erikson, 1968), as peers begin to take precedence over family, Cole (2001) has highlighted the negative impact a facial disfigurement can have on developing new relationships, social acceptance and feelings of worth. At this time the social stigma of being ‘marked’ (Clifford, 1973) may become increasingly apparent (Long & DeVault, 1990). An individual may be devalued by the association of negative connotations of a disfigurement which may be taken as a sign of mental retardation, contagious disease or even ‘evilness’, ideas rooted in folklore but seemingly upheld by popular fiction and television (Bull & Rumsey, 1988).

During adult life the luxury of ‘civil inattention’ (Macgregor, 1990), by which an individual can move anonymously and unhindered in society, is denied the disfigured. They are exposed to intrusive stares, questioning and pity by strangers all of which mark them as ‘other’ to the norm. They are further prone to being avoided and set apart socially due to people’s uncertainty as to how to react (Bull & Rumsey, 1988), a finding that is also evidenced in cross-cultural studies (Bull & David, 1986).

The potential of a facial disfigurement to impact on an individual’s life chances, opportunity for social interaction, self-concept, self-esteem and sense of worth would then seem clear (Bull & Rumsey, 1988; Burns, 1979; Newell & Marks, 2000), but what of my own experience? How might it be that I seemingly escaped the negative effects of having a different face, one that was marked ‘imperfect’?
In contemplating an answer to this I find it hard to either identify with a facially disfigured persona or one that is not; what was is no more, and I wonder how any of us fit into a single category for ‘classification’. I am white, I am middle-class, I am male. What do these categories that I sign up to in censuses, surveys and job applications say about me to others and what do they mean for me? Before you tire of this ‘philosophical pondering’, I suppose the answer I have prepared is simple. To think that descriptive group categories encompass the experience of those categorised or any one person in that category, in any essential way, would be to err. Such categories are means around which a standard distribution of experience might be gathered, and therefore it could be assumed that a number of the ‘categorised’ population, such as I, would fall outside such parameters of experience. However, it would seem that such categories are extremely hard to avoid, especially given the dominant ‘wisdom’ of an individualistic and pathologising medical model, a model within which Counselling Psychologists often have to work. It was this dilemma and my attempts at construing the purpose of ‘categorisation’, that drew me to social models in furthering my conceptualisation of facial disfigurement.

**Social models and facial disfigurement**

McGregor (1982, p. 283) has referred to facial disfigurement as a “psychological and social death”. While this may seem extreme and not applicable in all cases, the processes at work that might lead to such a suggestion need to be looked at. The literature on stigma sheds light on how having a facial disfigurement might impact on an individual. Throughout history physical differences have caused curiosity, revulsion or fear in any society where perception of ‘normality’ is one of the criteria by which people might be accepted or rejected (Rumsey, 1983). While it may be true that at least to some degree many physical or mental ‘abnormalities’ may remain hidden, those who find that they are unable to ‘pass’ as ‘normal’ are likely to be exposed to some ‘stigma’, marked as different and treated as such (Oliver, 1990). Given the importance of our faces, exposed as they are to public scrutiny, a facial disfigurement would seem particularly hard to disguise, and individuals with a facial disfigurement would seem particularly prone to being stigmatised.

**The experience of stigma**

Stigma can be seen as “a powerful phenomenon, inextricably linked to the value
placed on varying social identities” (Dovidio, Major & Crocker, 2000, p. 3). It has been suggested that “a person who is stigmatised is a person whose social identity, or membership in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others” (Crocker, Major & Steele, 1998, p. 504).

In the past the processes and consequences of stigmatisation have tended to be viewed in terms of individual difference (Dovidio et al., 2000), where personality traits were seen to stem from that ‘difference’ and their consequent impact on others (Allport, 1979), leading to stereotyping and prejudice. However, it is argued that this view has changed more recently with social psychologists coming to regard stereotyping as a normal consequence of people’s cognitive abilities and limitations, as well as their experience and the social information to which they are exposed (Dovidio et al., 2000). Furthermore, investigations into the effects of being stigmatised have also changed in focus. Rather than assuming that stigmatisation inevitably leads to profoundly negative consequences for the personalities of the stigmatised, it is realised that there is considerable variation between stigmatised individuals and groups, both as a consequence of individual variation in disfigurement and use of coping strategies (Breakwell, 1986; Dovidio et al., 2000), as well as the relevance of more macro-social processes, such as the influence of gender and class position, necessitating the heterogeneity of the ‘stigmatised’ (Oliver, 1990). From this standpoint the experience of stigma can be seen in the context of its social construction, as being influenced by cultural and historical forces in relation to group dominance and power (Burr, 1995). While such forces are likely to be situation specific (Gaertner & Dovidio, 1986) and largely dependant upon the social context (Crocker et al., 1986), an analysis of them grants a deeper understanding of the processes at work in the experience of stigma for those with a facial disfigurement.

**The stigma of facial disfigurement**

As highlighted above having a facial disfigurement may have a number of consequences for an individual at all life stages, but why would this be so? Goffman (1963) identified three types of stigmatising condition: body abnormalities such as facial disfigurement or physical disability; blemishes of character such as mental illness or ‘deviant’ social behaviour; and tribal identities such as race, sex or belief
systems. Using this model stigma could be seen as incremental in impact depending on how many stigmatised categories you belong to. For example being a white male with a scar (such as I) may lead to a very different experience of stigma than being a black female with a similar scar. Here it is the hierarchy of emphasis placed on any one stigma which is likely to depend on situational variables and social context. While Goffman’s (1963) analysis may earmark the likelihood of exposure to stigma, the approach of Jones and colleagues (1984) seems to be more sensitive to variants of stigmatising conditions. They suggest six dimensions of any stigmatising condition which is likely to impact on how that condition is received. First, concealability i.e. how visible a characteristic is; second, the prognosis of a condition i.e. whether it is likely to get worse or better; third, the disruptiveness of a condition i.e. whether it gets in the way of interpersonal interactions; fourth, the ‘aesthetics’ of a condition i.e. the degree to which it is likely to elicit a negative subjective response; fifth, the origin of the condition i.e. whether an individual can be held accountable for the condition; and sixth, the perceived ‘peril’ posed to the perceiver of the condition i.e. the ‘contagiousness’ of a condition (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984). Each of these dimensions would seem of particular relevance to the stigma of facial disfigurement. Depending on the extent and type of a disfigurement, the visibility and an individual’s ability to conceal or camouflage a disfigurement will vary. However, given the importance of face as a focal point for communication, visibility to some degree would seem unavoidable (Cole, 2001). With regard to prognosis, while facial scars or burns may heal to some extent or plastic surgery may be used to minimise ‘abnormalities’, disfigurements often remain in some residual form. Furthermore, given the cost and limited applicability of surgery to congenital birthmarks or cranial deformities, many disfigurements remain stable, neither getting better or worse, while facial cancers may progress, increasing their likely impact (Partridge, 1990). As already pointed out facial disfigurement may significantly disrupt an individual’s personal interactions, from experiencing avoidance of others (Houston & Bull, 1994) to more physiological impediments caused by lack of facial expressiveness possibly caused by stroke, or communication difficulties caused by cleft lip/palate (Simon, 1985). The aesthetics of a facial disfigurement are likely to vary and depend on the perception of others. However, there is much evidence that those who are perceived to be unattractive are likely to experience negative consequences as a result (Bull & Rumsey, 1988). The origin of a facial disfigurement,
alongside its visibility, has been suggested by Crocker et al. (1998) as the most important dimension of stigma. Perceptions of responsibility for a facial disfigurement are important, it is argued, because disfigurements that are perceived as a consequence of a person's own actions, such as through 'negligent' driving or attempts at altered 'normal' image through plastic surgery (commonly suggested in the case of Michael Jackson), are deemed less acceptable than those that are perceived as uncontrollable (Weiner, Perry & Magnusson, 1988), such as birth marks or scars sustained in war, possibly highlighted by the media's 'acceptance' of the Falklands veteran Simon Weston. Finally, the peril posed to others by a facial disfigurement would seem on the surface to be negligible. However, if a historical-cultural perspective is taken, those with a facial disfigurement have often been castigated as lacking morality, corrupting and prone to mental illness and criminality (Oliver, 1990). These are clearly suggestions of possible 'peril', and a possible reaction to the 'existential anxiety' caused by the realisation of one's own vulnerability as seen through the disfigurement of others (Dovidio et al., 2000).

In this context reactions to my own 'disfigurement' become clearer. The scars were on one side of the periphery of my face and thus not so visible; could not be said to be the fault of a nine month old baby; healed over time; did not physiologically disrupt any communication ability; and perhaps I was avoided due to aesthetics and perceived 'peril' but I'm sure I cannot purely blame my scars for that!

The present review has thus far focused primarily on the effects a facial disfigurement can have on a perceiver and the consequential impact on the disfigured, but this would only seem one aspect in conceptualising facial disfigurement. I used my scars as I grew for storytelling, social accolade and humour. How then might an individual's perception of their own disfigurement affect its impact? This question would seem particularly relevant to the practice of Counselling Psychology.

**The perspective of the stigmatised**

It has been stressed that the effects of facial disfigurement cannot be viewed simply in terms of their impact on the perceiver. Rather attention needs also to be focused on how having a 'disfigurement' effects an individual and the consequential dynamics of encounters (Bull & Rumsey, 1988). Put another way, those who are stigmatised are
not passive recipients but also active perceivers who interpret, cope and respond to stigmatisation (Hebl & Kleck, 2000).

It is commonly accepted that individuals acquire and develop a sense of self through social interaction with others (Cooley, 1912), allowing for social-comparisons (Festinger, 1954), the type and outcome of which are likely to influence one’s self-concept and body-image (Argyle, 1978). It has been argued that anything that affects or inhibits normal interaction patterns is likely to lead to anxiety and uncertainty (Sommer, 1969). Social comparison theory (Festinger, 1957) suggests that when people find themselves in uncertain situations they will seek the help of others to make sense of such situations, through which norms for self-evaluation and the evaluation of others are built up. Thus through interaction one comes to hold internal conceptions of the opinions and attitudes of others (Charon, 1979), which are likely to influence one’s own responses to interactions (Newell & Marks, 2000; Smith & Williamson, 1977). Having a self-concept that embodies the negative connotations of a facial disfigurement is thus likely to affect an individual in a number of ways. It is argued (Snyder, Tanke & Berscheid, 1977) that the social stereotypes held by those who are stigmatised may influence their information processing and behaviour in ways that confirm the stereotyped intuitions already held. Indeed Goffman (1963) suggested that the preconceptions, as to the reactions of others, of the stigmatised themselves may lead to avoidance of interactions and preoccupation with the ‘external’ causes of the stigma. Zimbardo (1981) suggested that such preoccupation with self and the reactions of others is likely to hamper interactions leading to a self-fulfilling prophesy in that the expectation of and heightened sensitivity to rejection may actually elicit such rejection. The research of Rumsey (1983) seems particularly apt here as she found that those with facial disfigurements often experience difficulties in social situations, exhibiting lower levels of eye contact, initiating conversations less frequently, and appearing shy or withdrawn, all of which might have a negative impact on social acceptance and thus hamper future interactions.

It would seem then that in attempting to conceptualise facial disfigurement a number of processes need to be understood. Research on social processes such as stereotyping and stigma has drawn attention to perceptions of perceivers, and how such perceptions might impact on those with a disfigurement. Research with those who
have a facial disfigurement has shown how cognitive, affective and behavioural responses might actually anticipate and in some way uphold such social processes.

Given this body of research my focus is now turned to traditional approaches to counselling that seem to have been influenced, at least in some way, by this literature.

**Counselling and facial disfigurement**

Traditionally the field of counselling has focused on improving self-attitudes of the facially disfigured, especially aspects of self-esteem aimed at improving the quality of social interactions (Rosenberg, 1975). Providing an environment in which difficulties related to a facial disfigurement can be discussed in an open and non-judgemental manner has been suggested as the first step in helping people come to terms with a disfigurement (Partridge, 1990). Self-help groups (Rumsey, 1983) and social skills training (Bull & Rumsey, 1988) have been seen as of particular relevance in helping those with a disfigurement confront their difficulties and overcome the social impact disfigurements are likely to have, including aspects of discrimination in liking, dating and marriage, education opportunities, and employment chances. Such approaches aim at promoting self-worth, and educating individuals in the understanding of how social processes of discrimination may actually be compounded by the behaviour of those with disfigurements themselves (Snyder et al., 1977). Social skills training is suggested as combating both the self-fulfilling stereotype that attractive people are more socially competent (Dion, Berscheid & Walster, 1972), and providing those with a facial disfigurement, that might uphold this stereotype, with the skills to test out its appropriateness (Gresham, 1981), and consequently raise self-esteem through raised exposure to positive social interactions (Festinger, 1954; Argyle, 1978), which in-turn might lead to reductions in negative attitudes according to contact theory (Hewstone, 2003).

While such traditional approaches are of obvious relevance to the field of Counselling Psychology, they seem to lack a comprehensive analysis of the internal processes involved in mediating the impact of facial disfigurement, processes that would seem of direct relevance to the profession of Counselling Psychology (and indeed applied psychology in general). Thus while the literature so far covered aids the conceptualisation of facial disfigurement, and would seem important for Counselling
Psychologists to be aware of, there is also another body of literature more focused on psychological theory that would seem especially relevant to the field of Counselling Psychology.

**Psychological theory and facial disfigurement**
The 1995 Disability Discrimination Act stated that severe disfigurement should be treated as if it were a disability (HMSO, 1995) due to the adverse effect it is likely to have on a person's day-to-day life. Livneh (1982) in his studies of attitude formation to disabled people identified seven factors that are likely to lead to negative attitudes and attributions towards those seen as disfigured. 1) Historical, social and cultural negative representations, such as portrayals of facial disfigurement as the punishment of God, or as a consequence of one's own shortcomings (McDaniel, 1969). 2) Current socio-cultural negative representations, such as an emphasis on 'body perfection' and notions of 'the body beautiful' espoused by advertising, 'glossy magazines' and other media (Bull & Rumsey, 1988). 3) Childhood influences, where negative connotations of disfigurement might be transmitted from the 'adult world' to a child's internal beliefs about themselves and others. 4) Degree of aesthetic aversion, which similarly to Jones et al.'s. (1984) analysis of the dimensions of stigma, is likely to influence the degree and strength of a negative attitude. 5) A disposition to reject the strange or unusual. Using Kelly's (1955) personal construct theory, Siller (1976) explains that people build up a construct system to predict events. If constructs are inadequate then anxiety is felt as there is no method of prediction. He suggests that when a disfigured person is encountered then the likely lack of previous experience and subsequent lack of constructs will increase anxiety, cause avoidance and reinforce this pattern in future encounters. 6) Perceived threats to one's own integrity. Again similar to Jones et al.'s. (1984) perception of peril, this may involve negative attitudes regarding superficial association in case of direct contamination or more in-depth association (such as sexual relationships) through fear of the effects on gene inheritance. 7) Marginal group comparability, through which people with a disfigurement might be associated with other devalued groups such as criminals and as 'equity theory' (Lerner, 1970) suggests a person is often held responsible for their own condition due to their actions. This, it is argued, makes it easier for others to ignore their own lack of control over events and take solace in the predictability and 'justness' of a world, where 'good things' happen to 'good people'.
Through consideration of these factors it has been argued (Bull & Rumsey, 1988) that psychologists might be able to suggest methods of attitude change which would go some way to improve the lives of the facially disfigured. Thus psychological input into the processes involved in individual attitude change would seem indicated. However, this would seem to pose a number of problems not only regarding the ethics of attitude change but also the ability to carry out such change given the function such attitudes might serve from a social constructionist perspective.

**The function of attitudes to facial disfigurement**

In looking at the functions of negative attitudes to the facially disfigured, the wider literature on the functions of stigma seems relevant. According to downward-comparison theory (Wills, 1981) the stigmatisation of others can increase a stigmatiser’s own sense of self-worth and self-esteem. Social comparison theory (Tajfel & Turner, 1979) suggests that categorisation of people into favourable in-groups and less favourable out-groups can lead to a sense of positive group distinction. Furthermore, justifications for stigmatisation might stem from the desire to uphold the status quo where minorities are discriminated against and thus the opportunities, both socially and economic, of the discriminating group are enhanced (Jost & Banaji, 1994). Thus the social construction of minority groups through processes of stigmatisation could be seen as serving the socio-political needs of the dominant group who in effect construct an ideology for this very purpose (Burr, 1995).

In this light psychological approaches to change negative attitudes might face formidable resistance. However, some approaches have been suggested.

**Psychological theory and changing negative attitudes**

Bull (1985) has suggested that the positive modelling of parents to people with disfigurements and other disadvantaged groups could go some way in offsetting Livneh’s factor of childhood influences in the development of negative attitudes. Furthermore, research by Jones, Sorrell, Jones and Butler (1981) has suggested that educational strategies aimed at raising the awareness of facial disfigurement in primary school children is likely to lead to more positive attitudes. However, changing negative attitudes in children may be short lived given the likely exposure
to negative socio-cultural representations of disfigurement as they grow into adults. Donaldson (1981) found that television reinforces negative attitudes to facial disfigurement, commonly depicting people with facial scars as being evil or having criminal intent. Given this influence much research has been conducted into the potential positive use of television and other such mass media, producing evidence that such media can help change negative attitudes (Dobo, 1982; Potter, 1978). However, such positive use does not seem to be evident given the current media backdrop of ‘celebrity’ and continued fascination with body image and appearance.

If then the impact of psychology on negative attitudes seems somewhat limited at a macro-social level, and one that might need to be viewed in the long term, what of psychology’s relevance to those with facial disfigurement at an individual level, in the short-term? Traditionally approaches here have focused on the attitudes and behaviour of people with facial disfigurements themselves, and it is with this regard that that field of Counselling Psychology seems most relevant, and one that as a Trainee Counselling Psychologist, I am particularly interested in.

**Counselling Psychology and approaches to facial disfigurement**

As already stated, people with a facial disfigurement may present a Counselling Psychologist with a number of issues either related or not to their disfigurement. Such clients may raise a number of issues for the practitioner including anxiety control regarding eye contact; awareness of the social process of stigma and discrimination and their detrimental potential in establishing empathy, unconditional positive regard and congruence; and awareness of the effects on ‘self’ of a client’s appearance and one’s own appearance on a client (Lewis & Walsh, 1978). Indeed research has shown that therapists prefer to work with young, attractive, verbal, intelligent and successful (YAVIS) clients (Schofield, 1964), all factors that, it is suggested, might potentially influence a therapist’s judgements of a client and thus the progress of therapy (Sandler, 1975).

Given such practical implications and the previous discussion of the literature pertaining to facial disfigurement, it is clear that Counselling Psychologists need to be aware of a diversity of factors at play, ranging from the social context to individual consequences; from the perspective of the perceiver to that of the perceived, when
approaching issues of facial disfigurement.

Whilst conducting the present review this point seemed to occur to me again and again, sometimes seeming trite but at other times seeming overlooked in its breadth by the literature. It seemed aspects of the jigsaw were falling into place but there was no particular configuration that was unifying, no final 'picture' to which the pieces were working. It was this lack of a 'unifying theory' that drew me to the literature on identity and specifically the work of Glynis Breakwell (1986; 1996) as being of particular value to this field and the profession of Counselling Psychology.

**Breakwell's Identity Process Theory**

Breakwell's (1986; 1996) Identity Process Theory provides a comprehensive framework by which the impact of a disfigurement might be understood, from internal intra-psychic processes to the external societal context.

Using this model an individual's identity can be seen as "a dynamic social product of the interaction of the capacities for memory, consciousness and organised construal which are characteristic of the biological organism, with the physical and societal structure and influence processes which constitute the social context" (Judd & Wilson, 1999, p.8). In structure identity is seen as being made up of a content and value dimension. The content dimension consists of all the defining elements of an individual's identity, such as descriptive characteristics, which distinguish them from others. The value applied to each of these elements makes up the value dimension. These structural dimensions are regulated by the interactive processes of assimilation, accommodation and evaluation which absorb new components into the existing identity structure; adapt the existing structure in order to integrate new elements; and apply value and meaning to the new identity content respectively. Breakwell suggested four principles that guide the above processes: distinctiveness (a person’s desire to be unique in a positive manner), continuity (a person’s desire to give a consistent account of themselves across time), self-esteem (a person’s desire to be evaluated positively) and self-efficacy (a person’s desire to be competent). These guiding principles offer us insight into threats to identity that the facially disfigured may come under. A threat, whether real or perceived, can be seen as arising when the identity processes are unable to meet the demands of the identity principles. Though
threats will obviously vary according to an individual's identity structure, the coping strategies used and their effectiveness in dealing with a threat, will inevitably decide the impact of a threat.

Breakwell identified three inter-related levels at which coping strategies operate to combat threats: intra-psychic, interpersonal and inter-group. Intra-psychic strategies, which operate at the level of cognitions and emotions, include deflection strategies such as denial, fantasy, reconstrual and reattribution; acceptance strategies such as change and compromise; and re-evaluative strategies aimed at either current or prospective identity content. Interpersonal strategies, which rely on changing relationships with others, consist of isolation from others; negativism towards others; attempts at passing as not being in a threatened position; and compliance with roles given to a threatened position. Inter-group strategies, which themselves can operate at a number of levels, include belonging to support groups and networks, as well as membership of pressure groups and large scale social movements aimed at change at a societal level.

This approach to identity would seem both to incorporate the breadth and depth of the literature so far reviewed, as well as enable a sophisticated evaluation of the impact of facial disfigurement at a number of levels relevant to Counselling Psychology.

Being born with a facial disfigurement, with consequent vulnerability to self-esteem problems and negative connotations to being distinctive (Easson, 1966; Kapp, 1979; Walters, 1997), will place an individual's identity in a 'threatened position'. Acquiring a facial disfigurement will be a severe disruption to the continuity of a person's identity, and will confront them with all the problems associated with the new 'threatened position' (Partridge, 1990). Furthermore, given the powerful processes of stigma and negative social representations at play (Dovidio et al., 2000; Jones et al., 1984), being 'other' may seriously compromise an individual's confidence, sense of self-efficacy and personal agency (Breakwell, 1992), not least due to the differential treatment and active discrimination of others at all life stages discussed above.

In approaching such threats to an individual's identity, Counselling Psychologists will
need a fully contextualised understanding of the issues involved, recognising that different individuals with disfigurements will vary as to cognitive resources available, salience of life experiences and preferred methods of coping, all of which are likely to vary according to the context and threat type.

Partridge (1990) has described how acquiring a disfigurement can be deeply distressing at an intra-psychic level. Counselling Psychologists may work with people in denial and fantasy, who avoid relating to the 'grotesqueness' of their new reality. For such people continuity, self-esteem and any positive aspects of distinctiveness may be eroded by a 'prejudicial' society, leading to a sense of remorse, self-blame and withdrawal (Partridge, 1990). While denial and fantasy may have short-term use, the role of the Counselling Psychologist may be to ease the path to accepting what has happened. Cognitive behavioural strategies (Beck, 1995) aimed at the re-construal and re-evaluation of a situation in a less negative light may promote self-esteem and feelings of continuity and thus bolster the content and value dimensions of identity.

Feelings of hostility and non-acceptance from others due to disfigurement may have devastating consequences for an individual and their interpersonal relationships (Partridge, 1990). Self-esteem and self-efficacy may come under attack as social-networks are challenged and possibly fragment, leaving a reduced sense of social competency. This may promote isolation and increase susceptibility to depression (Breakwell, 1986); suicidal ideation may pose a number of issues for a Counselling Psychologist in this context (Neiderland, 1975). While an individual may attempt to fight back with 'negativism' to others' judgements, or 'camouflaging' themselves in order to pass as non-disfigured, the literature overwhelmingly points to the use of social skills training in securing and building new relationships (Bull & Rumsey, 1988; Clarke, 1999; Kish & Lansdown, 2000; Partridge, 1990). Such training, often facilitated by a psychologist, may from an early age enable the facially disfigured to understand and deal with others' reactions; possibly helping to reduce their 'over-negativity' to such reactions (Rumsey, 1983). Bull and Rumsey (1988) have suggested that good social skills could go some way in removing many of the negative aspects of facial disfigurement, and such training may be particularly important for those in schooling (Frances, 2000).
Feelings of not belonging and loneliness may be further offset by group membership. Group sessions (which may need to be handled delicately to ensure their inclusiveness) with those that 'share' a disfigurement may provide a forum where feelings are expressed and support offered. Within such sessions differing experiences and coping methods could be explored, providing valuable insights and promoting a sense of 'camaraderie'. Through the power of others' stories and the provision of positive role models (Partridge, 1990), the negative connotations of being distinctive may be reduced, self-esteem and feelings of self-efficacy raised, and the content and value dimensions of identity bolstered.

While such examples of the application of Identity Process Theory are not aimed at being prescriptive, they are used here to highlight the potential relevance of this model at a number of levels, identified as relevant in the literature, to the application of Counselling Psychology in the area of facial disfigurement. From my own perspective such a model makes 'experiential sense', that is, I feel its relevance to my own experience of facial scarring and impact on identity and subsequent change in that identity. To put it more effectively it makes sense to me at some internal level, giving me a sense of 'rejoice' that I have a framework into which my own experience fits and through which I am 'given' a language to conceptualise and explore that experience.

**Overview and conclusion**

The present review aimed to explore how the current literature on facial disfigurement might be applied to the field of Counselling Psychology. With this regard it explored a number of perspectives ranging from social psychological approaches and the analysis of stigma, to the application of psychological theory and identity models in the field of facial disfigurement, all of which were suggested as having much to add to the conceptualisation of facial disfigurement from a Counselling Psychology perspective. Throughout the review my own experience of facial disfigurement was commented upon, contextualising my interest and providing, I feel, valuable insights into my own conceptualisation of disfigurement.

The review has also raised a number of questions that I feel as yet remain unanswered and of particular relevance to the profession of Counselling Psychology. While such
questions have been alluded to at times in the main body of the review, I shall now explicitly highlight them as possible avenues for future research in this area.

**Research questions**

Future research would seem particularly indicated in three areas. 1) The cognitive and affective reactions of those that are stigmatised would seem in need of exploration to further our understanding of the impact of facial disfigurement and the consequent behavioural reactions, which seem at present to dominate the focus of much of the literature (Bull & Rumsey, 1988). 2) Session dynamics in the practice of Counselling Psychology need further investigation with regard to the impact of facial disfigurement. Here the influence of a client’s and a psychologist’s facial appearance on session processes and dynamics could be explored. However, the relational aspect between facial appearance and client/psychologist judgements of their own appearance with regard to that of the other may prove particularly rewarding here, shedding light on context influences and differential comparison influences, according to relative perceptions of appearance. 3) Finally, while I have suggested the relevance of Breakwell’s Identity Process Theory to conceptualisations of facial disfigurement and the practice of Counselling Psychology, much research still needs to be carried out. Such research could include feedback from practitioners on how the model might actually be applied to clients, highlighting both benefits and weaknesses; the processes by which the salience of a particular identity principle to a particular situation may be determined; and investigations as to the substantive processes, such as memory encoding biases, at work in the biological organism, which are likely to influence structural components of identity.

Such research questions would seem to pose new opportunities for discovery in the field of Counselling Psychology, and given its relative ‘youth’, such opportunities grant trainee Counselling Psychologists, such as myself, the chance to engage in novel and rewarding research, pushing the scope and application of this profession.
References


Appendix 1 – Notes for Contributors

Social Science & Medicine - Guide for Authors

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Two types of contribution are welcomed: full papers (original research reports or critical reviews of a field, of no more than 8000 words, which include abstract, tables, footnotes and references as well as the main text), and short items (short reports of research findings, commentaries on topical issues or correspondence, of no more than 2000 words). Shorter papers are preferred and justification should be provided for word counts over these limits. Authors are requested to submit their original manuscript and figures with two copies and a matching disk to the Editor-in-Chief, Professor Sally Macintyre, MRC Social and Public Health Sciences Unit, 4 Lilybank Gardens, Glasgow G12 8RZ, UK; or to the relevant Senior Editor. Manuscripts can also be accepted by email. Please create one folder (with the name of the corresponding author) for all word and figure files, and email this to the Managing Editor at: amanda@msoc.mrc.gla.ac.uk

Submissions will be considered on the understanding that they comprise original, unpublished material and are not under consideration for publication elsewhere, and the study(ies) on which they have been based have been subject to appropriate ethical review. A covering letter to this effect should be enclosed with each submission, signed by all authors of the paper. Social Science & Medicine does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in Macintyre (1997, Vol. 45(1), 1-2).

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Contact details for questions arising after acceptance of an article, especially those relating to proofs, are provided after registration of an article for publication.
Appendix 2 — Literature search details

In searching the literature for the conduct of this review I employed three procedures:

1) A PsycINFO database search:

- This search was of all the available databases (including journal articles, book chapters and abstracts) published between 1872 and February 2003.
- The three most manageable and fruitful search terms for this review were:
  - Facial disfigurement - 63 relevant hits
  - Identity and physical disability - 16 relevant hits
  - Identity process theory - 4 relevant hits
- Searches which included reference to Counselling Psychology or Psychotherapy or Applied Psychology (or derivatives thereof) yielded very few relevant references outside the terms above.

2) Review of the reading list compiled by the Centre for Appearance and Disfigurement Research, May 2001 (available on phone request). This comprehensive 39 page list covered research into areas relating to disfigurement and appearance and included numerous references relating to, body image, burns, cancer, craniofacial disfigurement, dermatological disfigurement, dysmorphophobia, oral/maxillofacial disfigurement, port wine stains, quality of life issues, surgery and tattoos, as well as, a general reference list on facial appearance research articles.

3) On obtaining relevant articles from either the University of Surrey Library or the British Library I reviewed the articles reference lists. I felt this would aid my comprehensive coverage of the literature and, indeed, through this procedure I identified a number of references not otherwise obtained (on checking such references against the PsycINFO database I often found they were not included).
Research Report 1:
The influence of client facial appearance on therapists as mediated by therapists' self perceptions: a qualitative investigation into the views of trainee psychologists

Abstract
Given the lack of attention to social comparison aspects of the therapeutic encounter in the current literature, the present study sought to explore qualitatively trainee psychologists’ perceptions of how a client’s facial appearance might affect them in therapy; their perception of their own facial appearance; and their understanding of how the latter might influence the former. A total of ten trainee psychologists were recruited for this study, five trainee Clinical Psychologists and five trainee Counselling Psychologists, and asked to participate in one face-to-face interview of approximately 30-40 minutes. Interviews were based on a semi-structured interview schedule, which was developed for this study, and interview transcripts were subjected to an intensive analysis using the method of interpretative phenomenological analysis. Ten salient themes emerged from the transcripts which were grouped into four broad domains: 1) the nature of perception of facial appearance of self and others; 2) comparative aspects of facial appearance; 3) the impact of comparative aspects of facial appearance on therapy; and 4) difficulties with research topic. These domains and themes are discussed in light of the current theoretical and practice literature, as well as the researcher’s own insights and thoughts on their implications for practitioners. Finally, a number of study limitations are outlined and suggestions put forward regarding the development of future research in this clinically relevant area.
Introduction
During my first year of study on the Doctoral Programme in Psychotherapeutic and Counselling Psychology I conducted a literature review in which I sought to explore how the current literature on facial disfigurement might be applied to the field of Counselling Psychology (Boucher, 2003). Whilst I approached this review from a number of perspectives, including evolutionary conceptions of the origins of face and social psychological models of how having a different face might lead to the development of stigma, negative social representations and attitudes, the current study was born more specifically out of a particular body of literature, namely that relating to how we come to perceive ourselves in relation to the other. [I have been interested in the nature of interpersonal perception and the development of the self-concept throughout my ‘academic life’ and the current research enabled me to explore this area in relation to my chosen profession. Furthermore, my lived experience of how my own identity can change rapidly with the social/interpersonal context, often leaving me feeling anxious and uncertain as to the ‘roles’ I adopt, partly fuelled my interest in the research topic.]

It is has long been argued that individuals acquire and develop a sense of self through social interaction, a ‘looking-glass self’ where perception of self and other become intertwined in relational aspects of social being (Cooley, 1912; Mead, 1925). Such relational aspects of being have been seen as grounded partly in the social comparisons we make (Festinger, 1954), the type and outcome of which are likely to be the source of our self-concepts (Argyle, 1978). Thus through interaction one comes to hold internal conceptions of the opinions and attitudes of others (Charon, 1979) which in turn are likely to influence one’s own responses to interactions (Newell & Marks, 2000; Smith & Williamson, 1977). [In reflecting on the use of self I’m left with a dilemma at this juncture: if ‘self’ is as fluid and relational as I believe, then what is my ‘self’ in the context of this research? Who or what am I relating to here in order to construct a self on which to reflect? In considering an answer I find it easy to become lost in language, the first person ‘I’ becomes merged with the third person ‘Me’, I become both knower and known, self and other; I become reflective on reflection, ‘contained’ by the freedom of the process of “self”, and confused. I step back, read through my comments and cringe - it all sounds a bit indulgent. Do I delete and start again? No, I decide that this is as good a way as any to convey my dilemma.
I decide ‘who I am’ is a philosophical question to which I need not attend, and that in the current context of reflection on ‘the use of self’, my ‘self’ is in relation to the ‘other’ of the research I have conceptualised, undertaken and now construct, as well as the ‘others’ who might read it. While social comparisons may be made with regard to a multitude of factors, including our behaviours and attitudes, through which norms for self-evaluation and the evaluation of others are built (Festinger, 1957), it has been argued that facial appearance is a particularly important factor influencing both our judgements of others and the comparisons we make. Kleck and Rubenstein (1975) suggest that facial information is usually the first available to a perceiver and one which usually remains available throughout social interaction providing a continuous source for judgement and comparison. Maruyama and Miller (1981) suggest that facial appearance offers the first and simplest dimension by which we can evaluate others, and thus may be of primary use as a point of reference on which to base our judgements and adjust our behaviour. Others such as Bernstein (1976) and Cole (1988) place particular emphasis on the face as a communication centre, emphasising the face as the most important non-verbal instrument of communication, suggesting that, as such, it would naturally be the primary visual focus and a source of comparison. Social psychologists have long recognised such perspectives, acknowledging how our facial appearance, and the judgements and comparisons derived from it, are likely to impact on all aspects of our lives at all life stages, due to our own and others’ positive or negative evaluations of it (for a review see Bull & Rumsey, 1988). Indeed Bull and Rumsey (1988) state “the profound social significance of the face, taken together with society’s prejudices towards those who have an untypical appearance, can mean that an unattractive facial appearance could be a severe social handicap” (p.179). With this said, and in keeping with the broader perspective, it has been postulated that the categorisation of people into favourable in-groups and less favourable out-groups can lead to a sense of positive group distinction (Tajfel & Turner, 1979), and that justifications for stigmatisation might stem from the desire to uphold the status quo of such distinctions where minorities (such as those with atypical facial appearance) are discriminated against and thus the opportunities, both socially and economically, of the discriminating group are enhanced (Jost & Banaji, 1994).
Given such insights, it must be recognised that psychotherapy is almost exclusively carried out via 'face to face' contact between therapist and client and it would thus seem particularly relevant to appreciate the role of facial appearance in such a context. However, little comprehensive research has actually been conducted either by social psychologists or psychotherapy practitioners in this area. The little research that has been undertaken has suggested that therapists are indeed influenced by facial appearance and are likely to use negative-stereotypes of facial appearance in judging clients' self-concept (Hobfoil & Penner, 1978) or intellectual functioning (Sandler, 1975) and that therapists prefer to work with young, attractive, verbal, intelligent and successful (YAVIS) clients (Schofield, 1964) – all factors that would seem likely to affect the therapeutic process. However, it must be said that such research is quite limited, tending to focus solely on therapists' perceptions of clients' faces, thus ignoring potential social comparison elements in the therapeutic encounter with regard to perceptions of facial appearance and the values and judgements attached to them.

It was the lack of attention to such elements, elements that seemed to be explicit in theory yet overlooked in application to practice, which gave rise to the present research aimed at shedding light on how the facial appearance of a client might influence the therapist as mediated through the therapist's perception of their own facial appearance. It was felt that the conduct of such research might address a social comparison aspect of the therapeutic encounter which seemed absent from the current practice literature with regard to facial appearance and, as such, be of particular relevance to the field of Counselling/Clinical Psychology and Applied Psychology in general.

**Research aims**

The research aimed to explore qualitatively, through the conduct of interviews, trainee psychologists' perceptions of how a client's facial appearance might affect them in therapy; their perception of their own facial appearance; and their understanding of how the latter might influence the former. This exploration was conducted through discussion in relation to three 'face types'; one 'attractive', one 'unattractive' and one facially 'disfigured'. It was felt that such an approach might prove to be of interest not only to practitioners of psychology but also to all those that
work in specialist services, such as burns units, or with specific client groups such as those with facial disfigurements, where issues of facial comparison might impact on the nature of service provision.

Research questions:

1) Do therapists' perceptions of their own facial appearance influence how they perceive the facial appearance of clients and, if so, in what ways might this impact on the conduct of therapy, according to the opinions of trainee psychologists?

2) Do therapists' perceptions of clients' facial appearance influence how they perceive their own facial appearance and if so in what ways might this impact on the conduct of therapy, according to the opinions of trainee psychologists?

Method
Participants
The study sample was made up of trainee Counselling Psychologists studying on the practitioner doctoral programme at the University of Surrey and trainee Clinical Psychologists studying on practitioner doctoral programmes either at the University of Surrey or at University College London. Such trainees were chosen as it was felt they would represent the views and insights of the next generation of professionals in their fields (fields which have a significant standing in the remit of Applied Psychology) and consequently shed light on how those fields might develop. Potential participants were identified according to three criteria in order to provide a homogeneous group; first, that they were enrolled full time in the third year of study on either the Counselling or Clinical Psychology practitioner doctoral programmes at the University of Surrey or the Clinical Psychology practitioner doctoral programme at University College London. It was felt that third year trainees were the most suitable for this research as their participation guaranteed at least two years of supervised clinical practice allowing for some equity of experience; second, that equal numbers be recruited from the disciplines of Clinical and Counselling Psychology to allow for equivalent representation across each of these fields; and third, that equal numbers of males and females be recruited again to allow for equivalence in representation.
Potential participants were approached individually, given a brief outline of the research topic and procedures and, after reading the information sheet (Appendix 1) and consent form (Appendix 2), were asked if they would give signed consent to participate in the study. At this stage, it was highlighted that, though interviews would be audio-taped and transcribed for analysis, tapes would be kept securely, participants would not be identified in the write-up and after the study was complete the audiotapes would be erased.

Ten trainee psychologists were recruited in this manner to participate in the study. This number is in line with that suggested by Smith, Jarman and Osborn (1999) as suitable for the analytic method employed in the present study - interpretative phenomenological analysis.

Researcher

The interviews and data analysis for this project were carried out by me Terry Boucher (a 32-year-old, second year Counselling Psychology doctoral trainee at the University of Surrey). At the beginning of the research I tenuously held the view that a therapist’s perception of their own facial appearance might in some way influence their perception of a client’s facial appearance and subsequently the judgements made. This view was partly informed by my review of the literature on the potential for facial appearance to impact on someone’s life generally and the therapeutic encounter specifically (Boucher, 2003), as well as my own clinical experience and informal discussions with peers. However, I also recognised that I had no strong ideas about how the processes behind such influences, if any, might work nor how they might or might not impact on the conduct of therapy. It is felt that the overt recognition of the views that I myself brought to the study, as well as the repeated discussion of such views with the research supervisors, helped me reflect on my interpretations and analysis of the data generated by the study, a process which seems particularly in tune with the analytic strategy taken.

Throughout all stages of the research regular consultation was sought from Dr. Adrian Coyle and Dr. Evanthia Lyons (the research supervisors), both of whom had an interest in the topic and considerable experience in the use of interpretative phenomenological analysis, the research method employed.
Interview procedure

One face-to-face interview of approximately 30-40 minutes was conducted with each participant by me. Interviews were based on a semi-structured interview schedule which was developed for this study (Appendix 3). The schedule began with a number of demographic and background questions which participants were asked to complete themselves. They were then asked a series of open-ended interview questions about their perception of their own facial appearance; how they perceive others to perceive their facial appearance; their perception of how their facial appearance might impact on them and others; their perception of how others' facial appearance might impact on them; their perception of how a client's facial appearance might impact on them; their understanding of how their perception of their own facial appearance might influence their perception of a client's facial appearance, and how such influence, if any, might impact on therapy; and finally their understanding of how their perception of a client's facial appearance might influence their perception of their own facial appearance, and how such influence, if any, might impact on therapy. These questions were designed to be broad in nature to allow participants latitude in the expression of their views on the phenomena under investigation. However, they were supported by a number of prompt options should they require help in focusing on the research topic, the use of which was left to my discretion. The interview questions were generally derived from the literature on the impact a person's facial appearance might have on themselves and others (Bull & Rumsey, 1988), as well as my own insights into this topic based on my clinical experience and acknowledged gaps in the current literature. At the end of the interview, participants were asked for any additional information they would like to add and feedback on how they felt about being interviewed on this subject.

From its conceptualisation, it was recognised that such an area of enquiry might lead to socially/professionally appropriate answers. With this in mind, special attention was given to highlighting the self-reflective nature of this research, the confidentiality of its findings and the importance of gaining access to information on the phenomena under investigation for practice development. The researcher/participant relationship was also given particular attention. I aimed to provide a comfortable, non-judgemental, and relaxed interview environment, in which participants might feel more at ease with such self-reflective questions, thus optimising the interview's
potential to gather valuable open information. [While I have already stated that I am aware of how changes in my identity can leave me feeling anxious and uncertain, I must admit that I was surprised by the level of anxiety I felt in the ‘identity’ of researcher whilst conducting interviews for the present study. I have been in this ‘identity’ on numerous occasions in the past and have never felt as awkward and invasive as I did on this occasion. It was as if I was breaking some social convention that I shouldn’t by asking people about their facial appearance - it’s not the ‘done thing’. While participants were able to feedback their reactions to such questions at the end of the interview, I found myself contemplating again and again why I felt as I did, why was I so anxious? Answering this is hard, but to be honest, however much I’d like to hide it, I have to conclude that more often than not my self-concept of my own face is one of ‘inferiority’, that is, I generally perceive myself as less appealing facially in relation to others, which makes me somewhat anxious. I compensate through humour and ‘intelligence’ - I’ll be a doctor one day! But facially I feel ‘inferior’ and it is important to me. Whether this importance and sense of inferiority stems from my own early experience of facial scarring (discussed in last year’s literature review, see Boucher, 2003) or perceptions of how I believe people relate to me now, I don’t know, but it is something that is a part of me, no matter how strenuously I have argued against it previously, and indeed I can now see how my conflict in recognising this aspect of ‘me’ was indeed in many ways the driving force for the current research.]

**Piloting**

In order to identify any problems or weaknesses early on in the data collection process, after the conduct of the first and third interview the performance of the interview schedule was reviewed and discussed with the research supervisors. At these stages, minor revisions were made to the wording of some interview questions and, after interview three, one question was split into two simpler questions (questions six and eight on the interview schedule) to aid understanding. Through discussion with the research supervisors, it was decided that since only minor adjustments had occurred to the interview schedule and as such adjustments could be accommodated by the qualitative methodology undertaken, the first three interviews, which were initially envisaged as pilots, could be included as research texts in the main analysis.
Analytic strategy and procedures

Data were analysed using the procedures documented by Smith et al. (1999) which he describes as interpretative phenomenological analysis (IPA). This approach seeks to explore a participant's views of phenomena from their own perspective, while recognising the interpretative nature of this exploration due to the influence of a researcher's own conceptions (Smith, et al., 1999). IPA does not hold that it is possible to produce an 'objective' statement on a phenomenon. It focuses instead on the dynamic interaction between a participant's phenomenological account and a researcher's interpretative framework. It offers a systematic approach to the analysis of narrative data, allowing meaningful interpretations to be drawn from a participant's thinking and thus was felt pertinent to the focus of the present research.

Good qualitative research needs to be clear about its process of analysis (Smith, 1996; Coyle & Rafalin, 2000) and the analytic procedures used in the present study were as follows:

1) The audiotapes of participant interviews were transcribed onto A4 paper leaving wide margins on both the left and right sides of the paper.

2) Each of the ten transcripts to be used for analysis were read several times by me and one (presented in anonymised form in Appendix 4) was identified as the richest according to my assessment of the depth and breadth of question answers as well as insights gained into the research topic.

3) The richest script was then re-read a number of times by me noting anything that I thought of interest in the left margin. These notes included summaries, associations, connections or preliminary interpretations of the text.

4) The script was then read once more and this time, in the right margin, essential qualities and emerging themes were noted.

5) On a separate sheet of paper, emerging themes were listed and connections between them examined. Connected themes were then clustered together into
domains ensuring that any connections and links made were apparent in the text material.

6) A master table of domains and themes was eventually produced that was deemed coherent in nature. The script was then re-read to ensure that this table accurately reflected the participants’ perspectives in that the themes fitted with the data.

7) This master table was then used to analyse each of the nine subsequent transcripts in order of richness (again judged by my assessment of the depth and breadth of question answers as well as insights gained into the research topic). Here opportunities for elaborating, modifying, and editing the master table were noted and a final table of domains and themes (some directly reflective of the research questions), was eventually produced drawing from all ten transcripts. During this stage, to promote the credibility of the emerging final domains and themes (Elliott, Fischer & Rennie, 1999), I engaged in detailed discussions with the research supervisors regarding the content of the emerging final table as well as their interpretations, perspectives and thoughts on such domains and themes. I feel that, through such discussions, my awareness of what I was bringing to the research, through my interpretations, was heightened, and consequently the analytic process and the write up of the research was aided. [During the construction of the final table of domains and themes it must be said that I often felt over-whelmed by the scale of the data. 10 transcripts echoing 10 unique voices is a lot to keep in your head, especially when you are trying to listen to your own. I found it easy to get lost in the subtleties of phrasing, the complexity of the research topic and the ‘usefulness’ of my own interpretations which often seemed trite or incoherent. It was only through stepping back from a room full of spider-grams, dissected transcripts and post-it-notes, as well as staying focused on and confident in the analytic method, that a ‘story’ started to appear. Such an experience has taught me that the process of analysis is not only about the analytic strategy adopted but the internal management of that strategy. My anxieties as to the relevance of emerging themes and ultimately the use of ‘my’ research; my fluctuating level of engagement with the data given the distractions of my forthcoming wedding; and my annoyance at things not ‘fitting’ as I wished, all had to be managed. While at times this was hard going, as those around me will testify, on coming through it I can accept how this could be a necessary
process in the generation of new ideas an thoughts, which might be seen as the purpose of the research endeavour and, without being presumptuous, a hallmark of ‘good’ research.]

A note on evaluation

The analytic procedures employed in the present study aimed to address the guidelines pertinent to good research, specifically good qualitative research, outlined by Elliott et al. (1999). These include owning one’s own perspective; situating the sample; grounding interpretations in examples; providing credibility checks; coherence of analysis and presentation; accomplishing general versus specific research tasks; and aiming to resonate with readers. Such guidelines were approached in a number of ways. Through entering into an intimate relationship with the participants’ texts and repeatedly checking emerging themes against the primary source, the foundations for grounding my interpretations in examples were laid. Such examples are used throughout the write-up to allow for external appraisal of the marriage between the data in participants’ transcripts and my interpretation of such data, and also to give readers an opportunity to conceptualise possible alternative understandings. The credibility of the final analytic themes and analysis was felt to be enhanced by discussion with the research supervisors. This, it was believed, would both help mediate and shed light on my subjectivity in interpretations of the data and compensate for any idiosyncratic features of the approach taken by me which might lead to discrepancies or errors. It was also felt that such an approach would allow for greater coherence in the presentation of the final results.

A note on ethical issues

Ethical approval for this research was gained from the University of Surrey (Appendix 5), and, while it was envisaged that none of the procedures undertaken in this research would in any way cause physical or psychological harm to the participants, it was recognised that the subject matter and the reflective nature of the research may potentially provoke anxiety. With this in mind, during the conduct of interviews I closely monitored participants’ affective reactions to the subject matter and, while no interviews needed to be terminated due to the distress caused, at the end of each interview each participant was given information on potential sources of help should issues arise for them as a consequence of the interview.
Analysis

Demographic information

Five males and five females participated in this study. The mean age of the ten participants was 29.9 years (range 27-35; sd. 2.28), which can be broken down by gender into male mean age 30.6 (range 28-35; sd. 2.7), female mean age 29.2 (range 27-31; sd. 1.79). All participants described themselves as white, six describing themselves as white British; one as white Greek; one as white Australian; one as white German; and one described themselves as white – half French, half German. In terms of educational qualifications, six had postgraduate qualifications and four had undergraduate degrees. In terms of marital status, six participants described themselves as single; two as cohabiting; one as married; and one described themselves as divorced/separated. Five participants were full time third year trainee Clinical Psychologists (three studying on the practitioner doctoral programme at the University of Surrey and two studying on the practitioner doctoral programme at University College London) and five were full time third year trainee Counselling Psychologists studying on the practitioner doctoral programme at the University of Surrey. Five participants estimated they had seen between 31 and 45 clients during their training and five estimated that they had seen more than 46 clients during their training. Seven participants reported they had no experience of working with people with facial disfigurement while three reported they had such experience, two working with people with Downs Syndrome and one with a person with facial psoriasis.

Table of domains and themes

During the analysis, a wide range of themes emerged across the participants, highlighting the multi-dimensional nature of their views on the question of how the facial appearance of a client might influence the therapist as mediated through the therapist's perception of their own facial appearance. Ten salient themes, listed in Table 1, along with the number of participants who displayed them to allow for some consideration of their prevalence, were identified and grouped into four broad domains. The domains are heuristic organising categories and are not intended to represent discrete and independent entities. Each domain is considered in turn using verbatim excerpts to illustrate the salient themes they were felt to contain. In these excerpts the names and any identifying details of participants have been changed to ensure anonymity; empty square brackets indicate occasions where material has been
Table 1. Table of Domains and Themes

<table>
<thead>
<tr>
<th>Domain and Theme</th>
<th>No. of participants with theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>The nature of perception of facial appearance of self and others</td>
<td></td>
</tr>
<tr>
<td>1) Processes of perception</td>
<td>7</td>
</tr>
<tr>
<td>2) Macro/social influences on processes of perception</td>
<td>6</td>
</tr>
<tr>
<td>3) The influence of identification on processes of perception</td>
<td>4</td>
</tr>
<tr>
<td>Comparative aspects of facial appearance</td>
<td></td>
</tr>
<tr>
<td>1) Influence of own facial appearance on perception of client’s facial appearance</td>
<td>4</td>
</tr>
<tr>
<td>2) Influence of client’s facial appearance on perception of own facial appearance</td>
<td>6</td>
</tr>
<tr>
<td>The impact of comparative aspects of facial appearance on therapy</td>
<td></td>
</tr>
<tr>
<td>1) On therapists</td>
<td>8</td>
</tr>
<tr>
<td>2) On the conduct of therapy</td>
<td>6</td>
</tr>
<tr>
<td>3) Impact mediating factors</td>
<td>6</td>
</tr>
<tr>
<td>Difficulties with research topic</td>
<td></td>
</tr>
<tr>
<td>1) Difficulties with subject matter</td>
<td>5</td>
</tr>
<tr>
<td>2) Difficulties with research questions</td>
<td>4</td>
</tr>
</tbody>
</table>

The nature of perception of the facial appearance of self and others
This domain concerns participants’ views on the nature of how we come to perceive ourselves and others. It contains three themes encompassing processes of perception, macro/social influences on processes of perception and the influence of identification on processes of perception.

Processes of perception
In discussing how they came to perceive their own facial appearance and that of others, some participants identified an interactional aspect in the process of perception. Andrea stated explicitly:

I think that how one perceives his or her facial appearance depends largely on how others perceive them so it’s [...] through interactions and relationships and if you know you’ve been judged as [...] unattractive or attractive it is something that influences your own perceptions.
Such a view seems to fall in line with that of Cooley’s conception of a ‘looking-glass self’ where perception of self and other are inter-related (Cooley, 1912). This aspect of perception was also recognised by Brian:

[Your own] facial appearance I think depends on other people you are going out with too. [...] I certainly have friends who have time to spend in the gym, working out. They seem to work in places where appearances count, is a big part of their life, so they’re always well groomed [...] well looked after. I think I’d be more self-conscious in those situations than perhaps in others, where it’s sort of mates on a Sunday in a pub where appearance is very much secondary.

While Brian draws attention to the possible impact of perceptions of others, he also suggests a contextual component to perceptions of self in relation to others, a component also recognised by Gary when he said “Your face isn’t fixed. It depends on what’s going on around you”. Indeed the fluidity of the interactional process and subsequent perceptions seemed particularly emphasised by Andrea when she stated:

Who we are is always who we are [in] interaction with another and how I interact with you [...] differs to how I interact with other people and so who I am changes according to the person that I am with and so this sense of comparison [in] interaction is always there.

While such a description seems to encapsulate the idea of an ever changing relational self perception, one espoused by Cooley (1912), it also links such processes to comparison aspects of interaction, a view which seems to resonate with that taken by Gary:

I think there are comparisons [of facial appearance]. I view it in a sense of [...] rather than this distinction about separate cells, about individual self-contained cells, I see self or personhood as very much being [...] you can’t separate self from other [...] part of the other is present in ourselves. We know and define ourselves through the other.
Such views seem to recognise quite eloquently how comparisons might be tied in with interactional/relational aspects of being, a view consistent with that of Mead (1925) and Festinger (1954) where relational processes of being are seen as grounded in the social comparisons we make, comparisons ultimately from which we derive our self-concepts (Argyle, 1978) and through which assumptions about ourselves and others might be informed (Allport, 1979).

**Macro/social influences on processes of perception**

While discussing processes of perception and how they come to perceive their own and others’ facial appearance, some participants identified possible macro-social influences that might impact on such processes. Harriet identified gender differences as having an influence when she said “I think everyone is, but particularly women, [...] judged by the way you look. You’re categorised”. Erica drew attention to issues of race when she stated “I guess the first thing that I said [when describing my facial appearance] was white because in working with people from different ethnic groups it has been raised as an issue”. Indeed one participant drew directly on her personal experience describing how cultural difference might influence perception:

I’m dark and generally speaking culturally you’re not as dark and I am always perceived as Italian or Greek or Spanish. It’s something that stands out and it sort of makes it even more, even with clients they will ask you, “Are you Italian? Are you Greek?” Immediately they notice the difference... in my facial features and so it is something that [...] I can’t really escape, [...] It’s in the air and [...] I guess that it influences both myself and my client. (Andrea)

In discussing such influences, a few participants went on to draw attention to possible links between facial appearance and perceptions of social class or status:

It’s a bit like social class maybe. You live here, I live here, I’m in this place with my looks, I’m there too. (Ian)

I can sometimes think ‘More attractive, higher level of standing. Less attractive, lower level of standing’. (Brian)
Indeed a couple of participants referred to how perceptions of facial appearance might be seen as socially constructed – “looks are socially constructed [...] I think it’s about how looks are socially constructed” (Ian) – and one talked of how this might influence comparisons made:

The comparisons that you draw are against the norms of what is perceived as beautiful. They are culturally constructed kind of norms of a pretty face and you’re sort of bombarded with it [...] that’s really present in society so you look at yourself or I look at myself in comparison to that. (Gary)

He went on to suggest a power aspect in relation to facial appearance:

I suppose [facial appearance] comes into the realm of, you know, it’s political in a way, particularly when there’s going to be gender differences as well and a lot of it’s going to come down to power differentials. (Gary)

While potential power differentials in relation to facial appearance have been implicitly recognised in the literature with regard to economic opportunities, academic attainment and judicial judgements where ‘beautiful is good’ (Bull & Rumsey, 1988), the impact such power dynamics might have on the therapeutic encounter is as yet to be explicitly researched, an area that seemed to have left Ian to ponder:

[I] wonder perhaps if there’s something about power in therapy that, if you think you are better looking than your client, it gives you some sort of importance or something. (Ian)

[As the ‘story’ of my data unfolded the conception of a power dynamic in relation to facial appearance was the one that seemed to resonate most strongly with me. When I said earlier that more often than not my self-concept of my own face is one of ‘inferiority’, it seems this was exactly what I was pointing to. I do not think of my facial appearance as ugly or unattractive primarily - those are secondary evaluations some way divorced from me. I perceive myself as facially ‘inferior’ in relation to others, holding inferior facial status and power in the social politic where I feel ‘un-
The influence of identification on processes of perception

Also while discussing processes of perception in relation to facial appearance some participants drew attention to the possible influence of identification with similar face types:

I know there are some people who I would look at and instantly think of as more my sort of person [...] somebody more honest or somebody who's more friendly or might be have similar interests and I know that partly [...] might be facially. (Fred)

He went on to say:

Maybe if I had exactly the same look then I would feel more of a kinship, more of a strange identity that they might be similar to me in lots of other ways as well. (Fred)

The possibility of identification was also explicitly raised by Andrea:

I think identification plays a great role when you are trying to figure out attraction and how you seem to perceive others [...] I suppose it is a question of familiarity really. I feel far more familiar with people who are [like me].

The possibility of identification with 'similar' face types seems to tie in with Tajfel and Turner's (1979) conceptualisation of how people might become categorised into
favourable in-groups and less favourable out-groups according to comparisons made (as with gender, class and race). That is, similarities might be positively valued and differences negatively valued, following a positive attributional bias of our self-perceptions (Tillman & Carver, 1980). Such identification could then be seen as feeding into the development of stereotypes which, it has been argued, are a normal consequence of people's cognitive abilities and limitations, as well as their experience and the social information to which they are exposed (Dovidio, Major & Crocker, 2000). Such stereotypes might lead to the prejudice which Bull and Rumsey refer to when they point out “society’s prejudices towards those who have an untypical appearance can mean that an unattractive facial appearance could be a severe social handicap” (Bull & Rumsey, 1988, p.179), and indeed some participants identified how facial appearance might directly affect assumptions made:

A whole lot of assumptions are going to be linked into [perceptions of] attractiveness, whether they are going to be a nice person, or whether they are going to be arrogant, whether they are going to be self obsessed, whether they are going to be a person who I want to spend time with. [...] It's not purely based on facial features but I think you do make a huge number of assumptions based on somebody's [facial] appearance. (Joanna)

The potential of such assumptions, derived in part from social comparisons, to impact on the therapy context is dealt with later. The domain that follows explores the processes of perception and their influences in relation to the research questions.

Comparative aspects of facial appearance
This domain directly addresses the initial part of the two research questions. The first question relates to whether therapists' perceptions of their own facial appearance influence how they perceive the facial appearance of clients (the first theme). The second relates to whether therapists' perceptions of clients' facial appearance influence how they perceive their own facial appearance (the second theme). The subsequent part of these research questions, regarding the impact on the conduct of therapy, is addressed in the third domain.
Influence of own facial appearance on perceptions of client facial appearance

In response to this question some participants reported how they found it difficult to make a connection between perceptions of their own facial appearance and how these might influence perceptions of clients' facial appearance. Brian said “that link I'm finding very hard to make” while Donna reported “I haven’t noticed [any influence] yet”. A few participants however did seem to make a connection, highlighting how identification and comparisons of facial appearance might be at the heart of any influence:

If there was any kind of link between how I perceive myself and how I perceive someone else I suppose it would just be much more about [...] what we had in common with each other and perhaps what we had different [...], one of the things that I would do is think about them perhaps in terms of the sort of facial characteristics that I like [...] what I find perhaps more appealing. (Colin)

While Erica also identified a comparative/identification aspect to perceptions, she also linked any influence to strength of self-perception:

If I had very strong feelings about my facial appearance then it might come into it because then I might be comparing myself more to, you know, whichever end of the extreme I was feeling or I might identify very strongly. If I felt that I was very beautiful and I was speaking to a woman who was very beautiful, I might be more inclined to compare myself and to feel threatened [...] or if I was facially disfigured I might feel self-conscious.

It seems Erica pointed to extremes of perceptions of appearance as having potentially more impact on comparisons, a point which is recognised in the literature (Bull & Rumsey, 1988). Such a recognition, if taken with the fact that all the participants described themselves in the normal/average range of appearance/attraction early on in the interview, might in part explain participants' difficulty in considering the influence of their own facial appearance on perceptions of client facial appearance – that is, in such a range it has little perceptible influence. Future research might
therefore pay attention to gaining a greater range of self perceptions during participant selection in order to explore this issue further.

**Influence of clients' facial appearance on perception of own facial appearance**

In responding to this question participants seemed better able to conceptualise potential influences. Some participants identified how they might consider their own looks more if they perceived a client as attractive:

I guess with a really stunningly attractive client I'd probably think of myself as plainer. (Fred)

I think with some clients I'm not aware of [my facial appearance] at all [...] but with some clients I am. So possibly the ones that I'm more attracted to I would be more aware of my own facial appearance than those that are average and then ones that are facially disfigured I'd be more aware of it too. (Ian)

Again participants seemed to identify how facial appearance is more likely to impact on them at either the extreme of beauty or attraction or the extreme of disfigurement. In fact, one participant drew out how the focus of one's attention might actually change according to perceptions of others' facial appearance. He stated:

If they are attractive I am feeling much more nervous [...] but [if] I deem them to be average or less attractive or have some sort of outstanding facial feature then I would be more conscious about how I am making them feel and so monitor my own behaviour because of how it makes them feel. (Brian)

Here Brian seems to suggest that the perception of others' facial appearance as more attractive locates the focus of attention on oneself, while the perception of one's own facial appearance as more attractive locates the focus of attention on the impact it might have on the other. Furthermore, Brian seems to make a link between comparison aspects of facial perception and one's own feelings, that is, his feelings of nervousness when with a perceived attractive other. It is to a consideration of the impact of such links on the conduct of therapy that attention is now turned.
The impact of comparative aspects of facial appearance on therapy

Thus far, we have focused on participants’ views of the processes involved in perception of facial appearance and of the influences on this, as well as how such processes might be present in interpersonal aspects of therapy through comparisons of facial appearance. Attention now turns to the possible impact of such comparisons (the second part of the research questions) with regard to three themes: their impact on therapists; their impact on the conduct of therapy; and impact-modulating factors unique to the therapeutic context.

**Impact on therapists**

As with Brian when he said “If they are attractive I am feeling much more nervous”, several other participants identified how comparisons between their own and a client’s facial appearance might impact on their feelings or mood:

Well I guess if someone had a disfigurement I might be quite glad that I don’t in that sense I might be relieved. (Donna)

If someone was [very attractive] or something you could feel uncomfortable (Harriet)

With a facial disfigurement I guess […] I think it would make me consider my own face in terms of… in some way feeling […] a bit embarrassed or a bit guilty. (Fred)

Yeah I suppose when I’m, if I’m talking to someone who’s, a bloke who’s very obviously extremely handsome, in certain situations I’d feel less comfortable talking to him than somebody who I perceive as average like myself or just above average or whatever. (Ian)

A few participants also identified how comparisons might lead to a level of competitiveness with same sex clients in therapy:
Well with a very attractive client [...] all sorts of things could come into it. I mean if it was a woman I might feel a bit kind of, it might bring up competitive feelings in some way potentially (Erica)

I suppose in terms of another man then maybe it would be more competitive I suppose and more [a] rivalry type thing. (Gary)

While attraction might potentially lead to raised self-consciousness:

If I’m in a room with someone that I’m attracted to, and I think that’s true with clients as well, so I probably give a bit more thought at that time to my facial attractiveness, I think that wouldn’t be present if it was somebody who I didn’t find attractive. (Fred)

It is interesting that such discussions of competitiveness and self-consciousness take place with regard to perceptions of attractive clients. While this might reflect the potential link between facial appearance and social status or power differentials raised earlier, it should also be noted that several participants identified how, at either extreme of attraction or disfigurement, they might be curious as to how clients receive their (therapist’s) facial appearance. Ian considered:

I wonder if you do think [with an attractive client] if this wasn’t in a therapy session whether we could go out, whether you’d be interested in me.

Erica stated:

I would think about how it is for [someone with a facial disfigurement] to see me without that facial disfigurement and whether they think I can understand them [...] how they might feel about it.

It is felt such curiosity might belie a constant process of self-appraisal in relation to others, a view consistent with that of social comparison theory (Festinger, 1954), though this process might not always be in conscious awareness:
I think probably again largely at an unconscious or at the very least quite a periphery conscious level, [facial appearance] has quite a strong impact. (Colin)

I am not aware of myself [making comparisons], not so much anyway at a conscious level. (Joanna)

**Impact on the conduct of therapy**

In light of the above, attention is now turned to how comparisons of facial appearance might affect the conduct of therapy. A few participants pointed to how identification with clients with similar facial appearance might impact on the therapeutic relationship:

I suppose [in terms of therapeutic relationship] if you feel you’ve got some kind of allegiance with somebody I think that you perceive that you can get on with them better so perhaps somebody who I perceive is in the same facial status if you like, I’d perceive that perhaps I’d get on with them better. (Ian)

However, such references were minimal, with participants suggesting that it might not be so much identification with similar facial appearance but their level of resonance with facial communication that might impact more on the conduct of therapy, a point seemingly in tune with that of Bernstein (1976) and Cole (1988) who place particular emphasis on the face as a communication centre:

I think it’s more on the communication aspect of the face rather than the general structure or the appearance. I think that particularly affects relationships and the rapport in the therapy. It’s one of the most important aspects of the work. (Joanna)

I think what I respond to a lot more is expression, facial expression. I am influenced by facial appearance but I think that facial expression is really significant. (Erica)
Indeed some participants drew out reasons as to why comparison aspects of facial appearance might impact on therapists while they might not necessarily impact on the conduct of therapy.

**Impact-mediating factors**
Several participants suggested that the therapy setting is different from other settings where comparisons of facial appearance might have more impact. Donna said:

> When I go into the therapy setting I don’t really perceive myself as a woman who meets another woman [as] in a social setting where you might be more inclined to compete or something because it’s such a different environment.

She thus seems to qualify the earlier comments made by Erica and Gary as to how comparisons of facial appearance might impact on therapists and lead to a level of competitiveness with same sex clients in therapy. Harriet seemed to concur:

> In work with clients I think [comparisons are] just less likely to come up - not that [they] wouldn’t but I’m not kind of in that mode. (Harriet)

Others pointed to the reflective nature of the therapeutic context where monitoring of oneself and one’s reactions is prioritised:

> In this profession all these things need to be scrutinised all the time [...] so there are things that you need to be aware of and use them in an appropriate way. (Andrea)

> I have to monitor very carefully the kind of interactions, the interactional politics that we’re engaging in and to try and sort of open that up for discussion to step outside of those habituated or normal ways of relating [and] be able to reflect on that. (Gary)

He went on to say:
That's one of the key sort of challenges of working as a therapist in order to get that kind of [...] necessary capacity to take a step back and look at what's going on and not just get caught up in it. (Gary)

The idea of being able to step out of the therapeutic context and reflect on it was also raised by some in relation to the use of supervision. Erica said:

I would explore within myself how [someone's facial appearance] could maybe be affecting me, you know. If it was something that I felt was impacting on the relationship then I think I would take it to supervision.

If I really thought [someone's facial appearance] was distracting me [...] then I would talk about it in supervision. (Harriet)

While the impact of comparisons of facial appearance might be mediated through the monitoring/supervision processes above, one participant stated:

I suppose clients are generally quite a small part of your life. I suppose [perceptions of facial appearance] might be more influential in a social circle [...] rather than say a professional relationship with a client. (Joanna)

She went on to explain:

Your appearance probably wouldn't be brought into the therapy setting whereas you friends might comment on how you look. (Joanna)

This suggestion seems again to raise the idea that contextual factors as well as the value placed on differing settings for self-appraisal are likely to influence the frequency and strength of comparisons drawn. Given the general acceptance of the idea that we build up a continuous and changing picture of ourselves out of our interactions with others (Cooley, 1912; Gross, 1987), it should be recognised that such a picture is likely to be influenced to a greater or lesser extent by different contexts and relationships, depending on the value we attach to them. While this seems to fit with Kelly's (1955) personal construct theory of how we come to
conceive and interpret the world, it should be noted that little or no research has been
done with regard to how therapists' personal constructions of, and the value attached
to, facial appearance might impact on therapeutic contexts, an area which would thus
seem in need of attention.

Difficulties with research topic
During the conduct of interviews and in the feedback afterwards, several participants
pointed to difficulties they experienced in discussing the research topic.

Difficulties with subject matter
Joanna pointed to the potential pressure to give 'politically correct' answers:

It's a tricky issue actually. When you work in this kind of profession, you
have got to be seen to be very politically correct and it's quite difficult to talk
about these quite sensitive issues and bring your own perceptions into the
environment which you wouldn't do normally.

This was echoed by Fred:

I was trying to be very honest with you, where I probably wouldn't have been
had it not been for research, if I was having a general chat I suppose, so some
parts of it felt a bit awkward because I was trying to make sure that I wasn't
saying what I think a trainee psychologist should say.

While such difficulties might be seen as inherent in this potentially sensitive subject
matter where emphasis is placed on self-reflection with an unfamiliar interviewer - a
point realised by Donna who said "It's such an intimate thing [...] and that's why it is
so difficult to come up with something" - other participants identified difficulties with
the research questions.

Difficulties with the research questions
Erica seemed to find the interview schedule questions confusing when she said "I
found it a little bit difficult. I don't know if I understood it correctly", while Brian
said this, "It does get complicated, the questions are perceptions of perceptions".

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While attempts were made at clarifying and repeating questions to enhance participant understanding, it is accepted that the nature of the research topic was quite complex. Perhaps this complexity, taken with Andrea’s comment that “It is not an easy subject because you haven’t been asked in your career to think about it and so it catch[es] you unprepared in a sense”, might inform future research regarding the potential of preliminary work with research participants to aid their conceptualisation of the subject matter and the development of accessible interview questions.

Overview
The present research sought to explore qualitatively the views of trainee psychologists on the questions of 1) whether therapists’ perceptions of their own facial appearance might influence how they perceive the facial appearance of clients and if so in what ways this might impact on the conduct of therapy; and 2) whether therapists’ perceptions of clients’ facial appearance might influence how they perceive their own facial appearance and if so in what ways this might impact on the conduct of therapy. It was found that whilst most participants identified an interactional aspect in the process of perception between themselves and others, as suggested in the literature (Cooley, 1912; Festinger, 1954), generally they did not make a connection between perceptions of their own facial appearance and how these might influence perceptions of clients’ facial appearance. Although possible reasons for this might lie in the limited range of self-perceptions gathered, thus meriting further research, it should also be recognised that if no influence does in actual fact take place, there is very little or no theoretical basis for why this should be the case. Indeed, future research might do well in focusing on the processes involved in how such influence might be negated and thus contribute to an extension of current theoretical concepts in this area. In responding to the second research question, participants did seem much more able to conceptualise the potential influence of clients’ facial appearance on their perception of their own facial appearance. However, it must be recognised that while participants generally felt such influence might impact on therapists, due to a number of mediating factors in the setting of therapeutic work, they also felt such influence did not necessarily impact on the conduct of therapy. While such a finding might be taken as a positive reflection of the practice of therapy, a note of caution is due. As mentioned earlier previous research
has suggested that the conduct of therapy might indeed be influenced by the facial appearance of clients, particularly with regard to therapists’ judgements of clients’ self-concept (Hobfoil & Penner, 1978) or intellectual functioning (Sandler, 1975). It would thus seem that the ‘mediating factors’ identified as at play, in the conduct of therapy, during the present study, might not always be so. Future research might then investigate any underlying influences on such mediating factors, possibly attending to client and therapist characteristics; the therapeutic orientation; as well as context and setting characteristics, in understanding their interplay.

Given that this study was in many ways exploratory, several other issues were raised in its conduct (some of which have already been alluded to earlier), that might inform future research in this area.

It was realised from its conceptualisation that the research topic was a complex one trying to explore the link between the self-concept and interpersonal perception in the context of the therapy setting. While future research should recognise this and aim to simplify concepts for participants, possibly including some preparatory work, it should also recognise the inherent dangers in the research design above. Throughout the collection of data, it was acknowledged that participants were being asked to reflect on perceptions about face to face interaction whilst actually in face to face interaction with me the interviewer. Consequently a second layer of interactional processes was likely to be at play - that is, participants’ responses may have been influenced by their perceptions of my facial appearance (as well as my gender). While such an influence might be accepted as inevitable, and potentially at play in all face to face interviews as a research effect, it was felt that the present design might still elicit valuable information in this under-researched area. However, future research might consider alternative methods, away from face to face contact, in the collection of data in this area. Appropriate methods might include the use of postal questionnaires or telephone interviews, where participants’ information about the researcher’s appearance is kept to a minimum.

While the sampling procedures employed in this study were rigorous to ensure equal numbers of males and females and equal numbers of trainee Clinical and Counselling Psychologists, both of which seemed not to influence the responses given in any
substantive way (though these were never envisaged as categorical groupings in need of comparative analysis in this research), attention could have been paid to gathering a greater range in self-perceptions of facial appearance. All participants placed their appearance/attraction in the normal/average range and future research would do well to gain the voices of those that place themselves outside of this range, either at the attractive or unattractive end, and compare their findings to those presented here.

When using audiotapes in research, one should always bear in mind the possible influence that audio-taping could have on participants’ expression of views. In the present study it was recognised that participants might feel their professionalism or therapeutic skills were being evaluated, both due to the subject matter and being interviewed by a ‘peer’. In order to minimise the effects of this, I took account of my own active listening and therapeutic skills in order to create a relaxed and non-judgemental environment in which the interviews could take place. Furthermore, each participant was asked for feedback on how they felt about being interviewed about this topic which provoked a range of responses. While some identified how the subject matter made them feel uncomfortable and self-conscious, despite attempts as mentioned to create a relaxed and non-judgemental environment, others reported they felt it was an interesting and valuable research area and one that they hadn’t thought about previously. Indeed a few participants identified how participation had made them consider aspects of their practice from which they might draw in future client work. While the aim is in no way to be grandiose, such feedback might point to the possible merit of attending to the interplay between self-concept and interpersonal perception, with regard to facial and other aspects of appearance, in the training curriculum.

To conclude, the present study sought to shed light on how the facial appearance of a client might influence the therapist as mediated through the therapist’s perception of their own facial appearance, thus addressing a social comparison aspect of the therapeutic encounter which seemed absent from the current practice literature. It is felt that, despite a number of limitations, the present study adds an important qualitative dimension to this topic and it is hoped that, given its adherence to the guidelines pertinent to good qualitative research (Elliott et al., 1999), its contribution will be of value to the development of future qualitative research in this area.


Appendix 1: Participant information sheet

Terry Boucher
School of Human Sciences
University of Surrey
Guildford, Surrey. GU2 7XH
Department of Psychology
Tel: XXXXXXX
Fax: XXXXXXX
Research Supervisor
Tel: XXXXXXX

I am conducting a study investigating the influence of client facial appearance on therapists as mediated by therapists' self perceptions. The research aims, through the conduct of interviews, to explore trainee psychologists' perceptions of how different client characteristics might affect them in therapy. This exploration will be conducted through discussion in relation to three ‘face types’, one ‘attractive’, one ‘unattractive’ and one facially ‘disfigured’.

As part of the study, you will be asked to complete a demographic questionnaire and participate in one face-to-face interview which will be audio-taped and take approximately 1 hour. While the procedures used in this study are non-invasive and no physical or psychological harm is envisaged, it is recognised that the subject matter and the reflective nature of the research may potentially provoke anxiety. With this said I wish to make explicit your right to withdraw from the research, unquestioned, at any time and assure you that space will be given at the end of the interview to allow for any feedback you may wish to give.

Any information given by you in the course of the interview will treated in confidence and the audiotape recording will be used for the sole purpose of transcribing the contents of the interview for analysis. You will not be individually identifiable from this transcript, and the tape will be kept secure and erased after the completion of the study. Your name will not be used in any way during or after the
research and once the research has been written up you will be given a written summary of the research findings.

I would be very grateful for your participation in this study, and if you have any further questions please do not hesitate to contact me either in department or by telephone XXXXXXX or e-mail XXXXXXX.
Appendix 2: Consent form

Terry Boucher
School of Human Sciences
University of Surrey
Guildford, Surrey. GU2 7XH
Department of Psychology
Tel: XXXXXXXX
Fax: XXXXXXXX
20th January 2004

CONSENT FORM FOR RESEARCH INVESTIGATING THE INFLUENCE OF
CLIENT FACIAL APPEARANCE ON THERAPISTS AS MEDIATED BY
THERAPISTS’ SELF PERCEPTIONS.

a) The purposes of the research project and interview process have been explained to
me to the point that I am adequately satisfied that I understand what I am undertaking
and I hereby give my permission to be interviewed and for the interview to be
recorded.

b) I understand that the audiotape recording will be used for the sole purpose of
transcribing the contents of the interview for analysis, that I will not be individually
identifiable from this transcript, and that the tape will be kept secure and erased after
the completion of the study. I understand that all data will be handled in accordance
with the Data Protection Act 1988.

c) You may add any special conditions here;

Note: In giving this signature of consent you do not lose any rights to withdraw from
the research, unquestioned, at any time, nor of undertaking legal action should you
ever feel an audiotape has been used irresponsibly.

Name .................................. Signature ..............................
Date ..............
Researcher....................... Signature ..............................
Date ..............
Witness......................... Signature ..............................
Date ..............
Appendix 3: Interview schedule

A. PERSONAL DATA

A1. Are you?  
   Male ________  
   Female ________  

A2. How old are you?  
   [ ] years  

A3. How would you describe your ethnic origins?  
   Choose one section from (a) to (e) and then circle the appropriate category to indicate your ethnic background.

   (a) White  
      British  
      Irish  
      Any other white background, please write in below  

   (b) Mixed  
      White and Black Caribbean  
      White and Black African  
      White and Asian  
      Any other mixed background, please write in below  

   (c) Asian or Asian British  
      Indian  
      Pakistani  
      Bangladeshi  
      Any other Asian background, please write in below  

   (d) Black or Black British  
      Caribbean  
      African  
      Any other Black background, please write in below  

   (e) Chinese of Other ethnic group  
      Chinese  
      Any other, please write in below
A4. What is your highest education qualification?
    Tick the appropriate answer.
    Postgraduate degree/diploma
    Undergraduate degree
    Diploma
    A-level(s)/AS-level(s)
    GCSE(s)/O-levels/CSE(S)
    Other

A5. What is your current marital status?
    Tick the appropriate answer.
    Single
    Married
    Divorced/separated
    Widowed
    Co-habit

A6. What Psychology course are you training on?
    Please give year of completion.
    

A7. Could you briefly describe your current placement and your theoretical orientation?
    

A8. As a trainee Counselling or Clinical Psychologist, what would be your estimate of the number of clients you have worked with since the start of your training? Please circle.
    1-15    16-30    31-45    46+
A9. Do you have any experience of working with people with facial disfigurement? Please give details.

B. MAIN INTERVIEW

I am interested in how your perception of your own facial appearance might influence how you perceive the facial appearance of clients and how you perceive this might consequently impact on the conduct of therapy. I will ask a number of questions relating to this area and please feel free to express your thoughts openly in this confidential setting. (Possible prompts bulleted – if answers given in the negative then explore i.e. If not why not? How would you overcome/manage that?).

Q1. Could you please describe how you perceive your own facial appearance?
   • Attractive/unattractive
   • Distinguishing features

Q2. Could you please describe how you perceive others to perceive your facial appearance?
   • Attractive/unattractive
   • Distinguishing features

Q3. How do you think your facial appearance might affect a) you, b) others?
   • Socially (Cognitions,
   • Relationships emotions/mood,
   • Professionally behaviour)

Q4. How do you think others facial appearance might affect you? (Explore different face types).
   • Socially (Cognitions,
   • Relationships emotions/mood,
   • Professionally behaviour)
Q5. How might a client’s facial appearance affect you? (Explore different face types).
- Physical reactions (eye-contact/anxiety)
- Psychological reactions (empathy/blame)
- Any experience of working with facially disfigured?

Q6. How do you think your perception of your own facial appearance (cite own perception) might influence how you perceive a client’s facial appearance? (Explore different face types).
- Comparisons/disparities (gender issues/comfort/power)
- Timing in relationship (1st impressions)

Q7. How do you think this might impact on the conduct of therapy?
- Motivation/therapeutic relationship
- Judgements/formulation

Q8. How do you think your perception of a client’s facial appearance might influence how you perceive your own facial appearance (cite own perception)? (Explore different face types).
- Comparisons/disparities (gender issues/comfort/power)
- Timing in relationship (1st impressions)

Q9. How do you think this might impact on the conduct of therapy?
- Motivation/therapeutic relationship
- Judgements/formulation

Q10. Is there any additional information that you want to add?

Q11. How do you feel about being interviewed on this subject?

Thank you for your time; your answers have been most helpful to the project.
Appendix 4: Sample interview transcript

Researcher1: Could you please describe how you perceive your own facial appearance?

Participant 1: Umm... First of all I just, I just find it important how I don't discriminate how others perceive me and how I perceive myself I think that how one perceives his or her facial appearance depends largely on how others perceive them so it's a, a through interactions and relationships and if you know you've been judged as umm unattractive or attractive is something that influences your own perceptions so I have admit that so far especially through my relationship with um my mother really me and her have a very close relationship and generally come from a good background it's, we are rather overt with each other more than my experiences in this country at least. It's umm, I have a positive image about how I look and er it's something that I feel that I became conscious of quite early in my life because I was also an only child and the attention was much more I suppose than it would be if I had brothers and sisters so... umm. I have, have a positive idea about how I look and it's also it has become a bit more I think with this population in this country simply because I'm dark and generally speaking culturally you're not as dark and I am always perceived as Italian or Greek or Spanish. It's something that it stands out and it sort of makes it even more, even with clients they will ask you, 'are you Italian are you Greek?' Immediately they notice the difference... in my facial features and so it is something that I um I can't really escape really you know it is something that becomes even in first session... it's in the air and umm and umm I guess that it influences both myself and my client it has an influence.

R2: In what way does it have an influence?

P2: Umm... I guess immediately you know they will mention the darkness, although it is not really a skin colour but it's you know eyebrows and hair colour and then umm... they will infer possibly through my accent and everything that I have this Mediterranean air. This is something that I hear a lot... that you have these Mediterranean features and so I don’t know what the projections and what they think
after that but it's something that I find interesting that they mention without making any references myself in the first instance.

R3: So they may make assumptions?

P3: Well I guess that there are assumptions everywhere I suppose yes and they can be very personal so... how others perceive the whole idea of the Mediterranean culture is another thing entirely

R4: In a way you have anticipated my second question which was could you please describe how you perceive others to perceive your facial appearance?

P4: Umm... yeah it's umm usually exactly that they notice the darkness of it the, the it's... and most of the time they, which is something that which I always found very interesting everybody perceives me as Spanish so umm immediately I have to say, 'no, no I am Greek' you know, then usually a conversation follows “oh your Greek” and all this stuff and... it does influence it.

R5: So there is a cultural aspect to your facial appearance...

P5: Yeah yeah...

R6: So how do you think your facial appearance might affect you?

P6: I think that it is umm generally speaking through attendency I think identification plays a great role when you are trying to figure out attraction and how you seem to perceive others for example if I have in front of me someone whose extremely blonde according to my standards for example which is very different not only for me but for my own experiences as an adult in my country and so for example the blonde with blue eyes it strikes me as different and it can attract me or it can create this estrangement between two umm... so... I suppose it is a question of familiarity really I feel far more familiar with people who are darker than with those who are blonde or lets say with red hair... I haven't... I don’t know any person... anyway I don’t have any friends with red hair for example... once I was working with an Irish client and I
remember that initially was striking with a colour of hair and amazing blue eyes and although I didn’t immediately think wow what an attractive person definitely I noticed a difference in the appearance. So it plays a great role.

R7: So it’s through identifying with people...

P7: Through identification and difference, yes, yes absolutely

R8: And what I am picking up is that you identify with people with more of your own face type and hair colour

P8: I identify in terms of that they will... I think I can possibly ignore it, it can pass unnoticed when when a sameness exists but when something is strikingly different from me then it is on the spot.

R9: And that’s kind of like socially and maybe in relationships you’ve mentioned but also what about professionally how might...

P9: influence what?

R10: Your facial appearance, identifying people of your own face more or the relationship aspect of facial appearance

P10: Yeah

R11: Do you think it has an influence?

P11: Umm I think that.... I wonder if it’s a question to be honest a question of comfort really I mean professionally it wouldn’t be the first thing that I would think of but it definitely doesn’t pass unnoticed so the moment lets say that someone comes into the room and I feel that... I mean I play a role... appearance and also how I feel the other person doing even if we speak in terms of, of an aura, I know physically for example I have an extremely overweight person it will affect me in my thinking in how I will be with this person I will become more sensitive with this issues. I mean it
will definitely influence my behaviour for example or I don’t know an anorexic person. I will, I think that I will become more sensitive on certain issues for example as I said if it was body weight I would be sensitive on issues surrounding eating or something. If someone I feel that he is extremely attractive or extremely unattractive again I think I will be guarded when the conversation is relevant to these areas or guarded or a bit more careful let’s say. Or if I perceive them extremely attractive and umm... During the conversation that we are having or in therapy... who notice I don’t know, I notice areas that can be perceived as transference, counter-transference issues, my interpretation of those things will be relevant to how I feel about this person. For example, if I found them attractive I might say more easily that hey there might be an erotic transference here than it would be the case if the person that I had in front of me was unattractive. Which is not necessarily right because for the other person I might be attractive but for me if the other person is not attractive I don’t think that I would think immediately in terms of erotic transference or counter-transference.

R12: So someone’s facial appearance might affect you in your thoughts about them? Might it also affect your mood or behaviour in any way?

P12: Yes I don’t think that in anyway we, we... I mean I disagree with this idea that we compartmentalise ways of being with others I think that how we look with how we behave and how we are in the context of in a room... influences to a great extent our interaction with others and umm if I am in a bad mood and my first client is someone whom I like physically I might feel much better than having someone who is more umm.... Who makes me feel more tense for example or with whom I don’t feel that comfortable or I feel that there is a facial disfigurement or they are very unattractive and I am not really in the mood to be in this way, as I said before I might be more guarded and more uncomfortable. So yeah I think that it does influence how I feel and my mood and my interactions.

R13: Again we are kind of moving on to my question that I have which was how do you think others facial appearance might affect you? I mean referring to how I think...
P13: Yeah help me a bit because I think that I might of have, umm, not answered it but I don't know how to add to it...so

R14: Well I think we were discussing just then about how a client's facial appearance might impact be it a facial disfigurement or if they are very attractive how it might alert you more to the counter-transference.

P14: Yes and how it might affect my own mood and feeling and how umm.... In a way we might even say how conscious this other person makes of myself how I look. And how self-conscious I become and the funny thing is that in this profession all these things need to be scrutinised all the time because it's not like you know you go out and you can start flirting with someone or you can be critical or umm... judgemental. So there are things that you need to be aware of and use them in an appropriate way and within the context so you can, you can....ummm get things out of it really because as I say simply because theoretically I feel that we all use these aspects of ourselves in the way that we behave, then immediately these aspects become sources of understanding the other. So although some people might say we shouldn't judge and criticise someone whom we perceive unattractive if we are talking about facial disfigurement which it's different then just perceiving someone as unattractive, with facial disfigurement for me to some extent it is a stigma. It is something that the person who has it has lived with it and who has certain ideas and thoughts around what he or she looks like. So immediately they become sources of understanding his own identity and self and we can't really say, "oh no, no, no I don't look at appearances and I don't pay attention to that, I'm trying to understand the psychic of the other" for me it's bullshit you know... to understand the psyche is part of understanding how the other person looks externally as well. There aren't clear demarcations...

R15: Yes, so there's an interactive aspect...

P15: Element, yeah, yeah...

R16: ...when two faces meet if you like...
R17: Umm you mentioned about umm... facial disfigurement and my next question is really to focus more on how client’s facial appearance might affect you in therapy and I thought we might stay with the idea of a disfigured face or sort of a disfigurement... how that might affect you...

P17: In terms of feeling?

R18: Well feelings yes.

P18: First of all I’ll notice it... and depending on the disfigurement I might feel a range of experiences from sadness to I don’t know to a scar which I might have because I fell once in my life from a bicycle and I have I don’t know two scars on my face and I might start fantasising about that... umm... I might feel awkward, I might feel curious how it happened, whether it is a birth issue, or whether they had an accident. So it’s, it’s again I think it’s intricate and it will make me... and it will stand out and something that stands out, at least for me, is something that immediately attracts my attention and makes me interested and curious. So I think that as it the case with an attractive person or an unattractive person or someone with a facial disfigurement... and someone whom I perceive as a more or less normal face or let’s say not normal, umm....umm... fuck what’s the word, common, let’s put it that way something that you know you’re used to, you wouldn’t say that they are very attractive or very unattractive or have a disfigurement, someone who just passes, you know you are used to in terms of a sight. Those who belong to the category of something more extreme the effect is again, the intensity is again greater I think for me, when they first enter the room and then there are so many other things that happen in the interaction so I might after a while go with a completely different feeling, for example at the beginning I might of felt interested and curious how something happened lets say if it was a facial disfigurement, and after a while I might feel that wait a minute the way that he or she interacts with me is rather flat, so it affects but at the same time it doesn’t prejudge my interpretation of something but it definitely effects my first reaction.
R19: You mentioned there a lot of maybe cognitive and emotional reactions are there any physical reactions you could imagine having?

P19: Well with all emotions I have physical reactions...err. So it can be if I find someone umm... extremely attractive I will have a physical reaction that goes with being extremely attracted. If umm... something scares me or I find curious I might have a tightness in my stomach you know generally speaking I am very aware of my bodily... umm... feelings as well. And sometimes they come first...

R20: before the...

P20....yeah so I notice them and try and figure out why. It is not that obvious immediately.

R21: If we move on to the next question which is....well so far we have discussed your perceptions of your own face and also we have started to ask questions about how you might, how your own facial appearance might influence you possibly. I'm just wondering how you think your perception of your own facial appearance might affect your perception of a client's facial appearance?

P21: Give me more

R22: I am... you discussed initially the kind of relational aspects...

P22: Having a positive let's say aspect of how I look, let's start with that...

R23: Yep, having a positive aspect of how you look...

P23: Yeah...

R24: How that might influence how you perceive a client's facial appearance or just how your perception of how you look might then... I think you discussed it in terms of the relational aspect of how it's a mediating thing and a curious thing that is negotiated between you. So I'm really just trying to explore that a little.
P24: So do you mean that for example that if I feel that I am attractive how this will influence how I feel the other?

R25: Yeah

P25: Or how I see the other? So whether I will compare how I look with how the other person looks?

R26: How there might be some comparison there possibly, yes.

P26: Umm... I don’t think that this will come immediately to my mind, for example, once... but I think that it is there, and to give you an example, although it never happened during the session in an overt way, we never discussed it with this client. One day, she was a black attractive as far as I am concerned but she didn’t perceive herself attractive, a bit overweight woman, who out of the blue simply because she was talking about certain issues that she had, she couldn’t go to the gym or something like that, I can’t remember exactly, but out of the blue she said, “but you see, you are an attractive slim woman”, and this is something that came out of the blue but obviously it was something that she had in her mind and she had felt, I don’t know how early in the sessions, but I think that a comparison is always there and it is part of how we interact with others because I think that again I do not agree with this idea or theoretical standpoint who views individuals as unique autonomous umm... creatures that do not relate with the others, you know the Cartesian idea, the isolated mind. Who we are is always who we are interaction with another and how I interact with you is differs to how I interact with other people and so who I am changes according to the person that I am with and so this sense of comparison interaction is always there. Sometimes it just stands out when we are talking a patient with disfigurement but it is always there. So I don’t think that I am all time self conscious of my own looks or how my clients look. Umm... but I do think and I do feel that in a culture like ours, and not just you know the western lets say culture where we are bombarded by all these images. You can be highly threatened if you don’t look attractive. And so and vice versa, you can feel rather secure if you perceive yourself as attractive. And I think that all these things play a role in how we are and how we interact, in every setting, in the only difference is that in our setting it becomes
something that we can not use for our own means. You know what I mean? That simply because I might feel that I am attractive and one day I just feel, I don’t know, in the mood to flirt with someone doesn’t mean that I will flirt with my client. Umm... but it would cross my mind and I don’t think that we stop it completely. It will cross my mind and then I will stop it and I will possibly analyse it in supervision. You know it becomes something that you analyse, or you observe or you use.

R27: So there is a comparison aspect to both for yourself as a therapist and for the client and it’s something the therapist will use or work with? Or is there for the therapist to work with in therapy?

P27: Absolutely because I think that if a therapist for some reason if we’re talking about an extremely good looking person, who then becomes a therapist or decides to become a therapist, even if this person says, you know, ‘No....’ no I’m not sure, simply because I think that it is something that you can not avoid because others will notice so even if you are not, lets say, rather narcissistic in connotations in the sense a very self absorbed person who would use your facial features and how you look, still it is an issue for you. You are aware that you are attractive, one way or another, so in context in this profession I think it would be an underestimation to think that it doesn’t play a role in how the client will see you, perceive you and engage with you and be with you. So I think that you should be used in a way that it’s a productive way and that it is a way that can cultivate the atmosphere for the other, for the client being, because it can very easily put off the client who feels that they might not be good looking. Or umm... I had clients for example other cultures you know they are attracted to the lady of the Mediterranean culture. They start projecting sunshine, sea, this, that, you know people are more open, are more warm and suddenly I am surrounded by ten adjectives which if we sit down and try to objectively understand I might not have, I might have half of them. So if this happens about culture why not happening about how I look and I think that this are there but sometimes it a taboo. You wouldn’t say to the therapist, “oh my god you look so attractive”, it’s a taboo, you wouldn’t say that, but you would say, “I love Greece, I’ve been there, every summer I am there” And suddenly it’s an implied way of “hey I like you as well, I am happy that you come from there”. So if it happens for that why not happening for how I look or for how somebody else looks. And I think that.
R28: So, it's a perception, your own perception of your own face maybe used in a sense of understanding patient's world and understanding their relationship with you and how they are relating to you?

P28: Yes, yes because since it influences the other person and I believe that it does then for example when this happens with my client, when this client said to me, “but you see you are attractive and you are slim” one way is to say, “hey thank you” and then go home and say “hey my client feels that I am attractive”. The other way is to use it and say, “wait a minute, all this time when we talk about these things and you are telling me I'm not, I'm ugly”, this is how she was perceiving herself, “and I am over weight, at the same time you were feeling that I am the right kilos, the right weight, slim as you said and attractive. How does this influence you?” You can use this productively for the other, and fortunately unlock the client at that point and make something which is a taboo a, potentialise it and make it a topic of conversation, if not analysis, conversation you know to introduce, to bring it in the air, not to leave it there hidden.

R29: I get the sense that it is something that you think can be brought into the therapy, as it might be useful.

P29: If umm... potentially. You don’t choose it because you don’t know whether it is an overt issue for the other but if it comes up I think that it can be as important as others....so to use it, it’s a... out of context, I don’t think how, it can you know umm...you can help the other. But if the client has certain issues about how she he looks or how he feels about his own body or whatever and this comes up I don’t see any reason why not try to, to, to talk about it. Just not make it, not to hide it and not to feel bad about it because you see it can create other type of issues, like I don’t know, an inferiority issue, or I might start fantasising about it myself and then I have no reality testing, but by bringing it in the air, in the context you test it.

R30: Sure, umm... so we’ve talked broadly about a number of subjects, I would like you to be more specific about different face types. So if we thought of how your perception of your own face may influence you in the presence of a very attractive client. If you could imagine a very attractive client, how might that influence you?
P30: In what way influence me, umm...in what way?

R31: Umm...it could influence motivation or...your relationship...

P31: Oh I see in this way.

R32: I suppose in the conduct of therapy how...

P32: Apart from... I think apart from affecting the mood I’m in I want to believe my motivation to work with someone is not diminished if I felt that this someone is unattractive. Umm... but it might do that, because as I said if I am having a bad mood and I am seeing a client who evokes certain negative emotions in me it will affect me. But if I am in a bad mood and I am seeing a gorgeous client it might affect me in a positive way. So I think that the important thing is to be aware of these things and to try and use them productively, so, and that’s why I think that it is important to think of the physical appearance and to think of the body interaction with the other as an essential aspect in therapy and we should make everything as a mental, intellectual game between the two and segregate them. So I suppose that I mean, honestly when I think of my clients, apart from... very quickly the motivation is influenced by the type of difficulty that the other person has. So let’s say I might feel deskilled when I am having a very complicated client or case in front of me. Or I might feel more motivated when I feel that I am dealing with a difficulty that I feel comfortable to deal with. I am not that sure whether my motivation or way of working in terms of therapeutic way of working is influenced to a great extent by the other person’s facial appearance because even if it were I would feel bad about it, if it were a negative way, I would consciously criticise myself, because I will say this not the place where you might go, or you have to cultivate how you feel about the other, physical speaking, the focus is on how the other person feels. So immediately I would balance it more than I would if I were to go out for a coffee with someone. So although it plays a role in therapy as far as I am concerned in the therapeutic interaction, the main focus is not there. Umm... and so if I felt if I am not that motivated to work with that person I would scrutinise it a bit more to see whether there isn’t another motivation that’s how to do with how the other person looks. But it would be in my mind to check it out, absolutely.
R33: So it is something that is a, you would aim to be aware of in the therapeutic relationship and to monitor its impact.

P33: As I would monitor every single thing, everything really.

R34: Okay.

P34: Plus I have another thing, it's far more, I mean having the advantage of coming from a different culture, and not an advantage because it is a Greek culture but it is a different culture in terms of the PC we are not as PC as the English, and this PC, by politically correct I mean, so umm... something that here is perceived to be gossip in Greece is normal conversation. Judgements in terms of “hey she, he is gorgeous” or “oh my God he looks like a monster” come very easily in Greek culture. Here in my opinion they might be felt but they won’t be articulated as easy because it is not proper so I think that these types of issues are far more taboo in this country then they would be in mine and umm... and I've seen that in supervision because I have referred to these things and the reaction that I got was more like, there was a difference in the expression that made me feel, “oh oh” perhaps I said something that I shouldn’t have said. You know as if it was a personal judgement that I shouldn’t have made when everybody would feel if this person walked in the room that at least they are not common. They have something that is different and that might be appealing to some people or it might be I don’t know negative to some others. But to articulate it and to use it, I think that sometimes culturally it is not the same here.

R35: So the articulation of inner thoughts...

P35: To make this judgement immediately say and make the judgement, and think in this way, sometimes I think that it can be perceived as a judgement here when it is not in my country.

R36: Okay yes so...

P36: In my culture..... I'll give you an idea. Take some simple things. For example, discrimination of when it comes to handicaps, in this country for every single I don’t
know light on the street there will be this difference in the pavement so a wheelchair can pass. So there is a type of respect and also an attempt to equalise the difference and to respect that the other person it is not as healthy as say as you are. But the label, the idea is to make the label, for the label to stand out less, this whole idea of the handicap and how much they can do. In my country you don’t see people in wheelchairs in the street because they can’t go out, because we don’t have these facilities. So imagine if we once saw someone in the street immediately everybody would turn and look. Possibly they may turn to their friends and say, “hey look poor guy”. Things that perhaps you feel yourself when you see them here but simply because you are more accustomed to them and you are more in to a society that tries to equalise these things you won’t allow yourself to feel them. So it doesn’t become the same issues.

R37: so behaving in a socially appropriate way...

P37: Yeah, yeah

R38: ...okay. Is there anything else that you would like to add to what we have discussed? I mean how was it...

P38: I find it interesting the whole idea of how I feel about myself might influence my therapeutic practice. It was one of the questions that I found difficult to reply because usually I think the other way round, how the other affects me, and not how my self perception, how I use my self perception to be with the other. And I still have difficulties with that. I mean I, I... apart from what I said that I think that if you feel that you are a good looking person you possibly feel more secure in your existence. I am not able to elaborate on it and whether you had other stuff in mind that I can agree with or disagree, you know, and elaborate more if you want to...

R39: I really didn’t have any kind of prompts along that, it is more kind of, that is the key to the investigation, really, to find out what kind of things that... but certainly we’ve been, if you’ve got a positive appearance of yourself, the confidence that that might ensue in going into...
P39: You know how it is...

R40: ...therapy. I mean there might also be aspects of why, what confidence you need to be to actually become a psychologist, I mean what kind of personality traits you need to be confident enough that you can listen to someone else in the room.

P40: Which again you know yeah it depends, there are other people who they can use other lets say advantages they might have simply because they feel that they are not as attractive. So they can use, they can be even more motivated because they feel that they can win their case in a different way. You know what I mean?

R41: Yes, and there was also one aspect that didn’t really come up and I would be happy to run by you that if it is a relational aspect between faces, if there is a large disparity between say an attractive therapist and an unattractive client or vice versa how that might influence the power relationship? And whether one feels that one can be understood or understand the other if there is a disparity.

P41: I want to give you an example imagine if I am, if I am a client because and you know as I said if I am a therapist I won’t use it in this way because it wouldn’t be productive, helpful for the client, because lets say the client is an extremely attractive person, who is talking to a therapist who is unattractive. If for some reason they like each other so they feel that they can work with each other and they have a good therapeutic relationship and there is trust between them and they have a good working alliance and etc. etc. And one day the client wants to share an experience of him entering a room and every single woman turning and looking at him and drawing over him. There would be a second thought there to bring it in context because if this client perceives the other person as ugly then possibly he will feel that the other person is also feeling that she is not as attractive so it would be, he would censor, in my opinion, this type of comment because it could be perceived as an insensitive thing to say. If for example or with body weight, I have experienced this myself with body weight when the client does not bring this issue because she feels you’ve never been overweight in your life and you can’t possibly understand and unless you demystify that it becomes an obstacle. That is why I am saying it has to be used
appropriately, physical appearance or how we look, how we weigh, whatever because I think it is an issue but it doesn’t come out as easily as other issues.

R42: So what I am picking up there, if there is, if you are aware or conscious or if you perceive a disparity, maybe it’s that disparity that needs to be worked with at some point in the therapy if it should come up or it may come up in other forms. But if there is less disparity it is less likely that issue will come up.

P42: Yes because I think identification plays a great role in how we perceive others and how we relate with others. So if I feel that somehow I am the same with my client, my, when I used to be in analysis I used to be with an Italian therapist there were certain things that simply because I knew that culturally she understands I wouldn’t even bring up or I would bring up with less words then I would if my therapist was English. So simply because you identify with certain aspects with the other which mistakenly sometimes but other times quite correctly they don’t come up but if there is a disparity and you want to make yourself understood then you need to emphasise them and there are certain issues I think that they don’t come up easily and they should. If they are an issue for the client I guess I don’t see any reason why and that is for everything, not just physical appearance but other things that you might raise that you are interested.

R43: So in a sense it is the disparity that might affect the therapeutic relationship?

P43: Yeah some would say?

R44: To what sense?

P44: Because it makes things to stand out when things are the same, if you look, lets say for example if you have the mosaic with patterns and all the patterns look the same and then eventually you get used to what you see but if something is added which is completely different from the rest of the pattern then this something stands out and immediately becomes a focus. With certain things you feel okay to discuss them with other things you might feel you know I shouldn’t, or they are not relevant I feel that sometimes although the person comes to you lets say with a relationship
issues with their mother and this person is facially disfigured although initially you think okay they facial disfigurement has nothing to do with the issue that the client brings still it is a difference that stands out and makes, it has an affect. And I think it would be wrong to just neglect it and it should be, and it does effect how the therapist feels and how the therapist relates and if it comes out you use it. If it doesn’t you don’t bring it up but it still affects you, it still it has to be processed by the therapist.

R45: So I am picking up there that in a way it is something to be worked with if that comes up because it may be an aspect or if that comes up in that person with a disfigurements life at other stages for example with their mother...

P45: It could...and also I can end up being a highly judgemental person for example I know that I would be scared to work with an anorexic. So I think it is an advantage to know your own physical, my own physical and emotional reactions with an anorexic, to respect that about myself that I can not work with, with anorexics and to ethically make the decisions not to work with them because the issue would be such for me that I would never be able to deal with this with a client to help a client. And some people say this is barriered this is judgement why are they different, but they are different I mean simply because I can not look at depression it doesn’t mean that it’s not there or the other person doesn’t feel it but somehow working with depressive individuals does not affect me in order for me to leave my job depressed with myself I can use it therapeutically but with an anorexic I feel so sorry and so in need to help the other in some way, that it is my issue in the end and I think it is important to.... and for me it acts as a disfigurement to give you an idea.

R46: Well thank you very much is there anything that you would like to add any more?

P46: No... I don’t think that I can.

R47: How to you feel being interviewed about?

P47: I found it very interesting I enjoyed it. I felt that it was difficult for me to stay with a question and just answer the question I would, whatever came to my mind I
would share and try to see if it fit with the question so I don’t know whether, when you transcribe it you will be able to get some, find it coherent in terms of an answer to these questions that umm. It is not an easy subject, I don’t think it’s an easy subject and it could come up that if I continue talking about it others stuff will come to my mind. One of the reasons it is not an easy subject is because you haven’t been asked in your career to think about it and so it always catch you unprepared in a sense, and while I was talking I was feeling other stuff and other things were coming to my mind and then…. I would use it as much as I could. It is very fresh as a topic it is not something that I have a crystallised idea or opinion, lets put it that way.

R48: Ok, thank you very much.

P48: You’re very welcome.
Appendix 5: Ethical approval

27 February 2004

Mr T Boucher
Department of Psychology
School of Human Sciences

Dear Mr Boucher

The influence of client facial appearance on therapists as mediated by therapists' self-perceptions: a qualitative investigation into the views of trainee psychologists (EC/2004/16/Psych)

I am writing to inform you that the Ethics Committee has considered the above protocol, and the subsequent information supplied, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee's website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (EC/2004/16/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Ethics Committee: 28 May 2004
Date of expiry of approval by the Ethics Committee: 27 May 2009

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

c: Professor T Desombre, Chairman, Ethics Committee
Dr E Lyons, Supervisor, Department of Psychology
Appendix 6: Notes for contributors

Social Science & Medicine - Guide for Authors

Submission of Papers

Two types of contribution are welcomed: full papers (original research reports or critical reviews of a field, of no more than 8000 words, which include abstract, tables, footnotes and references as well as the main text), and short items (short reports of research findings, commentaries on topical issues or correspondence, of no more than 2000 words). Shorter papers are preferred and justification should be provided for word counts over these limits. Authors are requested to submit their original manuscript and figures with two copies and a matching disk to the Editor-in-Chief, Professor Sally Macintyre, MRC Social and Public Health Sciences Unit, 4 Lilybank Gardens, Glasgow G12 8RZ, UK; or to the relevant Senior Editor. Manuscripts can also be accepted by email. Please create one folder (with the name of the corresponding author) for all word and figure files, and email this to the Managing Editor at: amanda@msoc.mrc.gla.ac.uk

Submissions will be considered on the understanding that they comprise original, unpublished material and are not under consideration for publication elsewhere, and the study(ies) on which they have been based have been subject to appropriate ethical review. A covering letter to this effect should be enclosed with each submission, signed by all authors of the paper. Social Science & Medicine does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in Macintyre (1997, Vol. 45(1), 1-2).

All submissions may be subject to initial assessment by the Editor-in-Chief or appropriate Senior Editor to determine their suitability for consideration by Social Science & Medicine. Papers accepted for formal review will be sent anonymously to at least two independent referees. Authors are requested to alert the Editors in cases where rapid publication is especially appropriate.
Manuscript Preparation

General: Manuscripts must be typewritten, double-spaced with wide margins, on one side of white paper. Good quality printouts with a font size of 12 or 10 pt are required. The corresponding author should be identified (include a fax number and e-mail address). Full postal addresses must be given for all co-authors. Details of the APA reference style can be found on:


A disk copy of the paper should accompany the initial and the final version. The Editors reserve the right to adjust style to certain standards of uniformity. Authors should retain a copy of their manuscript since no responsibility can be accepted for damage or loss of papers. Original manuscripts and illustrations will be discarded one month after publication unless the Publisher is asked to return original material after use.

Abstract and keywords: Supply an abstract (without subheadings) of up to 300 words and up to six keywords. Give a word count for the abstract and for the main text, plus references etc.

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(without initials) and year of publication (e.g. "Since Peterson (1993) has shown that...") or "This is in the agreement with results obtained later (Kramer, 1994)"). For 2-6 authors all authors are to be listed at first citation, with "&" separating the last two authors, for more than six authors, use the first six authors followed by et al. In subsequent citations for three or more authors use et al. in the text. The list of references should be arranged alphabetically by authors' names. The manuscript should be carefully checked to ensure that the spelling of authors' names and dates are exactly the same in the text as in the reference list. References should be given in the following form:


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Research Report 2:
Therapists’ reactions to client facial appearance: the influence of therapists’ perceptions of their own relative facial appearance

Abstract
It is generally acknowledged that at all life stages our facial appearance has a profound influence on our lives. Given that psychotherapy is almost exclusively carried out in ‘face to face’ contact, between therapist and client, it would seem particularly relevant to understand the role of face in this context. However, little comprehensive research has actually been conducted either by social psychologists or psychotherapy practitioners in this area.

The present research aimed to explore, using a questionnaire constructed for this study, how therapists might be influenced by a client’s facial appearance in relation to their perception of their own relative facial appearance at first meetings. Furthermore, the research aimed to explore whether the sex of a therapist might be a significant factor of influence. The research hypotheses were: 1) therapists would have significantly different reactions to clients’ facial appearance, according to their perception of their own facial appearance in relation to that of a client, at first meetings; 2) the sex of the therapist would significantly influence the level of reaction stated in hypothesis one.

Of the 352 practising Counselling/Clinical Psychologists and Psychotherapists engaging in private sector work to whom the research questionnaire was sent, 112 responses were received and these were subjected to statistical analysis in order to test the hypotheses. While such analysis did not support either of the research hypotheses, it was felt that the present study had a number of implications for the conduct of future research as well as for practitioners of Counselling Psychology and applied psychology in general. These implications are discussed in relation to the research findings and the additional analysis conducted.
Introduction
Throughout the duration of my study on the Doctoral Programme in Psychotherapeutic and Counselling Psychology I have been interested in the potential for facial appearance, specifically facial disfigurement, to impact on the therapeutic setting. While this interest originally stemmed from my own experience of facial scarring (discussed in my first year literature review (Boucher, 2003)), the current focus of my attention and the subject of this report has shifted slightly due to a number of insights in the literature and the findings of my second year research project (Boucher, 2004). [I feel slightly disingenuous in typing the above. While it is true I am genuinely interested in this field, it has been the focus of my study for nearly three years and at times I wish to break free from the ‘chains’ of its direction and explore other aspects of the therapeutic encounter. With this admission of ‘topic fatigue’, I also wish to point out that at times I have noticed that I am fearful/avoidant of reading a book or an article relating to my chosen research field should it ‘disorientate’ my focus or shed doubt on the value of the research I have undertaken or plan to undertake. While I recognise such feelings as contrary to the espoused ethos of the research in which I am engaged, one that holds up the standards of neutrality and ‘blind’ inquisition, I have to accept such feelings as real intra-psychic phenomena and recognise that my investment in the research (both time, effort and professional standing) might mitigate against the possibility of attaining such ‘pure’ standards. When I re-read the report in front of you I am continually aware of the choices I have made in its presentation and I realise how present I am in this research. Simply put, I have selected the material that you are ‘allowed’ to view and I am engaged (in what sometimes feels like a covert manner) in a process of convincing you of the worth of my investment. While the credence you might pay to my efforts is likely to be influenced by your own investments as well as those deemed appropriate by the wider ‘academic/scientific community’, I feel restricted by the lack of a protocol whereby such person based influence might be explicitly recognised with regard to the conduct of quantitative research methodologies (unlike my last research report, which used the methodology of interpretative phenomenological analysis (Smith, Jarman & Osborn, 1999), where such influences were explicitly recognised), and in my opinion such an absence has the potential to depreciate the richness of the research process and its comprehension]
It is generally acknowledged that at all life stages our facial appearance has a profound influence on our lives, from the experience of our parenting and school to our employment opportunities and our ‘access’ to social relationships (see Bull & Rumsey (1988) and Boucher (2003) for reviews). Indeed in recognising the existence of negative stereotypes and prejudice against those with ‘different’ or ‘unattractive’ facial appearance Bull and Rumsey state “the profound social significance of the face, taken together with society’s prejudices towards those who have an untypical appearance, can mean that an unattractive facial appearance could be a severe social handicap” (Bull & Rumsey, 1988, p.179). Such a social ‘handicap’, the degree partly a function of the level of ‘stigma’ associated with one’s ‘undesirable’ appearance (Jones, Farina, Hastorf, Markus, Miller & Scott, 1984), has the potential to influence both intra-psychic and interpersonal functioning in a negative manner (Charon, 1979; Hebl & Kleck, 2000; Newell & Marks, 2000; Smith & Williamson, 1977). The exact mechanisms by which this influence comes to be experienced, however, would seem multi-faceted. Kleck and Rubenstein (1975) draw attention to the face being an information centre from which valuable information is gathered about the intentions of the perceived. Cole (1998) expands this informational function emphasising the communication aspects of face as one of the primary sources of social interaction and human relations. While such perspectives focus on the perception of face by others as a valuable (if sometimes flawed) information source, another body of literature points to the effects facial appearance might have on an individual’s perceptions of self. It has long been suggested that individuals acquire and develop a sense of self through social interaction with others (Cooley, 1912), allowing for social-comparisons (Festinger, 1954), the type and outcome of which are likely to influence one’s self-concept, esteem and body-image (Argyle, 1978). Perceptions of one’s own facial appearance are therefore likely to influence the social processes in which we engage as are the reactions of others to that appearance.

Given that psychotherapy is almost exclusively carried out in ‘face to face’ contact, between therapist and client, it would seem particularly relevant to understand the role of face in this context. However little comprehensive research has actually been conducted either by social psychologists or psychotherapy practitioners in this area. The little research that has been undertaken has suggested that therapists are also prone to use negative-stereotypes of facial appearance in judging clients’ self-concept
(Hobfoil & Penner, 1978) or intellectual functioning (Sandler, 1975), and that therapists prefer to work with young, attractive, verbal, intelligent and successful (YAVIS) clients (Schofield, 1964), all factors that are likely to affect the therapeutic process. Given that such research is clearly quite limited, tending to focus solely on therapists’ perceptions of clients’ faces with little or no consideration as to how therapists’ perceptions of their own face might influence their judgements, the present researcher conducted some preliminary research with such a focus (Boucher, 2004). This research sought to explore how the influence of a client’s facial appearance on a therapist might be mediated by a therapist’s self perceptions. While this research highlighted the potential for comparisons of relative facial appearance by therapists (between therapists and clients) to impact on therapist reactions to clients, it did not in any explicit way explore the nature of, or associations between, such reactions. Indeed, while it identified a number of possible ‘mediating factors’ in the therapeutic context that might mitigate against such factors impacting on the conduct of therapy, given the suggestion in the literature that such reactions could have a significant impact on the therapeutic context (Hobfoil & Penner, 1978; Sandler, 1975; Schofield, 1964) it was felt that further research into such elements was warranted.

The present research thus sought to expand on the earlier work (Boucher, 2004) aiming to shed further light on the specifics of how therapists’ reactions to client facial appearance might be mediated by therapists’ perceptions of their own relative facial appearance and consequently impact on therapy. Such a focus, it was felt, would also allow attention to be paid to the potential for social comparison aspects (from the therapist’s perspective) to impact on the therapeutic encounter, a focus seemingly missing from previous research in this area.

Furthermore, the current research was informed by a number of insights in the literature which were felt pertinent to its conduct. In looking at the mechanisms of therapeutic relationship building a number of authors have highlighted the potential influence of first impressions (Higgins & Rholes, 1976; Laungani, 2002). It is pointed out that from the first meeting both client and therapist are engaged in mutual assessments of each other which may operate at overt and covert levels. These assessments it is suggested are likely to be informed, at least in part, by an individual’s past experience, belief systems and cultural stereotypes (Bermudez,
1997). It is argued that such initial assessments of and reactions to clients by a therapist have the potential to significantly impact on later therapeutic work and thus ‘first impressions’ warrant attention in any practice focused research (Laungani, 2002). Additionally, the study of Jackson, Sullivan and Hymes (1987), into sex differences in self-assessment, was of interest to the current research as it suggested that one’s sex may influence how one assesses one’s own facial appearance and thus how one might make comparisons to others. Furthermore, the literature relating to body-image also seemed of relevance at this point as it drew attention to how person perception in relation to attractiveness may differ between males and females (Janda, O’Grady & Barnhart, 1981) and how evaluations of self-perceived attractiveness and self-esteem, with regard to body image, differed between males and females (Wade & Cooper, 1999).

Given the influences outlined above, it was felt this research would draw attention to social comparison and relational aspects of the therapeutic encounter, with regard to facial appearance at first meetings, and offer information on the impact of a therapist’s sex at such encounters. This was a focus which seemed predominantly absent from the literature and of clear relevance to the practice of Counselling Psychologists and the field of Applied Psychology in general.

**Research Aims**

This research aimed to explore how therapists might be influenced by a client’s facial appearance in relation to their perception of their own relative facial appearance at first meetings. Furthermore, the research aimed to explore whether the sex of a therapist might be a significant factor of influence. This exploration was conducted using a questionnaire (constructed for this research due to no suitable alternative questionnaire being found in this area) designed to gather information relating to therapists’ perception of four face types: one much more attractive than them; one equally attractive to them; one much less attractive than them; and one whom they perceive to be facially disfigured (suggested by Bull and Rumsey (1988) as likely to provoke extreme reactions). Additionally, the research aimed to test whether the reaction items on the final questionnaire could be reliably grouped into the distinct categories of affective reaction, cognitive reaction, physical reaction, and behavioural reaction. Such categories have been suggested in the literature (Heatherton, Kleck,
Hebl & Hull, 2000) as potentially aiding the conceptualisation of interpersonal reactions for both theory development and research purposes.

It was felt that this research would prove of special interest not only to practitioners of Applied Psychology but also to those that work in specialist services, such as burns units, or with specific client groups, such as people with facial disfigurements.

Research hypotheses

1) Therapists will have significantly different reactions to clients’ facial appearance, according to their perception of their own facial appearance in relation to that of a client, at first meetings.

2) The sex of the therapist will significantly influence the level of reaction stated in hypothesis one.

Method

Participants

Questionnaires were sent to all the 352 practising Counselling/Clinical Psychologists and Psychotherapists identified as engaging in private sector work in The Directory of Chartered Psychologists & The Directory of Expert Witnesses 2003/2004 (British Psychological Society, 2003) and the Register of Psychologists Specialising in Psychotherapy (British Psychological Society, 2005). Recipients of the questionnaire were asked to complete and return it only if they met the following three inclusion criteria; 1) that they were currently a Registered Psychotherapist/Chartered Psychologist; 2) that they were currently a practising Psychotherapist/Psychologist; and 3) that their practice was conducted at least in part in the private sector which they were able to refer to when completing the questionnaire. It was felt that the final criterion recognised that good research should be realistic about its resources. Given that the researcher was studying on a doctoral programme which had a specific deadline for research completion of 27th June 2005, it was recognised that the resource of time was limited. Given the available time scale it was felt that an application to the Central Office for Research Ethics Committees (COREC) would be too time restrictive and that it would be more consistent with the time available to
recruit from outside of the NHS, especially as there appeared to be no theoretical reason to suggest that therapists working inside or outside of an NHS setting would differ in response to the questionnaire items, and that often therapists have experience in both settings either concurrently or at different stages of their career.

A total of 112 questionnaires were returned completed, a response rate of 31.8%, which was lower than that expected, the literature pointing to response rates for postal questionnaires of between 40-80% (Fife-Schaw, 2000), and possible reasons for this response rate will be discussed later. [While I can rationalise as to why such a response rate was achieved, indeed that is my focus later, I was disappointed. In reflecting on this disappointment I recognise that while a non-response felt like a rejection of my time and effort, as well as the worth I attached to this research, the thing that disappointed me the most was some of the additional comments supplied at the end of the questionnaire. While some respondents took the opportunity to make constructive comments offering support and encouragement, a few took this space to ‘unleash’ condemnation of the research focus and point out my naivety. Indeed one stated: “this is a load of crap, facial appearance should not impact on the therapy, a total waste of time and money” - disappointed, I was shocked. I found it quite disheartening that a colleague should respond in such a way, and out of all the comments this is the one that stays with me, still angering me as I type. I am suddenly reminded of my ethics application. It asked if the postal questionnaire methodology could cause any harm to the researcher. I wanted to put “a paper cut or two”; I have learnt not to be so smug!]

Procedure
Once potential participants had been identified using the directories and register above they were posted a questionnaire which included a research information cover sheet (Appendix 1) and a research questionnaire guidance sheet (Appendix 2), detailing the research focus, inclusion criteria and procedures, as well as the questionnaire itself (Appendix 3). They were asked to read through the research information cover sheet and guidance sheet before completing the questionnaire (which they were informed would take approximately 15 minutes) and were asked to complete the questionnaire only if they felt the focus of the research would not cause them any distress and only if they met all the inclusion criteria. After completion of
the questionnaire, which also asked for some demographic information, participants were requested to return the questionnaire anonymously in a stamped addressed envelope provided, and it was explained on the cover sheet that the return of the questionnaire in this way would be taken as consent to participate in the study. On receipt of the completed questionnaires the researcher detached the back contact details sheet, if completed (a request for feedback), from the main body of the questionnaire and stored this and the questionnaire separately in a secure location.

**Questionnaire development and testing**

Given that there was no existing research tool, applicable to the focus of this research, found in the literature, it was decided that an original tool/questionnaire needed to be developed and tested for suitability. Each stage of this process is outlined below:

1) The researcher initially reviewed the literature (particularly the work of Bull & Rumsey, 1988) and the transcripts from his previous research (Boucher, 2004) identifying elements of the relational process where facial appearance seemed to provoke a reaction. From this review 20 distinct reactions were identified relating to people’s sense of the following: comfort, embarrassment, empathy, anxiety, awkwardness, motivation, responsiveness, curiosity, self-confidence, ability to build a relationship, distractibility, arousal, shock, physical aversion, power, ease at making eye contact, ease at making physical contact, self-monitoring, competitiveness, and focus of attention.

2) In order to see if it was possible to group these 20 reactions in any meaningful way according to the psychological domains of cognitive, affective, physical or behavioural reaction, they were subjected to the procedures of Multidimensional Scaling Analysis (Hammond, 2000). Here participants (twenty third year Trainee Clinical/Counselling Psychologists randomly approached in the Psychology Department of the University of Surrey) were asked to sort each of the 20 reactions (printed on separate laminated cards) into one of the four domains (printed at each corner of a sheet of A3).

3) After each sort the sort items were coded and entered into an Excel database matrix. Once all of the sorts were completed the results were subjected to
Multidimensional Scaling Analysis in order to give some idea of reaction/domain relationships. On examination of this analysis (Appendix 4) it appeared that out of the 20 initial reactions only 12 could be separated into 3 broad domains which made conceptual sense and these were put into categories as follows:

**Cognitive reactions:** motivation, curiosity, self-confidence, and self-monitoring.

**Affective reactions:** comfort, embarrassment, empathy, and anxiety.

**Physical/behavioural reactions:** shock, aversion, ease to make eye contact, and ease in making physical contact.

During the process of domain and category identification the researcher consulted closely with the research supervisor drawing on her wealth of experience in developing categories that met face validity. As a result of this process it was decided that the third category of physical/behavioural reactions was only identifiable by collapsing the conceptually distinct categories of physical and behavioural reactions into one category, and that the items of aversion and shock would benefit from being specified as physical aversion and physical shock due to their spread in the Multidimensional Scaling Analysis (Appendix 4). Furthermore, it was decided that other reactions that seemed to have anomalous sort results were best placed in a miscellaneous category recognising their relevance but acknowledging their lack of intuitive fit with other categories. This final category included reactions relating to the following:

**Miscellaneous reactions:** ability to build a relationship, power, competitiveness, and focus of attention.

As a result of the Multidimensional Scaling Analysis four items were dropped from the research as it was felt they lacked both relational clarity as well as conceptual sense in being grouped with the other items. They were the items of awkwardness, responsiveness, distractibility, and arousal.
4) While each of the 16 reactions above in the four categories made up the focus of the question items on the questionnaire (Appendix 3), given the nature of the research a number of other considerations influenced the questionnaire's final structure.

i) The questionnaire was focused on participants' reactions to each item in relation to four face types (broken down into four questionnaire sections): one much more attractive than them; one equally attractive to them; one much less attractive than them; and one whom they perceive to be facially disfigured. Thus it contained a total of 64 questions (4 x 16).

ii) As the researcher was interested in potential differences in reaction between each of the four contexts he employed a seven point Likert scale (Likert, 1932) through which each question item could be realised in a graded response. At this stage each question's focus, structure and response options were extensively reviewed by the researcher and the research supervisor to ensure that the questions and response options were appropriately worded and graded.

iii) Given that any practice based research should be aware of potential contextual and process issues at play that might influence its findings, and the fact that the researcher acknowledged the potential impact of first impressions (Laungani, 2002) on the therapeutic encounter, the researcher decided the time frame of reactions would be relevant to this research. Participants were consequently asked to contextualise their reactions in the time frame of first meetings as it was recognised that such a time frame might provoke strong reactions likely to impact on later meetings (Laungani, 2002). Furthermore, given the possible impact of a participant's sex on responses (Jackson et al., 1987; Janda, et al., 1981; Wade & Cooper, 1999) the researcher decided to focus on reactions to the opposite sex as he and his supervisor were of the opinion that this might provoke more extreme reactions that could impact on the therapeutic encounter. This opinion was informed partly by the researcher's previous qualitative research in this field (Boucher, 2004), where level of identification was suggested as potentially being inversely correlated with reaction level provoked. As well as, the propositions of Social Comparisons Theory (Festinger, 1954), which postulates that the act of making comparisons between similar positions (such as same sex comparisons) are less likely to provoke
affective/physical reactions than comparisons between different positions (such as opposite sex comparisons) due to a person's experience of the similar position and their subsequent increased confidence in anticipating the potential impact of making such comparisons. Both of these focuses were outlined at the top of each of the questionnaire sections (see Appendix 3).

iv) Once the questionnaire was constructed, giving attention to the above factors, it was given to five randomly chosen members of the researcher's Doctoral cohort for feedback on its ease to complete and time taken to complete. This feedback suggested that in its final format, the questionnaire was easy to follow in structure and content but that it required concentration due to its focus, and that it would take approximately 15 minutes to complete (which potential participants were informed of on the research information cover sheet, Appendix 1).

Analytic strategy
On receipt of returned questionnaires, the data from the questionnaires were coded and entered into a database using the Statistical Package for the Social Sciences (SPSS, 2003), ensuring item scales were recoded where necessary to maintain unidirectionality.

The first analytic task was to explore the construction of the questionnaire to see if the three categories of affective, cognitive and physical/behavioural reaction were sustainable in any meaningful way for rigorous analytic purposes. For this Factor Analysis and Cronbach’s Alpha analysis (Cronbach, 1951) were employed to explore the data set to see if the questionnaire items could be categorised into distinct and internally reliable groups. Given that such distinct and internally reliable groups could not be found then Cronbach’s Alpha analysis was again employed to explore the data set to see if a single internally reliable scale might be identified, from the 12 reaction items, measuring degree of reaction provoked by facial appearance.

Given that such a single scale was found to be internally consistent, this scale (of degree of reaction provoked by facial appearance) was employed to test the research hypotheses. The first hypothesis was tested using Pearson's correlation analysis which was deemed appropriate given the unequal self-rating sample sizes. The second
hypothesis was tested using Multivariate Analysis of Variance (MANOVA). Such analysis is appropriate in instances where there is one or more independent variable (in this instance respondents’ sex), and the dependent variable is measured at two or more levels (in this instance scores generated for each of the four face type conditions).

It was decided that after hypotheses testing further testing of the data set would be required using a mixture of statistical analysis available in SPSS to explore the relationship between the items in the miscellaneous category of the questionnaire with the scale of degree of reaction provoked by facial appearance. Further testing was also done to explore the influence of age and months registered on reaction provoked by different face types as well as that of age on self-rating.

A note on power

Given the exploratory nature of this study and the lack of literature in this area it was not possible to calculate the expected effect size and consequently conduct a power calculation to determine the appropriate sample size for this research. Therefore, the researcher (in consultation with the research supervisor) sought a sample size large enough to allow for the conduct of each of the statistical analyses used to test the research hypotheses. On this basis it was agreed that a minimum sample size of 96 was necessary, a figure which would cover the requirements of the largest MANOVA undertaken in this research (calculated using the guidelines of Tabachnick & Fidell (2001) as follows: 12 questionnaire items x 4 face type conditions x 2 sexes = 96 as the minimum number of participants required).

A note on ethical issues

Ethical approval for this research was gained from the University of Surrey (Appendix 5), and while it was envisaged that none of the procedures undertaken in this research would in any way cause physical or psychological harm to participants, it was recognised that the subject matter and the reflective nature of the questionnaire might have potential to provoke some anxiety or discomfort. In order to minimise such potential reactions it was felt that every effort should be made to accurately inform potential participants of the content of the questionnaire in the research information cover sheet (Appendix 1) and the research questionnaire guidance sheet.
(Appendix 2), to allow potential participants informed choice in their decision to participate. The research information cover sheet also advised potential participants that in filling in the questionnaire they may stop at any time and they were provided with the researcher’s and the research supervisor’s contact details should they wish to discuss any aspect of the research further; none did. It was also explained on the research information cover sheet that should participants wish to receive feedback on the research, in the form of a summary, they could supply their contact details on a sheet provided at the end of the questionnaire. It was made explicit that such information would be kept separate from the questionnaire responses so that the researcher remained ‘blind’ throughout as to participants’ names and their responses.

**Results**

**Demographic information**

Of the 112 returned questionnaires 46 (41.1%) were completed by males and 66 (58.9%) were completed by females. The respondents ranged in age from 23 to 80 years old, the mean age being 53.5 (sd. 11.2) years (mean 52.5 years (sd. 11.95) for males; mean 54.9 years (sd. 11.95) for females). 110 respondents described their ethnicity as White (98.2%), one described it as Mixed (0.9%) and one as Asian (0.9%). Respondents ranged in length of time registered/chartered from 23 months (one year 11 months) to 480 months (40 years), mean registration length being 166.79 months (13 years 11 months - sd. 101.87 months). In rating their own facial appearance 14.3% of respondents scored it as 2 (the attractive end of the scale); 38.4% as 3; 25% as 4; 18.8% as 5; and 3.6% as 6 (the unattractive end of the scale); no respondents scored it at the extremes of 1 or 7, the mean score for females being 3.76 (sd. 1.04) and males 3.35 (sd. 1.06).

**Factor Analysis and Cronbach Alpha analysis for item categories/questionnaire scale**

The data set was initially subjected to Factor Analysis to shed light on whether each of the three categories (cognitive reactions; affective reactions; physical/behavioural reactions), developed from the exploratory Multidimensional Scaling Analysis (Hammond, 2000), would hold up to more rigorous analysis. The analysis showed (Appendix 6) that for each of the four test conditions (reactions to the four different relative face types) the pattern matrix did not provide a simple solution identifying three factors in accordance with the categories postulated. Rather items were
generally loaded onto one factor and through discussion with the research supervisor as to factor possibilities it was decided that items lacked conceptual consistency to be meaningfully grouped together according to the factors identified.

Given that Factor Analysis had not supported the categories postulated it was felt that a test of internal consistency (given the a priori assumption that such categories did exist as postulated) might support the existence of such categories if at a less stringent analytic level. For this Cronbach’s Alpha analysis (Cronbach, 1951) was employed to test the internal reliability of each category in relation to the category items.

Table 1. Cronbach’s Alpha Coefficients for item categories

<table>
<thead>
<tr>
<th></th>
<th>Much more attractive facial appearance</th>
<th>Equally attractive facial appearance</th>
<th>Much less attractive facial appearance</th>
<th>Facially disfigured facial appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affective reactions</td>
<td>0.779*</td>
<td>0.733*</td>
<td>0.761*</td>
<td>0.714*</td>
</tr>
<tr>
<td>Cognitive reactions</td>
<td>0.530</td>
<td>0.554</td>
<td>0.565</td>
<td>0.649</td>
</tr>
<tr>
<td>Physical/ behavioural reactions</td>
<td>0.564</td>
<td>0.501</td>
<td>0.727*</td>
<td>0.762*</td>
</tr>
</tbody>
</table>

* identifies where a coefficient alpha is >0.7 and thus of significance (Nunnally, 1978).

The results of this analysis (see Table 1 above) demonstrated that while the category of affective reactions seemed to hold for each of the four test conditions (with an alpha coefficient of >0.7 suggested by Nunnally (1978) as necessary for tool development) none of the other categories showed such internal consistency across the test conditions (even allowing for item deletion). Such results suggest that while the research aimed to test whether 12 of the 16 reaction items on the final questionnaire could be reliably grouped into the distinct categories of affective reaction, cognitive reaction, and physical/behavioural reaction, in actuality they could not. As a consequence it was decided that a further test of internal consistency, relating to the 12 reaction items that could not be grouped thus far, should be undertaken to shed light on whether such items could be considered as an integral
single 12 item scale of reaction. For this Cronbach's Alpha analysis (Cronbach, 1951) was again employed to test the internal reliability of each item. The results of this analysis (see Table 2 below) demonstrated that the 12 item scale showed good internal reliability with alpha coefficients >0.8 across each of the differential conditions of facial appearance.

Table 2. Cronbach's Alpha Coefficients for 12 item scale

<table>
<thead>
<tr>
<th></th>
<th>Much more attractive facial appearance</th>
<th>Equally attractive facial appearance</th>
<th>Much less attractive facial appearance</th>
<th>Facially disfigured facial appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single scale of 12 items</td>
<td>0.834*</td>
<td>0.808*</td>
<td>0.880*</td>
<td>0.884*</td>
</tr>
</tbody>
</table>

*identifies where a coefficient alpha is >0.7 and thus of significance (Nunnally, 1978).

Such a finding, coupled with the fact that item deletion analysis did not identify any weak items across the conditions (see Appendix 7), suggested that the 12 items of degree of comfort, embarrassment, empathy, anxiety, motivation, curiosity, self-confidence, self-monitoring, physical shock, physical aversion, ease to make eye contact, and ease to make physical contact, could be treated as a single integral scale of degree of reaction provoked by facial appearance (indeed potentially negative reaction provoked given the possibility for higher levels of reaction, represented by higher scores, such as strong feelings of discomfort or embarrassment with regard to a client's facial appearance, to impact detrimentally on the therapeutic process). It was decided that this 12 item scale would be used to tests the research hypotheses.

Testing hypothesis 1
This hypothesis was that therapists would have significantly different reactions to clients' facial appearance, according to their perception of their own facial appearance in relation to that of a client, at first meetings. While participant's responses in self-rating demonstrated a normal distribution (see Figure 1 below), due to the unequal size of the groups and the skewness towards the attractive side of the scale, it was felt Pearson's correlation analysis (a conventional test for such data in the life sciences) would be a more appropriate test for the first hypothesis than the more sophisticated but sensitive MANOVA.
As can be seen in Table 3 below the significance levels found were very low (ranging from $p=0.940$ to $p=0.579$). Such low significance levels suggest that respondents did not vary in reaction level (as measured on the scale of degree of reaction provoked by facial appearance) across conditions according to self-rating and thus the first hypothesis of this research was not evidenced and the null hypothesis, that therapists would not have significantly different reactions to clients' facial appearance, according to their perception of their own facial appearance in relation to that of a client, at first meetings, was upheld.

Table 3. Correlation coefficients for self-rating and reactions to different face types

<table>
<thead>
<tr>
<th>Self-rating</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson’s correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much more attractive</td>
<td>-0.053</td>
<td>0.579</td>
<td>112</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>0.027</td>
<td>0.775</td>
<td>112</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>0.007</td>
<td>0.940</td>
<td>112</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>-0.018</td>
<td>0.851</td>
<td>112</td>
</tr>
</tbody>
</table>

Correlation is significant at the $p<0.05$ level (2-tailed)
Testing Hypothesis 2

This hypothesis was that the sex of the therapist would significantly influence the level of reaction stated in hypothesis one.

While the null hypothesis was upheld for hypothesis one, it was felt that sex differences in relation to respondents' reactions could still be explored. Given that the samples of males (41.1%) and females (58.9%) were of adequately equal size it was decided that Multivariate Analysis of Variance (MANOVA) would be a suitable test with which to explore the second research hypothesis. The results of this test (Table 4 below) demonstrated that while there were significant differences in reaction ($p=0.000$), for each of the tests of multivariate effect (on the scale of degree of reaction provoked by facial appearance), over the four conditions of facial appearance, the sex (reaction/sex output) of the respondents did not have a significant impact, with significance at the $p=0.117$ level for each test.

<table>
<thead>
<tr>
<th>Test of multivariate effect</th>
<th>Value</th>
<th>F</th>
<th>Hypothesis df</th>
<th>Error df</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaction Pillai's Trace</td>
<td>.725</td>
<td>94.924(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.000</td>
<td>.725</td>
</tr>
<tr>
<td>Wilks' Lambda</td>
<td>.275</td>
<td>94.924(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.000</td>
<td>.725</td>
</tr>
<tr>
<td>Hotelling's Trace</td>
<td>2.637</td>
<td>94.924(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.000</td>
<td>.725</td>
</tr>
<tr>
<td>Roy's Largest Root</td>
<td>2.637</td>
<td>94.924(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.000</td>
<td>.725</td>
</tr>
<tr>
<td>Reaction /sex Pillai's Trace</td>
<td>.053</td>
<td>2.006(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.117</td>
<td>.053</td>
</tr>
<tr>
<td>Wilks' Lambda</td>
<td>.947</td>
<td>2.006(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.117</td>
<td>.053</td>
</tr>
<tr>
<td>Hotelling's Trace</td>
<td>.056</td>
<td>2.006(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.117</td>
<td>.053</td>
</tr>
<tr>
<td>Roy's Largest Root</td>
<td>.056</td>
<td>2.006(b)</td>
<td>3.000</td>
<td>108.000</td>
<td>.117</td>
<td>.053</td>
</tr>
</tbody>
</table>

a Computed using alpha =.05, b Exact statistic, c Design: Intercept+sex; within subjects design

Such results suggest that the second hypothesis of this research was also not evidenced and the second null hypothesis, that the sex of the therapist would not significantly influence the level of reaction stated in hypothesis one, was also upheld. [The fact that neither of my research hypotheses were upheld was a second source of disappointment in the conduct of this research. While the word “salvage” kept ringing in my ear creating anxiety and prompting me to aspire to find something significant I
could report (from my Masters degree supervision I remember being told “without significant findings you have got no research”), my research supervisor this time round was very reassuring pointing out that in exploratory studies, such as mine, significance isn’t always the only worthwhile outcome. Instead she encouraged me to focus on what could be extrapolated from my findings, taking my analysis as a whole, and to locate the implications clearly within this under-researched topic. I raise this issue not to adorn my current supervisor with praise, but to point out how research at the level at which I have been engaged can provoke very different experiences. It seems the ground on which I stand as a trainee/researcher is prone to shifts and I am left wondering if this might be a consequence of my relative inexperience or again a sign of the inter-subjectivity of the research discipline. In honesty I feel it is probably both and am left again to ponder how such subjectivity might formally be accounted for in quantitative methodologies.]

However, while a therapist’s sex did not demonstrate itself as a variable of statistical significance in the MANOVA, Figure 2 below shows that females generally scored reactions provoked at a higher level than males over 3 of the 4 conditions (much more attractive; equally attractive; and much less attractive facial appearance) and then at the same level (for facially disfigured facial appearance).

![Figure 2. Reaction means for face type condition by sex]

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While such an observation might simply have been down to chance, the decision was taken to further explore differences in reaction between sexes over the four face type conditions using t-tests. The results of these t-tests (Table 5 below) demonstrated that while again differences were not generally found between sexes in degree of reaction, for reactions provoked by an equally attractive facial appearance there was a significant difference ($p=0.001$) between sexes. This finding will be discussed later.

Table 5. t-tests exploring sex difference and reaction provoked for the four face type conditions

<table>
<thead>
<tr>
<th>Face type condition</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>Std. Error Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much more attractive facial appearance</td>
<td>1.787</td>
<td>110</td>
<td>.077</td>
<td>3.736</td>
<td>2.091</td>
</tr>
<tr>
<td>Equally attractive facial appearance</td>
<td>3.404</td>
<td>110</td>
<td>.001*</td>
<td>5.420</td>
<td>1.592</td>
</tr>
<tr>
<td>Much less attractive facial appearance</td>
<td>1.299</td>
<td>110</td>
<td>.197</td>
<td>2.956</td>
<td>2.275</td>
</tr>
<tr>
<td>Facially disfigured facial appearance</td>
<td>.049</td>
<td>110</td>
<td>.961</td>
<td>.124</td>
<td>2.528</td>
</tr>
</tbody>
</table>

*significant found at the $p<0.05$ level (2-tailed)

Additional Analysis to explore the data set:
1) Reactions across face type condition

While neither of the research hypotheses were upheld, further analysis was undertaken to explore the data set. As already mentioned the results of the MANOVA above showed that there were significant differences in reaction ($p=0.000$, shown in Table 4 above), for each of the tests of multivariate effect (on the scale of degree of reaction provoked by facial appearance), over the four conditions of facial appearance. This significance was explored (disregarding sex) using MANOVA post hoc tests adjusted using the Bonferroni method to give a more robust indicator of significance (Kinnear & Grey, 2000).

The results of this analysis (Table 6 below) demonstrated that there were significant differences between reactions (on the scale of degree of reaction provoked by facial appearance) for five of the six possible combinations at the $p=0.000$ level. These were for:
1) Much more attractive facial appearance vs equally attractive facial appearance.
2) Much more attractive facial appearance vs facially disfigured facial appearance.
3) Equally attractive facial appearance vs much less attractive facial appearance.
4) Equally attractive facial appearance vs facially disfigured facial appearance.
5) Much less attractive facial appearance vs facially disfigured facial appearance.

In fact the only non-significant finding was between much more attractive facial appearance vs equally attractive facial appearance, with significance found at p=0.871.

**Table 6. Differences in reaction over the four face type conditions**

<table>
<thead>
<tr>
<th>(I)</th>
<th>(J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.(a)</th>
<th>95% Confidence Interval for Difference(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower Bound</td>
<td>Upper Bound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much more attractive</td>
<td>Equally attractive</td>
<td>6.263(*)</td>
<td>.894</td>
<td>.000</td>
<td>3.860 8.666</td>
</tr>
<tr>
<td></td>
<td>Less attractive</td>
<td>-1.299</td>
<td>.885</td>
<td>.871</td>
<td>-3.677 1.080</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-11.959(*)</td>
<td>1.004</td>
<td>.000</td>
<td>-14.659 -9.260</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>Much more attractive</td>
<td>-6.263(*)</td>
<td>.894</td>
<td>.000</td>
<td>-8.666 -3.860</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>-7.561(*)</td>
<td>.949</td>
<td>.000</td>
<td>-10.112 -5.011</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-18.222(*)</td>
<td>1.292</td>
<td>.000</td>
<td>-21.695 -14.749</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>Much more attractive</td>
<td>1.299</td>
<td>.885</td>
<td>.871</td>
<td>-1.080 3.677</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>7.561(*)</td>
<td>.949</td>
<td>.000</td>
<td>5.011 10.112</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-10.661(*)</td>
<td>.930</td>
<td>.000</td>
<td>-13.162 -8.160</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>Much more attractive</td>
<td>11.959(*)</td>
<td>1.004</td>
<td>.000</td>
<td>9.260 14.659</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>18.222(*)</td>
<td>1.292</td>
<td>.000</td>
<td>14.749 21.695</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>10.661(*)</td>
<td>.930</td>
<td>.000</td>
<td>8.160 13.162</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the p<0.05 level.

a Adjustment for multiple comparisons: Bonferroni.
Given that this was the anomalous finding it was further explored using paired sample t-tests. For this each item on the 12 item scale of degree of reaction provoked by facial appearance was compared across the two conditions of more attractive facial appearance and less attractive facial appearance.

Table 7. Paired sample t-tests comparing each item

<table>
<thead>
<tr>
<th>Item comparisons across 2 face type conditions</th>
<th>Paired Differences</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair 1 Comfort</td>
<td>-.152</td>
<td>1.875</td>
<td>-.857</td>
<td>111 .394</td>
</tr>
<tr>
<td>Pair 2 Embarrassment</td>
<td>.080</td>
<td>1.661</td>
<td>.512</td>
<td>111 .610</td>
</tr>
<tr>
<td>Pair 3 Empathy</td>
<td>.128</td>
<td>1.534</td>
<td>.874</td>
<td>108 .384</td>
</tr>
<tr>
<td>Pair 4 Anxiety</td>
<td>-.125</td>
<td>1.246</td>
<td>-1.062</td>
<td>111 .291</td>
</tr>
<tr>
<td>Pair 5 Motivation</td>
<td>.018</td>
<td>1.335</td>
<td>.142</td>
<td>111 .888</td>
</tr>
<tr>
<td>Pair 6 Curiosity</td>
<td>-.072</td>
<td>1.661</td>
<td>-1.457</td>
<td>110 .648</td>
</tr>
<tr>
<td>Pair 7 Confidence</td>
<td>.563</td>
<td>1.286</td>
<td>4.629</td>
<td>111 .000*</td>
</tr>
<tr>
<td>Pair 8 Self-monitoring</td>
<td>.318</td>
<td>1.354</td>
<td>2.464</td>
<td>109 .015*</td>
</tr>
<tr>
<td>Pair 9 Physical shock</td>
<td>-.500</td>
<td>1.315</td>
<td>-4.023</td>
<td>111 .000*</td>
</tr>
<tr>
<td>Pair 10 Physical aversion</td>
<td>-1.402</td>
<td>1.711</td>
<td>-8.671</td>
<td>111 .000*</td>
</tr>
<tr>
<td>Pair 11 Eye contact</td>
<td>.054</td>
<td>1.400</td>
<td>.405</td>
<td>111 .686</td>
</tr>
<tr>
<td>Pair 12 Physical contact</td>
<td>.184</td>
<td>1.384</td>
<td>1.352</td>
<td>102 .179</td>
</tr>
</tbody>
</table>

*significance found at p<0.05 level (2-tailed)

The results of this analysis (Table 7 above) demonstrated that there were only significant differences between reactions across conditions for the items of confidence (p=0.000), self-monitoring (p=0.015), physical shock (p=0.000), and physical aversion (p=0.000). All other reaction items (comfort, embarrassment, empathy, anxiety, motivation, curiosity, eye contact, and physical contact) demonstrated no significant differences across the face type conditions.

The findings of the post hoc tests when coupled with those demonstrated in Figure 2 above, suggest that the perception of an equally attractive facial appearance provokes lower levels of potentially negative reactions in therapists; that such potentially negative reactions rise significantly for both much more attractive and much less attractive relative facial appearances; and that the significantly highest level of potentially negative reaction provoked is done so by the perception of a facially disfigured facial appearance.
The findings of the paired t-tests suggest that while the degree of reaction provoked may not be significantly different between the perception of a much more attractive and a much less attractive facial appearance the items of confidence, self-monitoring, physical shock and physical aversion do significantly vary over these conditions. That is, therapists rated themselves as less confident, more self-monitoring, less shocked, and less averse in relation to a client with a relatively much more attractive facial appearance than a client with a relatively much less attractive facial appearance.

2) MANOVA analysis for miscellaneous items across face type conditions
Each of the miscellaneous items on the questionnaire (power, competitiveness, locus of attention, and ability to build a relationship) were analysed using MANOVA to explore whether scores on these items, deemed relevant to the therapeutic process, varied across the face type conditions.

Power
The results of this test (Table 8 below) demonstrated that over the six contrasted face type conditions (more attractive/equally attractive; more attractive/less attractive; more attractive/facially disfigured; equally attractive/less attractive; equally attractive/facially disfigured; and less attractive/facially disfigured) therapists’ perception of power (as shown by reaction level scored) significantly differed between each of the face type conditions except between perceptions of an equally attractive facial appearance and a facially disfigured facial appearance (p=1.000 n/s).
<table>
<thead>
<tr>
<th>(I)</th>
<th>(J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.(a)</th>
<th>95% Confidence Interval for Difference(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Much more attractive</td>
<td>Equally attractive</td>
<td>-.505(*)</td>
<td>.093</td>
<td>.000</td>
<td>-.755</td>
</tr>
<tr>
<td></td>
<td>Less attractive</td>
<td>-.838(*)</td>
<td>.116</td>
<td>.000</td>
<td>-1.148</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-.423(*)</td>
<td>.114</td>
<td>.002</td>
<td>-.730</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>Much more attractive</td>
<td>.505(*)</td>
<td>.093</td>
<td>.000</td>
<td>.254</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>-.333(*)</td>
<td>.063</td>
<td>.000</td>
<td>-.503</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.081</td>
<td>.098</td>
<td>1.000</td>
<td>-.181</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>Much more attractive</td>
<td>.838(*)</td>
<td>.116</td>
<td>.000</td>
<td>.527</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>.333(*)</td>
<td>.063</td>
<td>.000</td>
<td>.164</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.414(*)</td>
<td>.113</td>
<td>.002</td>
<td>.112</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>Much more attractive</td>
<td>.423(*)</td>
<td>.114</td>
<td>.002</td>
<td>.117</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.081</td>
<td>.098</td>
<td>1.000</td>
<td>-.343</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>-.414(*)</td>
<td>.113</td>
<td>.002</td>
<td>-.717</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the p<0.05 level.

a Adjustment for multiple comparisons: Bonferroni.

As Figure 3 below demonstrates, this significance seems to represent therapists perceiving themselves as least powerful when with a client whom they perceive as relatively much more attractive in facial appearance to them; their perception of power growing with perception of equally attractive clients and peaking with perception of much less attractive clients. However, the graph also shows that therapists perceive their power to be at a lower level than its peak (the same as when contrasted to an equally attractive facial appearance) when with a client with a
facially disfigured facial appearance. Thus perception of facial disfigurement may cause a reduction in power felt when contrasted to a much less attractive facial appearance, but not to the degree of reduction when contrasted to the perception of a more attractive facial appearance.

**Figure 3. Reaction means for power by face type condition**

![Graph showing reaction means for power by face type condition]

**Competitiveness**

The results of this test (Table 9 below) demonstrated that over the six contrasted face type conditions therapists’ perception of competitiveness (shown by reaction level scored) significantly differed between each face type condition except between perceptions of a much more attractive facial appearance and an equally attractive facial appearance (p=1.000 n/s); and a much less attractive facial appearance and facially disfigured facial appearance (p=1.000 n/s).
Table 9. MANOVA for competitiveness

<table>
<thead>
<tr>
<th>(I)</th>
<th>(J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.(a)</th>
<th>95% Confidence Interval for Difference(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Much more attractive</td>
<td>Equally attractive</td>
<td>.100</td>
<td>.135</td>
<td>1.000</td>
<td>-.264</td>
</tr>
<tr>
<td></td>
<td>Less attractive</td>
<td>.709(*)</td>
<td>.148</td>
<td>.000</td>
<td>.311</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.745(*)</td>
<td>.150</td>
<td>.000</td>
<td>.343</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>Much more attractive</td>
<td>-.100</td>
<td>.135</td>
<td>1.000</td>
<td>-.464</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>.609(*)</td>
<td>.134</td>
<td>.000</td>
<td>.250</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.645(*)</td>
<td>.136</td>
<td>.000</td>
<td>.280</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>Much more attractive</td>
<td>-.709(*)</td>
<td>.148</td>
<td>.000</td>
<td>-1.107</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.609(*)</td>
<td>.134</td>
<td>.000</td>
<td>-.968</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.036</td>
<td>.087</td>
<td>1.000</td>
<td>-.196</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>Much more attractive</td>
<td>-.745(*)</td>
<td>.150</td>
<td>.000</td>
<td>-1.148</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.645(*)</td>
<td>.136</td>
<td>.000</td>
<td>-1.010</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>-.036</td>
<td>.087</td>
<td>1.000</td>
<td>-.269</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the p<0.05 level.

a Adjustment for multiple comparisons: Bonferroni.

As Figure 4 below demonstrates, while therapists generally see themselves as uncompetitive with clients (shown by the low mean scores) the significance found could be seen as representing therapists' reduced sense of competitiveness as the facial appearance with which they are making relative comparisons becomes less attractive.
Figure 4. Reaction means for competitiveness by face type condition

<table>
<thead>
<tr>
<th>Face type condition</th>
<th>Competitiveness mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much more attractive</td>
<td>3.2</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>3.1</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>3.0</td>
</tr>
<tr>
<td>Facialy disfigured</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Locus of attention
The results of this test (Table 10 below) demonstrated that over the six contrasted face type conditions therapists' perception of their locus of attention (shown by reaction level scored) only significantly differed between perceptions of a facially disfigured facial appearance and each other face type condition (p=0.000).
### Table 10. MANOVA for locus of attention

<table>
<thead>
<tr>
<th>(I)</th>
<th>(J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.(a)</th>
<th>95% Confidence Interval for Difference(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Much more attractive</td>
<td>Equally attractive</td>
<td>.292</td>
<td>.118</td>
<td>.087</td>
<td>-.024</td>
</tr>
<tr>
<td></td>
<td>Less attractive</td>
<td>.302</td>
<td>.131</td>
<td>.142</td>
<td>-.052</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-.613(*)</td>
<td>.143</td>
<td>.000</td>
<td>-.997</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>Much more attractive</td>
<td>-.292</td>
<td>.118</td>
<td>.087</td>
<td>-.609</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>.009</td>
<td>.078</td>
<td>1.000</td>
<td>-.199</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-.906(*)</td>
<td>.133</td>
<td>.000</td>
<td>-1.263</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>Much more attractive</td>
<td>-.302</td>
<td>.131</td>
<td>.142</td>
<td>-.655</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.009</td>
<td>.078</td>
<td>1.000</td>
<td>-.218</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>-.915(*)</td>
<td>.120</td>
<td>.000</td>
<td>-1.238</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>Much more attractive</td>
<td>.613(*)</td>
<td>.143</td>
<td>.000</td>
<td>.229</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>.906(*)</td>
<td>.133</td>
<td>.000</td>
<td>.548</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>.915(*)</td>
<td>.120</td>
<td>.000</td>
<td>.592</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the p<0.05 level.
a Adjustment for multiple comparisons: Bonferroni.

That is, as Figure 5 below demonstrates, while therapists generally felt that their locus of attention was balanced between being focused on themselves and the other (shown by mean scores around the median Likert scale score of 4), the significance found would seem to be the result of therapists being much more focused on the appearance of the other when with a client that they perceive as facially disfigured than with any other face type condition. It should be mentioned, however, that this focus on the
appearance of the other also rises when with a client perceived as relatively much more facially attractive, though not to a significant degree.

Figure 5. Reaction means for locus of attention by face type condition

Ability to build a relationship
The results of this test (Table 11 below) demonstrated that over the six contrasted face type conditions therapists' perception of their ability to build a relationship (shown by reaction level scored) only significantly differed between perceptions of a much more attractive facial appearance and an equally attractive facial appearance \((p=0.012)\); an equally attractive facial appearance and a facially disfigured facial appearance \((p=0.000)\); and a much less attractive facial appearance and a facially disfigured facial appearance, \((p=0.009)\).
Table 11. MANOVA for ability to build a relationship

<table>
<thead>
<tr>
<th>(I)</th>
<th>(J)</th>
<th>Mean Difference (I-J)</th>
<th>Std. Error</th>
<th>Sig.(a)</th>
<th>95% Confidence Interval for Difference(a)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower Bound</td>
<td>Upper Bound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Much more attractive</td>
<td>Equally attractive</td>
<td>-.295(*)</td>
<td>.093</td>
<td>.012</td>
<td>-.544 - .045</td>
</tr>
<tr>
<td></td>
<td>Less attractive</td>
<td>-.107</td>
<td>.089</td>
<td>1.000</td>
<td>-.347 - .132</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.170</td>
<td>.113</td>
<td>.810</td>
<td>-.133 - .472</td>
</tr>
<tr>
<td>Equally attractive</td>
<td>Much more attractive</td>
<td>.295(*)</td>
<td>.093</td>
<td>.012</td>
<td>.045 - .544</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>.188</td>
<td>.073</td>
<td>.072</td>
<td>-.010 - .385</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.464(*)</td>
<td>.097</td>
<td>.000</td>
<td>.203 - .726</td>
</tr>
<tr>
<td>Much less attractive</td>
<td>Much more attractive</td>
<td>.107</td>
<td>.089</td>
<td>1.000</td>
<td>-.132 - .347</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.188</td>
<td>.073</td>
<td>.072</td>
<td>-.385 - .010</td>
</tr>
<tr>
<td></td>
<td>Facially disfigured</td>
<td>.277(*)</td>
<td>.085</td>
<td>.009</td>
<td>.048 - .506</td>
</tr>
<tr>
<td>Facially disfigured</td>
<td>Much more attractive</td>
<td>-.170</td>
<td>.113</td>
<td>.810</td>
<td>-.472 - .133</td>
</tr>
<tr>
<td></td>
<td>Equally attractive</td>
<td>-.464(*)</td>
<td>.097</td>
<td>.000</td>
<td>-.726 - -.203</td>
</tr>
<tr>
<td></td>
<td>Much less attractive</td>
<td>-.277(*)</td>
<td>.085</td>
<td>.009</td>
<td>-.506 - -.048</td>
</tr>
</tbody>
</table>

* The mean difference is significant at the p<0.05 level.

a Adjustment for multiple comparisons: Bonferroni.

As Figure 6 below demonstrates, while therapists generally rated their ability to build a relationship as quite high across all face type conditions (shown by the high mean scores) the significance found would seem to be the result of therapists perceiving that it would be more difficult for them to build a relationship with a client with a much more attractive facial appearance than them, and even more difficult with a client with a facially disfigured facial appearance.
3) Correlations between miscellaneous category items and reactions provoked by different face types.

Pearson’s correlation analysis was then used to explore associations between items in the miscellaneous category on the questionnaire (power, competitiveness, locus of attention, and ability to build a relationship), both with themselves as well as with reactions measured on the scale of degree of reaction provoked by facial appearance. The results of this analysis (Appendix 8) demonstrated that:

i) The item of competitiveness was significantly (p<0.05) negatively correlated with degree of reaction provoked by facial appearance across all of the face type conditions of much more attractive, equally attractive, much less attractive, and facially disfigured facial appearance (with coefficient scores of -0.522, -0.324, -0.358,
and -0.312 respectively). That is, as the degree of potentially negative reaction increased (as measured on the scale of degree of reaction provoked by facial appearance) so the level of competitiveness dropped. Given the earlier finding that degree of reaction provoked generally increased for therapists when not perceiving an equally attractive facial appearance (Figure 2), this finding suggests that therapists might be more competitive with those whom they find to be of equally attractive facial appearance. However, this result would seem to stand in contrast with that of the MANOVA results in Table 9 and Figure 4, where competitiveness is at its highest when perceiving someone with a much more attractive facial appearance (although this difference was not found to be significantly different from perceiving someone with an equally attractive facial appearance). While such a seemingly contradictory result might be a consequence of the added error caused by the 12 item degree of reaction provoked by facial appearance scale, it would seem to be in need of follow-up investigation in future research.

ii) The item of ability to build a relationship was significantly (p<0.05) negatively correlated with degree of reaction provoked by facial appearance across all of the face type conditions of much more attractive, equally attractive, much less attractive, and facially disfigured facial appearance (with coefficient scores of -0.480, -0.603, -0.726, and -0.541 respectively). That is, as the degree of potentially negative reaction increased (as measured on the scale of degree of reaction provoked by facial appearance) so therapists’ perceived ability to build a relationship decreased. This finding would seem to stand in support of the results of the MANOVA in Table 11 and Figure 6, where ability to build a relationship diminished with regard to the perception of less equal facial appearance, the perception of which is likely to provoke greater reaction as demonstrated in Figure 2.

No other correlations, such as for power or locus of attention, stood out across the face type conditions in this analysis.
4) The impact of age and months registered on reaction provoked; and age on self-rating

Pearson’s correlation analysis was employed to explore if months registered and/or age (see Table 12 below for descriptive information) had any bearing on reactions provoked across the face type conditions.

Table 12. Descriptive data for months registered and age

<table>
<thead>
<tr>
<th></th>
<th>Months registered</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Valid</td>
<td>112</td>
</tr>
<tr>
<td>N</td>
<td>Missing</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
<td>166.79</td>
</tr>
<tr>
<td>N</td>
<td>Median</td>
<td>144.00</td>
</tr>
<tr>
<td>N</td>
<td>Std. Deviation</td>
<td>101.874</td>
</tr>
<tr>
<td>N</td>
<td>Range</td>
<td>457</td>
</tr>
<tr>
<td>N</td>
<td>Minimum</td>
<td>23</td>
</tr>
<tr>
<td>N</td>
<td>Maximum</td>
<td>480</td>
</tr>
</tbody>
</table>

The results of this analysis (Table 13 below) demonstrated that both age and months registered (which themselves were significantly positively correlated as might be expected, \( p=0.000 \)) were significantly negatively correlated to reaction provoked across each of the face type conditions. This finding suggests that as therapists gain in age and experience, the potentially negative reaction provoked by a client’s facial appearance is at a reduced level when compared to younger less experienced therapists.
Table 13. Correlation coefficients for age, months registered and reactions to different face types

<table>
<thead>
<tr>
<th>Pearson’s correlation</th>
<th>Age</th>
<th>Months registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Correlation Coefficient</td>
<td>1</td>
<td>.472(**)</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
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<tr>
<td>N</td>
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<td>112</td>
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<tr>
<td>Months registered</td>
<td>Correlation Coefficient</td>
<td>.472(**)</td>
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<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>.000</td>
</tr>
<tr>
<td>N</td>
<td>112</td>
<td>112</td>
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<tr>
<td>Much more attractive facial appearance</td>
<td>Correlation Coefficient</td>
<td>-.395(**)</td>
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<tr>
<td>Sig. (2-tailed)</td>
<td></td>
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<tr>
<td>Equally attractive facial appearance</td>
<td>Correlation Coefficient</td>
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<tr>
<td>Less attractive facial appearance</td>
<td>Correlation Coefficient</td>
<td>-.249(**)</td>
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<td>Sig. (2-tailed)</td>
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<td>.008</td>
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<tr>
<td>Facially disfigured facial appearance</td>
<td>Correlation Coefficient</td>
<td>-.282(**)</td>
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<td>Sig. (2-tailed)</td>
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<td>.003</td>
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<tr>
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</tbody>
</table>

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

However, Pearson’s correlation analysis found no significant correlations between age and self-rating (p=0.158) (see Table 14 below). Suggesting that a therapist’s age does not have an influence on how they perceive the attractiveness of their facial appearance.
Table 14. Correlation coefficients for age and self-rating

<table>
<thead>
<tr>
<th></th>
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</thead>
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<td>Pearson’s Age</td>
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<tr>
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<td>Sig. (2-tailed)</td>
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<tr>
<td>Self-rating</td>
<td>Correlation Coefficient</td>
<td>.134</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.158</td>
</tr>
<tr>
<td>N</td>
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</table>

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

Discussion

Given that in many ways the present research was an exploratory study into a number of processes and elements that might impact on the therapeutic encounter, the discussion of its findings and implications have been broken down into three sections. These represent the areas that are felt most pertinent to the field of Counselling Psychology and Applied Psychology in general, as well as to the development of future research in this field.

1) Questionnaire development and response rates

The 12 item degree of reaction provoked by a client’s facial appearance scale, developed and tested for use in this study, is in need of comment. While it was found that the items in this scale could not be subdivided into the conceptually useful (Heatherton et al., 2000) sub-scales of cognitive, affective and physical/behavioural reaction, it is recognised that this does not in any way suggest that such sub-scales could not be developed. It was the intention of this research to explore the existence of such sub-scales in relation to the items on the questionnaire (which originated in the researcher’s review of the literature and conduct of previous research), not to develop such subscales in themselves. It is felt that future research with such a focus would be well merited, and, given the experience of the current study, such research would benefit from more extensive piloting. Such piloting might do well to include a qualitative review of item conceptualisation by practitioners (an issue raised on numerous occasions in the additional comments supplied by participants in this study), in order to shed light on potential variance in item understanding and ‘operationalisation’ caused by a practitioner’s theoretical orientation. Additionally,
while the 12 item scale developed for this research was deemed appropriate for testing the research hypotheses of this study, it is recognised that future research using such a scale would also do well to refine its items along the qualitative lines suggested above.

Furthermore, while the questionnaire used in this study was felt to be sophisticated in that it paid due attention to contextualising its questions within a clear frame of sexual reference and time-frame (brought out by Laungani (2002) as an important consideration), due to the constraints of ensuring a suitable questionnaire completion time it was limited in its scope, that is only first impressions and opposite sex reactions were investigated. Future research would then seem indicated to further explore the current research hypotheses within different time frames and with different points of sexual reference. Such research would shed light on the impact of the contextual elements imposed on this study and grant the hypotheses, which would seem of clear clinical relevance, a fuller scope in which to be explored.

Given that the response rate of 31.8% was lower than that expected (the literature pointing to response rates for postal questionnaires of between 40-80% (Fife-Schaw, 2000)), it should be recognised that, the estimated completion time of 15 minutes, the subject matter which required concentration and may have provoked some discomfort in some participants (with them having to make judgements on their facial appearance and the practice implications of such judgements) and the possibility that the rigid inclusion criteria may have excluded a number practitioners to whom the questionnaire was sent, may all be explanatory factors for such a rate which future research could take into account when ascertaining its population parameters.

2) Support for the null hypotheses
The two hypotheses of this research were not evidenced in the data and consequently the null hypotheses were upheld. There are however a number of points that would seem worth drawing out from the testing of the hypotheses.

It is felt that while the first null hypothesis was upheld, given the unequal sample sizes for self-rating (no respondents categorised themselves at either pole, 1 or 7 on the scale, and those categorising themselves as 6 only made up 3.6% of the research
population contrasted to 38.4% who categorised themselves as 3, see Figure 1) and the consequent risk of under/anomalous representation, caution should be taken as to the possibility of a Type II error, that is, rejecting a hypothesis unduly. It is felt that future research should try to sample its population differently as a consequence. Quota sampling rather than random population sampling (as used in this research) would seem to be indicated here to ensure adequate samples with regard to the range of self-ratings are attained for analysis. Given that no a priori knowledge was available as to the likely self-ratings of the research population, it is felt that the finding that most therapists (and indeed males more so than females) rated their facial appearance towards the attractive end of the self-rating scale (52.7%) provides the field with a new insight previously unknown. In considering why this might be the case it is speculated that to become a therapist one may need a certain amount of self-confidence (participants in this study generally rated their self-confidence as high across all of the face type conditions and given the link between one’s facial appearance, one’s positive/negative self-image and one’s confidence/social skills (Bull & Rumsey, 1988), it might be that to put oneself in the ‘role’ of a therapist one is likely to be confident/positive about one’s appearance, a factor that that this research found did not seem to be affected by one’s age (Table 14). However, it is recognised that such speculation is in obvious need of further research.

With regard to the support for the second null hypothesis, it should be noted that while a therapist’s sex did not demonstrate itself as a variable of statistically significant influence in the sophisticated MANOVA (a possibility inferred from the work of Jackson et al. (1987), Janda, et al. (1981) and Wade and Cooper (1999)), in the less robust and exploratory t-tests a significant difference in reaction provoked was found (see Table 5) between males and females for one of the face type conditions (with regard to the perception of an equally attractive facial appearance). While caution needs to be paid to this finding, it might suggest that a therapist’s sex does play some role in level of reaction provoked, though possibly only with regard to certain relative face types. It would then seem advisable that this issue receive further enquiry, for if sex is a possible factor of influence the exact mechanisms by which this influence might come about in inter-personal interactions would merit attention. Here it is felt a range of methodologies might prove of use, from further quantitative research along the lines of the present study but with a wider scope of
sexual reference (e.g. same sex reactions) and with a more refined measurement tool (as previously discussed), to discourse analysis looking at the micro-process of therapists’ interpersonal orientation in relation to sex role construction.

3) The implications of the additional analysis

The additional analysis undertaken in this research raised a number of issues that would seem relevant to the field and the practice of Counselling Psychology and Applied Psychology in general.

Firstly, the findings of this research (as evidenced in the MANOVA, Table 4, and the post hoc tests, Table 6) were consistent with those of previous research (Bull & Rumsey, 1988; Hobfoil & Penner, 1978; Sandler, 1975; Schofield, 1964) in finding that a person’s facial appearance is a factor of significance in interpersonal interaction, in this case influencing degree of reaction provoked. Simply put it was found (Figure 2) that reaction provoked in therapists by a client’s facial appearance is lowest when confronted with an equally attractive facial appearance, rises significantly when confronted with a more attractive and a less attractive facial appearance (the rise not being significantly different between these two conditions) and rises significantly again to its highest when confronted with a facially disfigured facial appearance. While it is not possible from this research to state explicitly whether such elevated reaction is likely to have a detrimental impact on the therapeutic process, though its potential negative orientation was pointed out (indeed the researcher’s previous research (Boucher, 2004) highlighted a number of mediating factors that might mitigate against such an impact), it does seem to suggest that a client’s facial appearance is an important factor for consideration in the transferential relationship of the therapeutic process, and consequently a consideration therapists should be explicitly aware of making. It is the researcher’s opinion that only through such enhanced awareness (a consequence of practice based research such as this) can therapists inform their ‘internal supervisor’ (Casement, 1985) and thus enhance that supervision in the therapeutic encounter.

Secondly, the MANOVA results for the miscellaneous items over the four face type conditions (drawn out in Tables 8 to 11 and Figures 3 to 6, and briefly reviewed in the results section) suggested that therapists’ perceptions of their power, competitiveness,
locus of attention, and ability to build a relationship are all affected by their perception of different facial appearances. While again this finding seems in line with those of previous research (Bull & Rumsey, 1988; Hobfoil & Penner, 1978; Sandler, 1975; Schofield, 1964), the fact that these items were deemed by the researcher and the research supervisor to be of clear relevance to the therapeutic process would seem to warrant their further and more vigorous investigation. Such investigation might use a mixed methodology aimed at qualitatively shedding light on the exact processes by which judgements over these items are made, as well as quantitatively seeking clarification over how such items might be interrelated. It is recognised that while this research found (see Appendix 8) that a therapist's ability to build a relationship was negatively correlated to degree of reaction provoked (which seems logical given that the scale used referred to the degree of potentially negative reaction provoked), there was inconsistency in this research over the exact relationship between a therapist's degree of competitiveness and level of reaction provoked (a feature future research could aim to clarify).

Finally, this research found that a therapist's age and experience (shown by months registered) were negatively correlated to degree of potentially negative reaction provoked across each face type condition (Table 13). While this suggests that age and experience are likely to be beneficial therapeutic factors, given the high correlation between age and experience in this research it would seem advisable that further research be conducted to tease out the likely relative influence of each of these separate factors, i.e. is it age or experience (or some corollary of them both) that is of greater significance when it comes to reactions provoked by different facial appearance?

[This piece of work has been the most enduring piece of work I have had to complete so far in my life. The sheer thought and energy that had to be applied to its development and conduct, as well as to its write-up, when I look back makes me shudder. I have, with the support of my research supervisor and others, however 'come out the other side' and consequently feel I am a more robust individual for it. While its conduct has taught me much about the quantitative research process, a process I feel I may have previously underestimated in intensity and value, it has left a number of questions burning in my mind as to the further development of my]
research questions and more generally the application of one’s subjectivity to the quantitative methodology.

This is the final ‘academic’ piece of work I have to hand in for my Doctorate and I feel it is a fitting end to my experience of training, that is, as a body of work it does not fill me with answers to my questions but leaves me grappling with questions about my answers.]
References


Appendix 1: Research information cover sheet

School of Human Sciences
University of Surrey
Guildford, Surrey. GU2 7XH

Department of Psychology
Tel: XXXXXXX
Fax: XXXXXXX

Research Supervisor
Tel: XXXXXXX

3rd March 2005

Dear colleague,

I am a third year Counselling Psychologist in Training studying at the University of Surrey. I am conducting research into how therapists' reactions to client facial appearance might be mediated by therapists' relative perceptions of their own facial appearance. I am using a questionnaire that will take approximately 15 minutes to complete and would appreciate your time and assistance in researching this clinically relevant topic.

NB: Please only complete the attached questionnaire if you meet all the following inclusion criteria:

1) You are a Registered Psychotherapist/Chartered Psychologist.
2) You are currently a practicing Psychotherapist/Chartered Psychologist.
3) Your practice is conducted, at least in part, in the private sector and you are able to refer to your experience in this sector when completing the questionnaire.

If you meet the above criteria I would ask you to read the questionnaire guidance sheet. Once you have read this sheet, and only if you feel the focus of the research would not cause you any distress, I would then ask you to complete the questionnaire before returning it anonymously in the stamped addressed envelope provided.

I would like to make it clear that while the return of the questionnaire will be taken as confirmation of your informed consent to participate in this research, participation is
completely voluntary and you may discontinue with the questionnaire at any time. Should you wish to receive feedback on the research in the form of a summary you can supply your contact details on the sheet provided at the back of the questionnaire (all such information will be kept separate from the questionnaire responses so that the researcher remains ‘blind’ as to your responses). Furthermore, the content of all returned questionnaires will be kept confidential and secure at all times and if you supply contact details you will not be identifiable in any way in any write-up of the research.

Should you have any questions regarding the above research please do not hesitate to contact me either in department or by telephone XXXXXXX or e-mail XXXXXXX.

Thank you for your time and participation.
Yours sincerely,

Terry Boucher (Counselling Psychologist in Training)
Appendix 2: Research Questionnaire Guidance Sheet

- The following questionnaire contains some demographic questions then a total of 64 questions (over 4 sections) regarding your potential reactions to the facial appearance of a client, of the opposite sex, who you meet for the first time.

- The questions require you to refer to your own actual reactions experienced at such meetings or your hypothesised reactions if you have no direct experience.

- The questionnaire will ask you to score your reactions on a series of seven point scales, one for each question. The seven point scales should be broke down as in the example here for question 1. Question 1 asks you to rate your level of comfort where:

  1 = very comfortable
  2 = mostly comfortable
  3 = moderately comfortable
  4 = neither comfortable nor uncomfortable
  5 = moderately uncomfortable
  6 = mostly uncomfortable
  7 = very uncomfortable

Please bear this breakdown in mind when answering each question.

- Each question relates to your perceived reactions in relation to four differing relative facial appearances: a facial appearance which you perceive as much more attractive than yours; a facial appearance which you perceive as much less attractive than yours; a facial appearance which you perceive as equally attractive to yours; and a facial appearance which you perceive to be facially disfigured.

- I would ask you to please take time in answering each question as honestly as possible as the results are likely to be clinically important with practice implications, and please ensure you answer all of the questions.

Thank you for your time and participation.
Appendix 3: Questionnaire

1. Are you? Male ________
   Female ________

2. How old are you? [ ] years

3. How would you describe your ethnic origins?
   Choose one section from (a) to (e) and then circle the appropriate category to indicate your ethnic background.

   (a) White
       British
       Irish
       Any other white background, please write in below
       ________________________________

   (b) Mixed
       White and Black Caribbean
       White and Black African
       White and Asian
       Any other mixed background, please write in below
       ________________________________

   (c) Asian or Asian British
       Indian
       Pakistani
       Bangladeshi
       Any other Asian background, please write in below
       ________________________________

   (d) Black or Black British
       Caribbean
       African
       Any other Black background, please write in below
       ________________________________
(e) Chinese of Other ethnic group
Chinese
Any other, please write in below

4. How long have you been a Registered Psychotherapist/Chartered Psychologist? ________

5. With what bodies are you currently registered/chartered? ________________

6. How would you rate your own facial appearance on a scale of 1 to 7 where 1 is very attractive and 7 is very unattractive?

1  2  3  4  5  6  7
Section A: The following questions relate to your perceived reactions to a client, of the opposite sex, who you meet for the first time and perceive to have a much more attractive facial appearance than yours.

1) How would you rate your level of comfort in relation to their facial appearance?
Very comfortable - 1 2 3 4 5 6 7 - Very uncomfortable

2) How would you rate your level of embarrassment in relation to their facial appearance?
Very embarrassed - 1 2 3 4 5 6 7 - Not embarrassed at all

3) How would you rate your level of empathy in relation to their facial appearance?
Very empathic - 1 2 3 4 5 6 7 - Very unempathic

4) How would you rate your level of anxiety in relation to their facial appearance?
Very anxious - 1 2 3 4 5 6 7 - Not anxious at all

5) How would you rate your level of motivation to work with them?
Very motivated - 1 2 3 4 5 6 7 - Very unmotivated

6) How would you rate your level of curiosity in their facial appearance?
Very curious - 1 2 3 4 5 6 7 - Not curious at all

7) How would you rate your level of self-confidence when with them?
Very confident - 1 2 3 4 5 6 7 - Not confident at all

8) How would you rate your level of self-monitoring when with them?
Very self-monitoring - 1 2 3 4 5 6 7 - Not self-monitoring at all

9) How would you rate your level of physical shock to their facial appearance?
Very shocked - 1 2 3 4 5 6 7 - Not shocked at all
10) How would you rate your level of physical aversion to their facial appearance?
Very averse - 1 2 3 4 5 6 7 - Not averse at all

11) How would you rate your ease at making eye-contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

12) How would you rate your ease at making physical contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

13) How would you rate your level of power in relation to them?
Very powerful - 1 2 3 4 5 6 7 - Not powerful at all

14) How would you rate your level of competitiveness with them?
Very competitive - 1 2 3 4 5 6 7 - Very uncompetitive

15) How would you rate your locus of attention when with them?
Very focused on your - 1 2 3 4 5 6 7 - Very focused on facial appearance

16) How would you rate your ability to build a relationship with them?
Very able - 1 2 3 4 5 6 7 - Not able at all

Section B: The following questions relate to your perceived reactions to a client, of the opposite sex, who you meet for the first time and perceive to have an equally attractive facial appearance to yours.

17) How would you rate your level of comfort in relation to their facial appearance?
Very comfortable - 1 2 3 4 5 6 7 - Very uncomfortable

18) How would you rate your level of embarrassment in relation to their facial appearance?
Very embarrassed - 1 2 3 4 5 6 7 - Not embarrassed at all
19) How would you rate your level of empathy in relation to their facial appearance?
   Very empathic - 1  2  3  4  5  6  7 - Very unempathic

20) How would you rate your level of anxiety in relation to their facial appearance?
   Very anxious - 1  2  3  4  5  6  7 - Not anxious at all

21) How would you rate your level of motivation to work with them?
   Very motivated - 1  2  3  4  5  6  7 - Very unmotivated

22) How would you rate your level of curiosity in their facial appearance?
   Very curious - 1  2  3  4  5  6  7 - Not curious at all

23) How would you rate your level of self-confidence when with them?
   Very confident - 1  2  3  4  5  6  7 - Not confident at all

24) How would you rate your level of self-monitoring when with them?
   Very self-monitoring - 1  2  3  4  5  6  7 - Not self-monitoring at all

25) How would you rate your level of physical shock to their facial appearance?
   Very shocked - 1  2  3  4  5  6  7 - Not shocked at all

26) How would you rate your level of physical aversion to their facial appearance?
   Very averse - 1  2  3  4  5  6  7 - Not averse at all

27) How would you rate your ease at making eye-contact with them?
   Very easy - 1  2  3  4  5  6  7 - Not easy at all

28) How would you rate your ease at making physical contact with them?
   Very easy - 1  2  3  4  5  6  7 - Not easy at all

29) How would you rate your level of power in relation to them?
   Very powerful - 1  2  3  4  5  6  7 - Not powerful at all
30) How would you rate your level of competitiveness with them?
   Very competitive - 1  2  3  4  5  6  7 - Very uncompetitive

31) How would you rate your locus of attention when with them?
   Very focused on your - 1  2  3  4  5  6  7 - Very focused on their facial appearance

32) How would you rate your ability to build a relationship with them?
   Very able - 1  2  3  4  5  6  7 - Not able at all

Section C: The following questions relate to your perceived reactions to a client, of the opposite sex, who you meet for the first time and perceive to have a much less attractive facial appearance than yours.

33) How would you rate your level of comfort in relation to their facial appearance?
   Very comfortable - 1  2  3  4  5  6  7 - Very uncomfortable

34) How would you rate your level of embarrassment in relation to their facial appearance?
   Very embarrassed - 1  2  3  4  5  6  7 - Not embarrassed at all

35) How would you rate your level of empathy in relation to their facial appearance?
   Very empathic - 1  2  3  4  5  6  7 - Very unempathic

36) How would you rate your level of anxiety in relation to their facial appearance?
   Very anxious - 1  2  3  4  5  6  7 - Not anxious at all

37) How would you rate your level of motivation to work with them?
   Very motivated - 1  2  3  4  5  6  7 - Very unmotivated

38) How would you rate your level of curiosity in their facial appearance?
   Very curious - 1  2  3  4  5  6  7 - Not curious at all
39) How would you rate your level of self-confidence when with them?
Very confident - 1 2 3 4 5 6 7 - Not confident at all

40) How would you rate your level of self-monitoring when with them?
Very self-monitoring - 1 2 3 4 5 6 7 - Not self-monitoring at all

41) How would you rate your level of physical shock to their facial appearance?
Very shocked - 1 2 3 4 5 6 7 - Not shocked at all

42) How would you rate your level of physical aversion to their facial appearance?
Very averse - 1 2 3 4 5 6 7 - Not averse at all

43) How would you rate your ease at making eye-contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

44) How would you rate your ease at making physical contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

45) How would you rate your level of power in relation to them?
Very powerful - 1 2 3 4 5 6 7 - Not powerful at all

46) How would you rate your level of competitiveness with them?
Very competitive - 1 2 3 4 5 6 7 - Very uncompetitive

47) How would you rate your locus of attention when with them?
Very focused on your - 1 2 3 4 5 6 7 - Very focused on their facial appearance

48) How would you rate your ability to build a relationship with them?
Very able - 1 2 3 4 5 6 7 - Not able at all
Section D: The following questions relate to your perceived reactions to a client, of the opposite sex, who you meet for the first time and perceive to be facially disfigured.

49) How would you rate your level of comfort in relation to their facial appearance?
Very comfortable - 1  2  3  4  5  6  7 - Very uncomfortable

50) How would you rate your level of embarrassment in relation to their facial appearance?
Very embarrassed - 1  2  3  4  5  6  7 - Not embarrassed at all

51) How would you rate your level of empathy in relation to their facial appearance?
Very empathic - 1  2  3  4  5  6  7 - Very unempathic

52) How would you rate your level of anxiety in relation to their facial appearance?
Very anxious - 1  2  3  4  5  6  7 - Not anxious at all

53) How would you rate your level of motivation to work with them?
Very motivated - 1  2  3  4  5  6  7 - Very unmotivated

54) How would you rate your level of curiosity in their facial appearance?
Very curious - 1  2  3  4  5  6  7 - Not curious at all

55) How would you rate your level of self-confidence when with them?
Very confident - 1  2  3  4  5  6  7 - Not confident at all

56) How would you rate your level of self-monitoring when with them?
Very self-monitoring - 1  2  3  4  5  6  7 - Not self-monitoring at all

57) How would you rate your level of physical shock to their facial appearance?
Very shocked - 1  2  3  4  5  6  7 - Not shocked at all

58) How would you rate your level of physical aversion to their facial appearance?
Very averse - 1  2  3  4  5  6  7 - Not averse at all
59) How would you rate your ease at making eye-contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

60) How would you rate your ease at making physical contact with them?
Very easy - 1 2 3 4 5 6 7 - Not easy at all

61) How would you rate your level of power in relation to them?
Very powerful - 1 2 3 4 5 6 7 - Not powerful at all

62) How would you rate your level of competitiveness with them?
Very competitive - 1 2 3 4 5 6 7 - Very uncompetitive

63) How would you rate your locus of attention when with them?
Very focused on your - 1 2 3 4 5 6 7 - Very focused on their facial appearance

64) How would you rate your ability to build a relationship with them?
Very able - 1 2 3 4 5 6 7 - Not able at all

Thank you for your time and participation, do you have any further comments you would like to make?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

222
If you would like to receive feedback on this research please provide your contact details below (e-mail preferable):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

223
Appendix 4: Multidimensional Scaling Analysis

CODES

**Affective reactions:** Items 1 = comfort, 2 = embarrassment, 3 = empathy, and 4 = anxiety.

**Cognitive reactions:** Items 6 = motivation, 8 = curiosity, 9 = self-confidence, and 18 = self-monitoring.

**Physical/behavioural reactions:** Items 13 = shock, 14 = aversion, 16 = ease to make eye contact, and 17 = ease in making physical contact.

**Miscellaneous category:** Items 10 = ability to build a relationship, 15 = power, 19 = competitiveness, and 20 = focus of attention.

**Dropped items:** Items 5 = awkwardness, 7 = responsiveness 11 = distractibility, and 12 = arousal.
Appendix 5: Ethical approval

09 February 2005

Mr Terry Boucher
Department of Psychology
School of Human Sciences

Dear Mr Boucher

Therapists' reactions to client facial appearance: the influence of therapists' perceptions of their own relative facial appearance (EC/2004/123/Psvch)

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 09 February 2005

The list of documents reviewed and approved by the Committee is as follows:-

Document Type: Application
Version: 1
Dated: 12/12/04
Received: 14/12/04

Document Type: Research Protocol
Version: 1
Received: 14/12/04

Document Type: Appendix 1 - Research Information Cover Sheet
Version: 1
Dated: 25/10/04
Received: 14/12/04

Document Type: Appendix 3 - Questionnaire
Version: 1
Received: 14/12/04

Document Type: Your Response to the Committee's Comments
Version: 1
Dated: 27/01/05
Received: 01/02/05

225
This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethics Committee
    Dr E Lyons, Supervisor, Dept of Psychology
    Dr A Coyle, Supervisor, Dept of Psychology
Appendix 6:
Factor Analysis pattern matrices for item categories over four conditions

Pattern Matrix condition 1: much more attractive facial appearance

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<th>Item</th>
<th>Factor</th>
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<td>comfort</td>
<td>.858</td>
</tr>
<tr>
<td>empathy</td>
<td>-.816</td>
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<tr>
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<td>-.774</td>
</tr>
<tr>
<td>eye contact</td>
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<tr>
<td>physical contact</td>
<td>.564</td>
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Pattern Matrix condition 2: equally attractive facial appearance

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</tr>
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Pattern Matrix condition 3: much less attractive facial appearance

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<td>.468</td>
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<td>curiosity</td>
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<tr>
<td>physical aversion</td>
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<td></td>
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<td>.841</td>
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Pattern Matrix condition 4: facially disfigured facial appearance

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<th>Factor 3</th>
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<td>.474</td>
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<td>.815</td>
<td>.347</td>
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<td>anxiety</td>
<td>.628</td>
<td>.795</td>
<td>.347</td>
</tr>
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<td>motivation</td>
<td>.826</td>
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<td>curiosity</td>
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<td>physical contact</td>
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Extraction Method: Principal Component Analysis.
Rotation Method: Oblimin with Kaiser Normalization.
## Appendix 7:
### Cronbach’s Alpha if item deleted for 12 item scale over four conditions

### Condition 1: Much more attractive facial appearance

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Squared Multiple Correlation</th>
<th>Cronbach’s Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>comfort</td>
<td>30.96</td>
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<td>.554</td>
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<td>.817</td>
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<td>93.134</td>
<td>.644</td>
<td>.521</td>
<td>.810</td>
</tr>
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<td>97.601</td>
<td>.570</td>
<td>.498</td>
<td>.817</td>
</tr>
<tr>
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<td>92.702</td>
<td>.674</td>
<td>.649</td>
<td>.807</td>
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<td>105.492</td>
<td>.326</td>
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<td>.805</td>
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<td>.245</td>
<td>.201</td>
<td>.842</td>
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<td>101.151</td>
<td>.445</td>
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<td>110.482</td>
<td>.225</td>
<td>.306</td>
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<td>92.969</td>
<td>.687</td>
<td>.615</td>
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### Condition 2: Equally attractive facial appearance

<table>
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<th>Item</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Squared Multiple Correlation</th>
<th>Cronbach’s Alpha if Item Deleted</th>
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</thead>
<tbody>
<tr>
<td>comfort</td>
<td>24.97</td>
<td>59.009</td>
<td>.578</td>
<td>.488</td>
<td>.781</td>
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<tr>
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<td>60.877</td>
<td>.709</td>
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<td>.773</td>
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<td>.529</td>
<td>.783</td>
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### Condition 3: Much less attractive facial appearance

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<th>Scale Mean if Item Deleted</th>
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<th>Squared Multiple Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
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<tr>
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### Condition 4: Facially disfigured facial appearance

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<th>Squared Multiple Correlation</th>
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<td>.876</td>
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Appendix 8:
Pearson’s correlation analysis for miscellaneous category items and reactions provoked by different face types.

Table A1: Correlations for condition of much more attractive facial appearance

<table>
<thead>
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<th></th>
<th>Power</th>
<th>Competitive -ness</th>
<th>Locus of attention</th>
<th>Ability to build a relationship</th>
<th>Scale of reaction provoked</th>
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<td>-.237(*)</td>
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<td>.012</td>
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<td>106</td>
<td>111</td>
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<td>Competitiveness</td>
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<tr>
<td>Correlation Coefficient</td>
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<td>1</td>
<td>.049</td>
<td>-.522(**)</td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.797</td>
<td>.763</td>
<td>.610</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>110</td>
<td>110</td>
<td>106</td>
<td>110</td>
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<td>Locus of attention</td>
<td></td>
<td></td>
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<tr>
<td>Correlation Coefficient</td>
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<td>.062</td>
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<td>.763</td>
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<td>111</td>
<td>110</td>
<td>106</td>
<td>112</td>
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<tr>
<td>Scale of reaction provoked</td>
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<tr>
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<td>110</td>
<td>106</td>
<td>112</td>
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</table>

** Correlation is significant at the p<0.01 level (2-tailed).
* Correlation is significant at the p<0.05 level (2-tailed).
Table A2: Correlations for condition of equally attractive facial appearance

<table>
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<tr>
<th></th>
<th>Power</th>
<th>Competitive -ness</th>
<th>Locus of attention</th>
<th>Ability to build a relationship</th>
<th>Scale of reaction provoked</th>
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</thead>
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<td><strong>Pearson’s correlation</strong></td>
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</tr>
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<td>Power Correlation Coefficient</td>
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</tr>
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<td>111</td>
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<td>111</td>
<td>111</td>
</tr>
<tr>
<td><strong>Competitiveness</strong></td>
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<tr>
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<td>.049</td>
<td>.148</td>
<td>-.324(**)</td>
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<td>.011</td>
<td>.616</td>
<td>.123</td>
<td>.001</td>
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<td>.616</td>
<td>.021</td>
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<td>.148</td>
<td>.224(*)</td>
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<td>-.603(**)</td>
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<tr>
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<td>.123</td>
<td>.021</td>
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<td>106</td>
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* Correlation is significant at the p<0.05 level (2-tailed)

** Correlation is significant at the p<0.01 level (2-tailed)
Table A3: Correlations for condition of much less attractive facial appearance

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<th>Pearson’s correlation</th>
<th>Power</th>
<th>Competitive -ness</th>
<th>Locus of attention</th>
<th>Ability to build a relationship</th>
<th>Scale of reaction provoked</th>
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** Correlation is significant at the p<0.01 level (2-tailed)
Table A4: Correlations for condition of facially disfigured facial appearance

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<th>Locus of attention</th>
<th>Ability to build a relationship</th>
<th>Scale of reaction provoked</th>
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<tr>
<td>Correlation Coefficient</td>
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<td>-.312(**)</td>
<td>.274(**)</td>
<td>-.541(**)</td>
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</table>

** Correlation is significant at the p<0.01 level (2-tailed)
Appendix 9: Notes for contributors

Social Science & Medicine - Guide for Authors

Submission of Papers

Two types of contribution are welcomed: full papers (original research reports or critical reviews of a field, of no more than 8000 words, which include abstract, tables, footnotes and references as well as the main text), and short items (short reports of research findings, commentaries on topical issues or correspondence, of no more than 2000 words). Shorter papers are preferred and justification should be provided for word counts over these limits. Authors are requested to submit their original manuscript and figures with two copies and a matching disk to the Editor-in-Chief, Professor Sally Macintyre, MRC Social and Public Health Sciences Unit, 4 Lilybank Gardens, Glasgow G12 8RZ, UK; or to the relevant Senior Editor. Manuscripts can also be accepted by email. Please create one folder (with the name of the corresponding author) for all word and figure files, and email this to the Managing Editor at: amanda@msoc.mrc.gla.ac.uk

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