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**RE: Psychotherapy and Craniofacial Disorders**

Dear Doug,

Enclosed you will find a copy of a psychological paper entitled "Psychotherapy for Persons with Craniofacial Deformities: Can We Treat without Theory?" This paper, authored by Bennett and Stanton, was published in the Cleft Palate-Craniofacial Journal, July, 1993, Vol. 30 No. 4. This information is provided to facilitate your understanding of my disability because it is both frustrating and non-productive when Florida DVR repeatedly refers psychologists who are ignorant of craniofacial disorders and their related psycho-social implications.

This information is offered in the spirit of cooperation and evidence of my continued submission to the process. Thank you for your consideration.

Sincerely,

**COPY**

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enclosure

# Psychotherapy for Persons with Craniofacial Deformities: Can We Treat without Theory?

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**In recent years, increasing numbers of experts have recommended that psychological support be available for cleft children and their parents. Few cleft palate centers however offer comprehensive psychological services. This paper presents some conceptual factors which may contribute to the paucity of psychological treatments available to cleft children and their families. Shortcomings in current concepts of emotional dysfunction in cleft children are discussed, and the effects of conceptual confusion on options for psychotherapy are outlined. Suggested directions in psychotherapy research for cleft children are discussed.**

KEY WORDS: *clefting, emotional dysfunction, psychotherapy*

Numerous studies have documented psychosocial problems associated with cleft lip and palate. Children with clefts have been reported to have lower self-concepts than normals (Broder and Strauss, 1989), lower self-esteem than normals, impaired peer relationships, and increased dependency on adults (Pillemer and Cook, 1989). In addition, poor body image (Strauss et al., 1988) and poor academic performance have been noted in children with clefts (Richman et al., 1988). Teachers have also reported that cleft children more frequently display conduct disorders when compared with their normal peers (Richman, 1976). Information from surveys of the parents of cleft children suggests that cleft children master developmental tasks more slowly and resist separation from parents more strongly (Benson et al., 1991).

Given this list of psychological problems and familial distress associated with clefting, it is not surprising that numerous authors have suggested that psychological treatment should be available to children with clefts and their families (Heller et al., 1981; Arndt et al., 1987; Bjornsson and Agustsdottir, 1987; Pertschuk and Whitaker, 1987, 1988; Broder and Strauss, 1989). Such recommendations are so common that cleft palate centers were surveyed (Broder and Richman, 1987) to determine what psychological services were available to children receiving treatment at cleft palate centers.

The results of the Broder and Richman survey were discouraging. Few centers reported offering psychological treatment for cleft children. Less than 50% of centers offered mental health screening interviews, and fewer still offered short term therapy (21%). In 1987, only 13% provided long-term psychological support for children with clefts or their families. Although these figures may have

improved over the past 5 years, this seems unlikely because of the low priority of mental health services in most publicly funded agencies.

How is it that psychological services are so difficult to come by in a population which has consistently been identified as needing psychological care? At least two factors may contribute to this, including (1) the relatively low priority of psychological services in public assistance programs mentioned previously, and (2) the inherent difficulties of providing weekly psychological interventions to center populations which may be diverse economically, geographically, and culturally.

## The Problem of Psychotherapy

While either factor just mentioned may be partially responsible for the generally low level of psychological services available to cleft children and their families, we believe there may be a more obvious and troublesome root to the lack of psychological services. Having determined that psychological services are a necessary adjunct to cleft treatment, few investigators have defined which psychological treatments are suitable for cleft children. We could locate no controlled studies that differentially evaluated the efficacy of psychotherapy for cleft children or their families.

As Strupp (1978) notes in his studies of psychotherapy outcome, it is not enough to demonstrate that psychotherapy is effective in a general sense. Because the major issue of psychotherapy is behavior change, researchers must define what is to be changed and how change can be brought about. In the area of facial deformities, we are largely unable to answer these questions. What does a cleft child (or adult) want to change? What should the aim of psychotherapy be for a cleft child? What are the chief emotional problems of individuals with facial deformities?

## Emotional Dysfunction in Cleft Persons

A review of the literature provides few answers to the first question, "What does a cleft child or adult want to

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change?" Although we found numerous studies which described emotional problems in cleft children, many lacked appropriate control groups. Thus, it is impossible to draw firm conclusions from these studies because equivalent, noncleft children drawn from the same sorts of populations may experience emotional problems as well. An examination of those studies which did employ adequate or methodologically appropriate empirical techniques suggest that questions remain regarding what, if any, emotional problems typically accompany a diagnosis of cleft lip/palate.

For example, Richman (1983) reported that cleft adolescents did not show significantly more personality or adjustment problems than did normal controls. In addition, this report noted no significant differences in self-perceived academic functioning and social satisfaction in cleft persons compared with their noncleft peers. Similarly, Bjornsson and Agustsdottir (1987) concluded that cleft individuals were relatively well adjusted socially and achieved educational levels similar to those of normal controls. Most important, these researchers noted that their cleft subjects did not believe that their craniofacial defect had significantly influenced their lives.

In contrast, Heller et al., (1981) reported that a significant number of cleft patients report continuing dissatisfaction with appearance, hearing, speech, and teeth. Similarly, Kapp-Simon (1985) reported that cleft patients had poorer self-concepts than normal controls. With regards to achievement motivation, Peter and Chinsky (1975) reported that cleft subjects had significantly lower educational aspirations when compared with their normal peers. Additionally, McWilliams and Paradise (1973) reported that fewer cleft subjects were married during adulthood when compared to their normal peers.

Clearly, there are inconsistencies in the data regarding emotional/social dysfunction and clefts. While some reports seem to indicate that clefting has relatively insignificant effects on emotional functioning, other data provide strong evidence to the contrary. Such contradictions have not gone unnoticed in the literature, leading at least one author (Tobiasen, 1984) to suggest that consistent, meaningful answers to questions about emotional dysfunction and clefting cannot be answered without sufficient theoretical specificity. Even if we accept that there are emotional problems which occur more frequently in cleft children than in normal children, Strupp's second question, "how change can be brought about" cannot be addressed without theory.

#### **How Can Change be Brought About?**

This question must be answered in the context of theory; a theory of how dysfunction develops and how it can be changed. Although broad theories of personality may be of use in generating general answers about human emotional dysfunction, they may be considerably less useful in providing specific answers for the facially deformed.

For example, both psychodynamic and social learning theorists would postulate that emotional distress arises in part from repeated, painful, developmental experiences. However, such broad hypotheses tell us little about the nature of those experiences for facially deformed persons. It is understandable that researchers have sought a model more specific to the experiences of cleft palate children to answer questions relevant to the development and treatment of emotional dysfunction in cleft children.

The most popular notion of emotional dysfunction in cleft children has been that of "reflected appraisals" or the "looking glass self" (see Shrauger and Schoeneman, 1979, for a review). From this theoretical viewpoint, cleft children are at a developmental disadvantage emotionally because they incorporate a negative societal view of facial deformity into the self-concept. Researchers into cleft-palate issues have noted support for this concept of emotional development in the extensive literature on physical attractiveness. This large and frequently cited literature suggests that there are far-reaching social benefits to being physically attractive, and severe negative social consequences for those who are physically unattractive (see Berscheid, 1980; Dion, 1981, 1986; Adams, 1984; Patzer, 1985; Alley and Hildebrandt, 1988 for reviews). To summarize, researchers have discovered that physically unattractive people of all ages are perceived less positively by observers of all ages than attractive people. Assuming that faces with deformities are inherently unattractive, some researchers have suggested that negative reactions from observers are partly responsible for the emotional distress noted in cleft children (Tobiasen, 1984).

The appeal of this concept of emotional dysfunction is clear. Not only does the idea of reflected appraisals conform to common sense notions of emotional development (e.g., "children learn what they live"), but in the case of cleft children, the concept is supported by a literature that delineates society's negative views of physically unattractive children. It should not be surprising therefore, that this particular view of dysfunction has been frequently cited in the cleft literature (see Clifford, 1973; Glass and Starr, 1979; Edwards and Watson, 1980; Tobiasen, 1984) as a useful theory of emotional dysfunction in cleft children and adults.

Although intuitively pleasing, such an explanation is problematic for several reasons. Researchers have recently begun to question the benefits of physical attractiveness. Often referred to as the "what is beautiful is good" phenomenon, the benefits of physical attractiveness have been noted as some of the most replicable and robust findings in the social science literature. However, a recent meta-analysis of the physical attractiveness literature (Eagly et al., 1991) found major limitations in such conclusions. The results of their meta-analysis suggest that beauty serves as a strong cue for suppositions of social ease, but has little effect on perceptions of intelligence, honesty, virtue, helpfulness, potency, or general emo-

tional adjustment. Other investigators have noted instances in which beauty may be a handicap, especially in inferences about vanity, and self-centeredness (Cash and Janda, 1984).

Additional doubts concerning the applicability of the physical-attractiveness literature have recently arisen. Several authors, both in the psychological (Zuckerman et al., 1991) and dental literatures (Pertschuk and Whitaker, 1987) have cautioned against over-simplified interpretations of the "beauty is good" phenomenon. These authors have noted that a myriad of factors contribute to impression formation, including vocal attractiveness, nonverbal gesturing, mannerisms, and social skills. Others have noted that frontal photographs, typically employed in physical attractiveness research, are not representative of real-life interaction, as three-quarter and profile views are also captured in day to day interactions (Shaw et al., 1985). While some research has moved to impression research using video images and field research, these studies are rare (e.g., Reis et al., 1980, used standardized diaries to study naturalistic interactions). Not surprisingly, the results of field-based versus lab-based physical attractiveness studies have produced less clear results concerning the benefits of beauty. For example, Reis et al. (1982) found that moderately attractive college women had more dates and more same-sex socializing than did very attractive college women.

Another problem with the "reflected appraisals" concept of emotional development is the implicit equation between perceptions of physical unattractiveness and physical deformity. Both Reis and Hodgins (in press) and Pertschuk and Whitaker (1987) caution against applying the literature on physical attractiveness to craniofacial populations. They propose that unattractive individuals, even very unattractive individuals, may have profoundly different social experiences from the facially deformed. Reis and Hodgins cite the social science literature devoted to physical stigmata as an alternate source for theory concerning social development in cleft populations (e.g., Katz, 1981). Katz postulates that the experience of a stigmatized individual is marked by societal ambivalence. That is, there are strong cultural traditions which dictate help and sympathy for the handicapped, but such traditions coexist with societal avoidance and discomfort with handicapped persons. Reis and Hodgins postulate that the experience of ambivalence (strong positive reactions and strong negative reactions) should be markedly different from that of the generalized negativity thought to accompany physical unattractiveness. As additional support for a distinction between the effects of unattractiveness and stigmata, they note the societal distinction between stigma and unattractiveness; there is a Cleft-Palate Craniofacial Association but no association for "homely individuals or parents of homely babies" (p.21).

Finally, the distinction between unattractiveness and craniofacial defect has profound consequences for concepts

of the development of self-esteem in cleft children. While the prevailing theory of reflected appraisals clearly predicts lower self-esteem in cleft children, recent work suggests that members of some stigmatized groups may actually use their stigmatized status for self-esteem enhancement (Crocker and Major, 1989; Hillman, 1992). Briefly, Crocker and Major outline an attribution-based model whereby the stigmatized individual may attribute negative feedback to factors associated with their stigma (e.g., he doesn't like me because I have a scar above my lip) rather than to factors more closely aligned with the self (e.g., he doesn't like me because I'm an unacceptable person). In so doing, these theorists note, stigmatized people can and do protect their self-esteem. This effect has been noted clinically in facially deformed populations, but has not been studied explicitly (see Baker and Smith, 1939; Macgregor, 1979). The applicability of this model to the cleft population warrants further study. While some studies suggest that self-esteem is lower in cleft children (Broder & Strauss, 1989), Brantley & Clifford (1979) found higher self-esteem in cleft teens than in normal teens.

#### Providing Treatment in the Absence of Theory

At first glance, differing theoretical models concerning emotional development of cleft children may appear removed from the day to day concerns of the psychologist interested in psychotherapy for cleft patients. A closer examination reveals that different models of emotional development may lead to divergent clinical treatments. For example, if facial deformity can be considered as equivalent to extreme unattractiveness, a clinician might assume that any cleft child is regarded with uniform negativity, a victim of cultural prejudices against unattractive persons. Therapy might consist of social skills training to overcome initial negative reactions from peers and teachers. In contrast, if facial deformity is conceptualized in line with Katz's (1981) ambivalence model, a therapist would make an entirely different set of assumptions about the cleft patient's social experience. Assuming that the cleft child is met with extremely positive reactions in some instances (e.g., teachers more likely to provide help, parents inviting the child to birthday parties) but extremely negative reactions in other instances (e.g., peers avoiding interaction, being chosen last for teams), therapy that is focused on coping with inconsistent social experiences might be most appropriate.

Similarly, a therapist assuming low self-esteem in cleft clients might focus on interventions aimed at enhancing self-esteem. If a therapist accepts Crocker and Major's (1989) attribution-based model, however, a therapy aimed at making accurate and adaptive attributions for social feedback would be warranted. In addition, if a therapist assumes that the stigma serves to protect the self-esteem, additional psychotherapeutic support might be necessary

for patients undergoing surgical interventions aimed at cosmetic improvements. In other words, patients who receive noticeable cosmetic benefits through surgery (i.e., the stigma becomes less visible) may be less able to protect their self-esteem by using their facial stigma. Thus psychotherapy aimed at helping patients make other attributions for interpersonal events may be useful.

Shortcomings in current concepts of emotional dysfunction in cleft populations leave the clinician with little empirical guidance for psychological treatment. Not only are we unsure about which treatments are most appropriate, we have little data that compare different treatments for cleft clients. In the absence of theory, clinicians follow general principles of psychotherapy (e.g., acceptance, empathy, warmth, skills training) on a case-by-case basis. Evidence from the limited literature on psychotherapy for physically handicapping conditions suggests that few empirical data are available in those areas either (e.g., Servoss, 1983; Hoxter, 1986; Jureidini, 1988).

It is not suggested that therapists currently providing psychological treatments to cleft patients are offering ineffective treatments, or even that a specific theory of psychological dysfunction is necessary to help a given cleft patient or family. Studies of the outcome of psychotherapy strongly suggest that on the whole, psychotherapy is effective in reducing emotional distress for a wide range of clients and emotional problems (Garfield and Bergin, 1984). A skilled clinician will also conduct a thorough assessment of a client's social environment regardless of population-based data. However, in order to develop programs specifically for cleft patients, especially programs designed to teach effective coping early in social development, a more specific plan is needed.

How can research contribute to the development of specific treatments for cleft children who are experiencing emotional distress? How can research contribute to the development of primary prevention interventions that might offset the effects of facial deformity? In the course of our research, we have formulated the following suggestions:

1. Cleft palate centers and organizations should encourage and promote cross-fertilization between social scientists outside the cleft area and scientists working primarily in cleft palate. Researchers who focus on other stigmatizing conditions (e.g., obesity) and scientists who develop and refine theories of stigma (e.g., Katz, 1981; Jones et al., 1984) are rarely cited in the cleft literature. The information and insights they have to offer should become integrated with information specific to clefting. Some attempts have been made to incorporate study of other stigmatizing conditions (e.g., Harper and Richman, 1978; Brantley and Clifford, 1979), and further work in this tradition should be encouraged.
2. Longitudinal field studies of cleft children in their social environment should become a funding priority. Sur-

vey studies and impression studies are useful, but the information they offer is limited. Mental health interventions for cleft children can only be developed when we understand what makes a cleft child's social environment different from that of a normal child. We cannot expect to treat psychological distress effectively if we cannot define how the distress manifests itself in day to day functioning. There are well-validated means for measuring social interaction in an ongoing fashion which have been used in studies of smoking cessation, weight control, and intimacy (see Reis, 1983, for a review). The application of similar assessment techniques to cleft populations may be feasible.

3. Studies which focus on individual differences and risk factors in cleft populations should be encouraged. As we noted earlier, there are no clear answers regarding the association between clefting and emotional distress. Identification of mediating and moderating factors will enable us to predict which cleft children are at risk for emotional problems. For example, it may be that there are important parental variables which will predict which cleft children will experience emotional problems. Studies of individual differences in cleft children, such as different coping styles, may also be useful in understanding which cleft children will experience emotional dysfunction. If such variables prove to be important, we may be able to learn, and eventually teach how some cleft children cope effectively with their facial differences.

4. Research concerning the mutability of attitudes towards physical deformity will enable therapists and community leaders to launch programs intended to change societal attitudes towards physical stigmata. If we accept the premise that in some fashion, emotional problems associated with clefting stem from negative societal views, a logical research question is whether such attitudes are changeable. With the advent of popular television characters with visible (e.g., obesity) and invisible (e.g., homosexuality) stigmata, we may be able to study the extent to which societal treatment of stigmatized persons can change.

A focus on any of the above areas will bring valuable information to those interested in developing and refining mental health interventions for cleft children and adults. As mental health interventions are developed, controlled studies can be launched, and better matches can be made between clients, therapists, and interventions. Although there is much to be learned about the psychological treatment of cleft individuals, we believe that there is much to be gained through the study of psychological problems associated with clefting. When social scientists have empirically demonstrated psychological treatment needs for cleft patients in conjunction with replicable, specific treatment plans, we believe that funding for mental health services will be substantially easier to secure.

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