

THE REPRESSION POLEMIC: CONSTRUCTING NORMALCY
AND DEVIANCE WITHIN THERAPY DISCIPLINES

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

UNIVERSITY OF FLORIDA

2004

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by

Michael Ryan

I dedicate this dissertation to my parents, Pansy Anna Kelly-Ryan and Venice Alton (Pete) Ryan, Sr., who have dedicated their lives to their children. I also dedicate it to Eric Lee Ryan and Wesley Gilbert Ryan, my children, who have filled my heart and thoughts with joys and pains every day of my adult life. My brothers and sisters (Alton, Danny, Kay Ryan-Niemeyer, Louis, Rita Ryan-Pinner, and Linda Ryan-Waddell) have supported my efforts throughout, and cheered me in my endeavors. Finally, I dedicate my dissertation to all of the non-traditional students who will join me in fulfilling the dream of sailing the academic-scholar ship once again.

ACKNOWLEDGMENTS

I received a tremendous boost from Dr. Lon Lanza-Kaduce, chairman of my supervisory committee. Dr. Lanza-Kaduce picked up on the depth and intricacies of possibilities of the research and encouraged me, while giving me leeway to develop. His assistance in the final stages of the writing verged on heroic. The advice and assistance in research of my other committee members (Dr. Ronald L. Akers, Dr. Richard Hollinger, Dr. Constance Shehan and Dr. Joseph Spillane) contributed greatly to the success of this dissertation. I cannot express sufficiently my gratitude for Dr. Terry Mills and Dr. Chuck Peek, who saved me by substituting at the last minute when a member could not be there during my hearings. The thoughtful suggestions and review by all the above have helped keep me focused while confronting the confounding morass of inter- and intra-disciplinary, micro/macro research. Dr. Jaber Gubrium also provided a tremendous amount of information and assistance on the qualitative elements of the dissertation while he was at the University of Florida. While I was happy at his promotion to chair another sociology department, I *sincerely* regretted his absence for the final stages of the dissertation.

I do not know how my dissertation would have been completed without the sociological discussions with my friends, Dr. Sylvia Ansay, Dr. Amir Marvasti, and Dr. Erica Owens. On numerous occasions when complicated concepts and hard and discouraging days cooled the embers of my endeavors, they stoked my passion by providing sorely needed compassion, insightful observations and helpful suggestions.

Drs. Felix Berardo, John Scanzoni, and Hernan Vera all offered me advice and encouragement to complete this work even though none were on my. I am very grateful for the assistance and advice on teaching issues tendered by Drs. Marian Borg and Chuck Peek. Without their help I would have needed hours and hours of time away from my dissertation. I am deeply appreciative of the devotion to scholarship and to graduate members of the Sociology Department exhibited by all these professors.

Drs. George Lowe and Charley Peek of Texas Tech University were instrumental in the earliest phases of planning my dissertation; and their concern from afar was very heartening during many times when my progress was less than I hoped. Many unnamed professors at both Texas Tech University and the University of Florida provided encouragement through their own exemplary scholarship and devotion to academia.

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Abstract of Dissertation Presented to the Graduate School
of the University of Florida in Partial Fulfillment of the
Requirements for the Degree of Doctor of Philosophy

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December 2004

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Department: Sociology

My research adds to the sociology of deviance. Labeling and reactions to deviance by therapists are examined. The debate over orientations toward the discovery of repressed memories, and reactions to this debate, are used as a starting point for this examination of how deviance is constructed by therapy practitioners. Interviews of certified and/or licensed practitioners in the three major therapy disciplines of mental health (clinical social workers, clinical psychologists, and psychiatrists) are subjected to qualitative analysis.

This inquiry discusses the narratives of ten therapists who revealed four major areas for conceptual analysis. These are orientations to therapy; memory, suppression and repression; accountability and ethics; and the interaction of legal issues and therapy. While little difference was found between the narratives when examined by discipline, arenas of individual differences were uncovered.

Training did not seem to affect orientations to therapy. The therapists all related narratives stressing problem solving in the present. Their definitions of good practice included maintaining confidentiality, doing no harm to the client, and following an agenda coming from and about the client rather than the therapist. Few of the therapists used any practices that are essential for extracting repressed memories. The line between normative practices and deviance was seen to be crossed when the above were violated.

While professional and legal sanctioning of deviant actions was advocated, the therapists who commit breaches were seen as impaired. Remedy was expressed in terms of how to get these individuals “repaired” and back to normative practice. Organizational or institutional remedies were seldom recommended (e.g., change in socialization, closer monitoring by local boards, national registries of deviance, etc.). Reclamation rather than proactive action was advanced in all but two interviews. Conducting the research also provided insights into problems encountered in cross-disciplinary study—namely the study of therapy discipline (and effects of legal sanctioning) from a sociological vantage.

CHAPTER 1 INTRODUCTION

This dissertation examined how the labeling of deviance is affecting mental health therapy. It contributes to understanding the construction of deviant therapy practices. To this end, it considered the following: how therapists with different training and various kinds of practices think about deviance in their work (i.e., how they draw the line between “good” and “bad” applications/therapists); how professional ethics and training affect therapists’ constructions; and how therapy and legal developments that regulate practice play off each other. Because important legal developments have keyed on childhood sexual abuse and the discovery of memories, the controversy over regression techniques that recover “repressed” memory provides a strategic site for studying how deviance is constructed and normative practices affected.

Before the 1960s, the term “child abuse” was not in general usage. In 1967 there were 7,000 cases of reported child abuse and neglect, but by 1981 there were 1.1 million reported; and in 1989, 2.4 million (Hacking 1991). Child abuse had to be constructed as deviance (Pfohl 1977), and was responded to accordingly. Not surprisingly, part of the reaction to the problems associated with child abuse involved therapy. Some therapy techniques were expanded or developed, including regression therapy, to meet the needs of victims. Because the discovery of child abuse reflected changing definitions and constructions as much as abusive behaviors, many victims entered adulthood without

having had their abuse treated or even recognized. The promise of regression therapy was that it could address how past abuse was a factor in current problems.

The increase in the popularity of regression therapy can be documented. A review of the professional and academic journals covered in Sociofile reveals that before 1965, only one article contained the word "repression." From 1965–1975 there were 142 entries, 1976–1985 contained 483, and 1986–1995 had 672 entries.

This dissertation takes advantage of the changing constructions of child abuse to study controversial therapy techniques and shed light on how the delivery of therapy may be constructed as deviant. The concept of “Repression” as used in this research involves lessening access to an unpleasant memory with the following characteristics: 1) traumatic or negative event/s occurred to the person, 2) memory of that/those event/s cannot be recovered by normal memory processes, 3) the repressed memory affects the person's present behavior, and 4) the way to cure the effects of repression is to make the event conscious and relive it.

My study adds to the sociological tradition of studying the construction of deviance and the effects of deviance labels. Some examples of research in that tradition illustrate the wide range of topics that informs our knowledge about deviance. Erikson (1966) examined the construction of witchcraft by Puritan society. Construction of deviance between officers by police internal organizations was studied by Punch (1985). The construction of computer crime by lawmakers was detailed by Hollinger and Lanza-Kaduce (1988). Gubrium and Holstein (1990) found that deviance in families can be constructed by therapy organizations. Construction of addiction by practitioners and

researchers was recounted by Akers (1991). Holstein (1993) found that mental illness can be constructed by attorneys in competency hearings.

A more complete exposition of how the study of therapy fits within a comprehensive deviance framework is presented in the next chapter. By way of introduction, suffice to say that the study of deviance poses two central issues according to Akers (1977, 13) “how and why certain kinds of behavior and people become defined and reacted to as deviant” and 2) “how and why some people come to engage in actions or acquire the characteristics defined as deviant.” Much of the study of deviance and crime focuses on the second issue. The labeling or social-reaction perspective draws our attention to the former, and focuses on “*the behavior of those who label, react to, and otherwise seek to control offenders*” (Cullen & Agnew 2003, 295; emphasis in the original) .

Social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labeling them as outsiders. From this point of view, deviance is not a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an “offender.” The deviant is one to whom that label has successfully been applied; deviant behavior is behavior that people so label. (Becker 1963, 9; emphasis in original)

The labeling perspective is similar to the conflict approach in emphasizing the formation and application of definitions. Indeed, the two approaches have become so closely identified in arguing that social interactions to deviance are unequally applied against the less powerful groups that some sociologists see conflict and labeling theorists as almost interchangeable (Hagan 1973, Wellford 1975).

The question of how labels are applied, therefore, revolves around the issue of power. The behavior of less-powerful groups or individuals is more likely to be defined

as deviant; more-powerful groups or individuals are in a better position to resist labeling, or to negotiate when or how behaviors are labeled (Hawkins & Tiedeman 1975).

The study of therapy and therapists involves groups and individuals that possess education, status, and some level of power. They are not free to disregard external efforts to regulate their practices and must work within the existing legal structure. As professionals, they enjoy considerable autonomy over their work, and belong to professional associations that are often successful in insisting on self-regulation through certification and codes of ethics.¹ When professionals fail to regulate themselves sufficiently, there is great pressure for external constraints.

Therapists hail from different training backgrounds, and therapy cuts across different disciplines and schools of thought. Abbott (1988, 325) reminds us that we must “start studying work” rather than the profession. He calls for the study of the history of the work, who was involved and where they came from, how markets for their services were created, and how conflicts shaped those who practiced.

Deviant therapy practices are the concern of both professional associations and the law. The professional associations to which therapists belong promulgate ethical codes and standards of practice in an effort to regulate therapists and therapy. Professional associations also provide certification. Such efforts represent a form of self-regulation. My study focused on *how* the practice of therapy has been affected by this self-regulation,

¹ Codes of ethics for therapists are similar to each other. These codes can be found through the national organizations or online at:

- 1) National Association of Social Workers: <http://www.socialworkers.org/pubs/code/code.asp>
- 2) American Psychological Association: <http://www.apa.org/ethics/code2002.html>
- 3) American Psychiatric Association: http://222.psych.org/apa_members/ethics_opinions53101.cfm

and *what* this effect on therapists has done to change conceptions of mental health practice.

Deviant therapy practices can also give rise to legal controls that go beyond self-regulation by the professional associations. One way this control is exerted is through state licensure. Legal controls have also been imposed through court cases [e.g., *Tarasov v. Regents of the University of California* (1976) and *Ramona v. Isabella* (1994)] and through legislation (e.g., mandatory reporting of abuse). Although therapists have long been accountable to their clients for deviant practices, more recent case law has established their potential liability to others. *Tarasov* was a landmark case in which a therapist was held liable for his client's injuries to a third person because the therapist failed to report credible threats made by his client. *Ramona* established that therapists could be held liable in tort for damages caused by a client's accusations stemming from therapy techniques which manufactured memories of childhood sexual abuse. Statutes now mandate reporting of suspected child abuse, creating a quandary for therapists. They are required to report suspected child abuse, but need to determine which accounts are credible to stay within strictures to maintain the client's confidentiality. In the process, they are potentially liable for tort suits if their techniques lead to false or unreliable accounts of abuse. The legal problem is compounded by the power differential between therapists and clients, and by different levels of suggestibility in clients. The role of court cases and public awareness may be affecting therapists' practices in these disciplines, as explored in the interviews. One focus of this study is on how the practice of therapy has been affected by these legal controls and professional guidelines.

My research analyzed interviews with licensed and/or certified therapists to investigate how the labeling of deviance² within the institution of mental health³ is done (constructed). This approach used narrative analysis, supplemented by content analysis and conversation analysis. Cards that identified concepts frequently found in the literature were offered to the interviewees. The interviewees' selections helped structure the narrations. The goal was to allow them to define the concepts, set priorities for the interviews, and minimize the interviewer's role. Accordingly the interviews were loosely structured, but all of them provided for narrations on a series of topics: 1) orientations to therapy; 2) memory, suppression, and repression; 3) accountability and ethics; and 4) legal issues and therapy.

² Two types of deviance and two types of construction are discussed in this dissertation. The type of deviance that is focal is *deviance within therapy*, which can mislead or harm clients and others. This type of deviance is contrary to the ethical standards of each of the therapy disciplines and sometimes is actionable. The *deviance of perpetrators of childhood sexual abuse* is also an element discussed in this dissertation.

The construction that is focal involves *how the therapist-respondents construct* how therapy should be done, and which therapy practices and therapists are labeled as deviant. Unfortunate for the sake of clarity, the deviance of persons who commit childhood sexual abuse and the therapeutic method of *constructing a new life* by confronting a past event are also essential factors. Rather than label them as type "A" or type "B" or some other artificial demarcation, context within my text indicates which types are under discussion in a particular segment.

³ An institution has been defined sociologically a "a major sphere of social life, or societal subsystem, designed to meet basic human needs" (Macdonis 2004, 301); as "a collective solution to a problem of social life [that] includes a variety of groups and organizations that address a problem of social life" (Lauer & Laurer 1998, 124); and also as "stable set of roles, statuses, groups, and organizations . . . which provides for behavior in some major area of social life" (Newman 2000, 29). Mental health can be conceived as a social institution under each of the above definitions:

A. The way of behaving is through the theory and organization of psychology. The human need is mental health.

B. The problem of social life is maintaining an efficient populace and workforce.

C. The social structures (roles, statuses, groups, and organizations) are found in the disciplines that include psychiatry, clinical psychology, and clinical social work—all of which have similar ethical standards of action but different statuses, functions, and ways of interaction in pursuit of their common goal of treating mental illness and, sometimes, providing theoretical and methodological resources for the maintenance of mental health. The culture is a merged one stemming from neurology and psychological foundations. Finally, the technologies of the institution of mental health are those which have evolved and are evolving from neurology, psychology, and the needs of public service.

CHAPTER 2 THERAPISTS' CONSTRUCTIONS OF THERAPIST DEVIANCE

The study of deviance confronts the problem of defining deviance and identifying who is considered deviant. Goode's exposition (1994, 1997) presents a framework for considering deviance and therapy. His framework begins by discussing approaches to defining deviance. Goode (1994, 12-15) rejects five "naive" and/or "misleading" definitions based on absolute moral standards, statistical analyses, social harm, criminality, and "positive" deviance. He then concentrates on two "fruitful (but flawed)" approaches that focus on social norms (normative definition) and social reactions to behavior (reactive definition). Goode notes that the normative definition is the most commonly accepted approach.

"Norms define appropriate acts and conditions for a society's members" (Heitzeg 1996, 3). "The normative definition locates the quality of deviance not in actions or conditions themselves but in the fact that they violate the norms of the culture or subculture in which they take place and exist" (Goode 1994, 15). It "locates deviance in the *discrepancy* between an act or a condition and the norms" present at that place at that time (Goode 1994, 16). Goode also notes that it implies relativity—norms will differ from group to group and time to time. "What makes a given action or condition deviant is the fact that it is a violation of the custom, rule, law, or norm *when and where it occurs.*" (Goode 1994, 16).

One of the major problems that Goode (1994, 16) links to the normative definition is that it "ignores the distinction between violations of norms that generate no special

attention or alarm and ones that cause audiences to punish or condemn the actor.” For over 80 years, social scientists have noted that relatively little attention has been paid to societal reactions to deviance (Dewey 1922, Kitsuse 1968). The reactive definition addresses that omission. “What makes an act or a condition deviant . . . is how it, and the individual who enacts or possesses it, are reacted to by actual people, audiences, or others who punish or condemn the individual” (Goode 1994, 17). The reactive definition of deviance requires “actual, concrete instances of punishment and condemnation” (Goode 1997, 26). One of the major problems with over-reliance on the reactive definition is that it de-emphasizes the original behavior or condition that gives rise to the condemning or punishing reaction. For example, Akers and Sellers (2004) argue that labels are attached to behaviors and that deviance cannot be studied by only looking at the social reaction.

“Soft” Reactive Definition of Deviance

Goode offers a compromise by adopting a “soft” or “moderate” reactive approach to defining deviance, the construction of deviance, and reactions to deviance.

In sum, by deviance, I mean . . . behavior or characteristics that some people in a society find offensive or reprehensible and that generates—or would generate if discovered—in these people disapproval, punishment of, condemnation of, or hostility toward the actor or possessor. Goode 1997, 37.

Goode (1997) adopts his “soft” reactive definition of deviance to incorporate three features that he claims advance the conceptualization of deviance. First, since no rules are absolute, “one should be able to infer from reactions by a wide range of audiences to behavior and conditions what the norms are” (26). One of the goals of this dissertation is to learn from therapists what “the norms are.” That includes general normative orientations to therapy that contextualize understandings of deviance in therapy. The

interviews explore how therapists understand the norms and how that reflects various audiences. Goode notes that “It is the *audience* which determines whether something or someone is deviant: no audience, no labeling, therefore, no deviance” (Goode 1997, 107).

A second advantage that Goode (1997, 26) claims for his soft reactive definition of deviance is that it recognizes that “the enactor of potentially deviant behavior, or the possessor of potentially discrediting characteristics must operate in a sea of imputed negative judgments.” Another of the goals of this dissertation will be to explore, from the perspective of the therapists, how reactions by audiences affect the therapists’ norms and behaviors.

The third advantage is that the soft reactive definition allows Goode to escape from the dilemma presented by “secret” or undetected deviance. If most norm-violating behavior or conditions remain undiscovered, they are not reacted to. To the strict reactivist, they would not be deviant. On the other hand, the normative approach, which defines secret norm violations as deviant because they would be reacted to if they were discovered, misses the important role that social reaction has in contributing to their stigmatized status. “Although social reaction does not create the actual behavior, it does lend to it a stigmatized status, and it influences certain features of that activity and the lives of men and women who engage in it that would be lacking in the absence of negative labeling” (Goode 1994, 21). Goode concedes that “the reactions of audiences do not necessarily create the behavior in question out of thin air,” but that social reaction affects people who engage in that behavior regardless of whether their deviance is detected. Secret deviance plays a role in forming the norms which other individual therapists (as members of the audience) profess and that are revealed in their practices. A

goal of the dissertation is to learn about reactions by therapists to various therapy practices and practitioners, regardless of whether norm violations have been detected. What do therapists react to strongly when it comes to deviance within their ranks?

The literature on deviance suggests that Goode could have gone further in developing the point. Social reaction has social utility in several ways. Durkheim (1893/1933) noted how it could reinforce shared norms. To him, shared norms rather than threats of punishment, were functional for social control. Erikson (1966) demonstrated how social reactions helped establish and maintain the moral or normative boundaries for groups. In this sense, social reactions to deviance are educative for those who are compliant as well as those who are deviant. A goal of this dissertation will be to explore how various social reactions to therapy practices and therapists, including some official legal and professional reactions, have affected therapists' own views about deviance and practice.

Audiences play a critical role in Goode's discussion. Their reactions help identify the norms, and actors have perceptions about how various audiences feel about deviance. Goode identifies different potential audiences at different levels of analysis—individual actors, potential victims, social intimates, witnesses/bystanders, members of small groups, societal members, formal social control officials and systems, and distant observers. He notes that “attitudes toward and reactions to potential deviance are held and expressed by people with vastly differing degrees of power—power to have their views of what is right and wrong win out over those of other people” (Goode 1994, 23). He goes on to assert that what needs to be known is “*which forms of behavior and what*

conditions stand a high chance of earning condemnation and punishment for the individual” (23).

Goode identifies three dimensions that determine the likelihood of something being labeled deviance: the *numbers* who are likely to punish or condemn a phenomenon, the *power* of those who disapprove of the phenomenon, and the *intensity* of their beliefs. Punishment or condemnation is more likely to occur if more people define something as deviant, if they have relatively more power, and if they hold strong beliefs about the inappropriateness of the deviance.

The centrality of the role of audiences in labeling deviance becomes more complicated by the challenge of relativity that Goode incorporates into his approach. He notes that audiences are relative and the “greatest amount of variation occurs *from one specific person to another*” (Goode 1994, 25). The relativity in audience is compounded by relativity in individual actors and situations. Some individuals are in better positions to resist deviance labels. “High status individuals are allowed a great deal more leeway in what they do and are; they aren’t judged as harshly as lower-status people are, and they have resources to deflect criticism that might be headed their way” (Goode 1994, 27). Erikson (1962) indicates that some who engage in behavior that is labeled as deviance can avoid being labeled as deviant individuals. Similarly, some situations are more likely to escape labeling. “The *setting* makes a great deal of difference in how audiences judge behaviors, actors, conditions, and their possessors” (Goode 1994, 28).

The settings of therapy have been examined by others, elements such as the effects of the “fifty minute hour,” therapists not providing answers to direct question but asking questions as a response to questions they are asked, etc. (Lindner 1955, Goldman

1996, Frank 1998, Frawley-O'Dea 1998). Other major elements of the social environment which bear upon therapists are found in legal rulings, the organizational structure and messages of their discipline, and the media exposure of actions and attitudes of public opinion.

One variation on relativity is potentially important to a study of deviance in therapy. Individual therapists may know of acts which have been labeled deviant through societal normative standards (law and ethics boards) and even know of therapists who have been sanctioned and stigmatized for these acts (or who could be). Yet, some therapists may be reluctant to affix the deviance label. The research explores whether therapists distinguish between the act of deviance and the deviant actor—they may be willing to condemn the sin but not the sinner. They may grant wide berth to many practices and other practitioners. Therapists may be slow to judge fellow therapists since all therapists are potentially vulnerable to errors of professional judgment and few may want to have their own professional judgment questioned or reacted to strongly. Moreover, therapists may be reluctant to put their occupation in a bad light. Airing even others' dirty laundry in public (i.e., opening the therapy relationship to consideration by other audiences such as the media) may hold implications for themselves as well as for all therapists. The analogy would be to the "blue curtain" that insulates law enforcement and the concomitant reluctance of police to report the deviance of fellow officers (Westley 1970; Crank 1997). The interviews will shed light on how therapists react to potential audiences.

Changes in therapy (discussed in more detail in the next chapter) may affect how therapists label deviance and deviant practitioners. The introduction of Rogerian therapy

stressed unconditional positive regard. As behaviorist and problem-solving therapies became commonplace, the focus centered on current behaviors rather than intrinsic traits or past conditions. The actors are not labeled as bad, and the behaviors are to be treated or mitigated, not condemned. Has the ethos of therapy change enough so that therapists do not view behaviors generally as matters of deviance—including professional behaviors? Has a new ethos developed so that actors are not seen as deviant even if problem behaviors are?

The study of deviance among therapists raises some questions about audiences, actors, and situations. Although many people may condemn blatant abuses of therapy relationships (e.g., having sex with clients), other aspects of practice may be much less clear-cut. Victims may not be a large or powerful audience in the attribution of deviance in therapy. As clients, they seek therapy because of various problems which are often not concrete; treatments and outcomes are not standardized. The independent professional judgments that therapists are expected to exercise are necessary given the uncertainty surrounding the therapy context. Clients also have relatively less power than the “experts” they seek out, and they are not in a good position to know about which therapy practice will or will not help them. The uncertainty may be functional for therapists in that members of the larger society are not in good positions to condemn various techniques and practices that may be especially tailored to fit the particular needs of a client. In other words, the number of potential condemners is reduced, they lack the expertise (and hence the power) of the professionals who practice therapy, and they are on grounds too shaky for strong condemnation.

The exalted prestige, autonomy, deference to professional judgment, and latitude in self-regulation and judgment that have been available for psychoanalysts and other regression therapists may be at risk. Reflection and reflectivity are undoubtedly occurring among psychoanalysts and regression therapists as they confront changes in social conditions described above. The labeling of parts of regression therapy as deviant has cast a shadow on therapists who use these techniques. Since this was the main perspective of psychiatry at the height of its professional dominance, denigrating this practice may have contributed to some of the loss of its dominance over the other disciplines and other, less formal types of therapy.

The issues are compounded by the norm of confidentiality in therapy relationships. Indeed, breach of confidentiality may be one of the normative violations that is condemned (and condemned strongly) by many people, including other therapists and powerful social control officials. Confidentiality allows for instances of deviance within therapy to remain secret. Moreover, “victims” of deviant therapy who think about reporting the therapist face some constraints. Those in therapy are suspected of having coping or mental issues, which may be stigmatizing in themselves. Their private problems become public concerns if they report, and they may be less credibly received than would be the professional if a dispute arises about what happened. Moreover, therapists derive power from their formal training and their individual experience of framing issues (which is a component of their work). They are uniquely in a position to present a case that puts them in the best light—they can use their expertise to discredit client behaviors and cast doubt about motives of clients making accusations.

Therapists constitute a key audience for learning about the norms and social reaction to potentially deviant therapy practices. They may be engaging in deviant practices, reacting to the deviance of other therapists, or adjusting their own practices because of broader social reactions to deviant practices or practitioners.

Goode's lessons about relativity suggest that a study of deviance in therapy needs to explore across different kinds of therapists and different situations. Therapists can vary by type of training (e.g., social work, psychology, psychiatry), extent of training (e.g., MSW, Ph.D., M.D.), nature of practice (e.g., solo, group, self-employed, salaried), and nature of clientele (e.g., specialty populations like children or the elderly versus general clienteles).

Another key audience for the study of deviance in therapy arises within the official social control system. Some of the social reaction that is important for understanding deviance in therapy emanates from official social control agents. Indeed, formal social control reverses the power arrangements in ways that may affect perspectives on deviance. Professional practices are regulated by law and by professional groups which promulgate ethical standards for their members. However, different states/jurisdictions can advance different laws (e.g., psychiatrists in Florida will work with different laws from those in New York) and different professional associations can present different standards for therapists (e.g., psychiatrists will belong to different associations than will social workers). This contributes to the perception of the nebulous nature of normative definitions. Given the relativity, therapists may have different understandings about deviance in their workplaces.

Goode asserts that “it is important to identify the party [or parties] judging the behavior or condition . . . the relevant audience” (Goode 1997, 29). In addition to the legal system which serves as an audience, the national, state, and local organizations of therapy disciplines (see footnote 1) intervene to prevent outsiders including moral entrepreneurs from regulating their practices [persuasive, legitimate, active, credible figures who launch a campaign to discredit an activity (108)]. The societal norms for therapists are prescribed or proscribed through the formal standards of ethics of each of these therapy disciplines. Other components of the audience are the therapists who are labeled, their clients and victims and their social intimates, other direct observers of the act(s) judged deviant or of the labeling process, members of the mass media, members of society who follow the process through media, and others who read or hear about the behavior labeled deviant but are at a social distance precluding their being influenced by the judgment in any way. Some “parties or audiences, from the participant to the detached observer, would condemn the behavior, the condition, the actor or the possessor, were they to come face to face with them” (28-9).

Constructionist Versus the Essentialist View of Deviance

Goode (1997) rejects an essentialist view of deviance—one which holds that essential differences exist which can be used to categorize phenomena, including deviance. Instead he adopts a moderate constructionism which recognizes that many categories are social and mutable rather than derived to reflect inherent properties or “essences.” The constructionists hold that “definitions have no absolute, objective validity; they are meaningful *only* within the context of the criteria spelled out by a particular classification scheme” (Goode 1997, 34).

Constructionists expect that social conditions evolve. For example, they would expect therapy to change and the problems therapists deal with to change. Definitions of deviance in therapy are also expected to evolve as problems develop and norms shift. The changes may occur at the therapist level (e.g, individual reactions and responses to issues and vicissitudes of practicing in an otherwise changing social and physical climates), at the mental health institutional level (e.g., imposition of revised standards and sanctions by the therapy organizations), and/or at the inter-institutional level (e.g., reactions to emerging laws and to exposure by the media).

The discovery of child abuse generally (Pfohl 1977) and the ongoing discovery of sexual child abuse created a new context and prompted change in the larger society and among therapists. Mental health professionals spent multiple hours accessing client/patient's memories as a first step in transforming a client/patient's dysfunctional or unhappy life. Their present problems are rooted in past events so that memories seem to hold the key for successful interventions. An institutional familiarity with Freudian techniques and notions of repression may have also contributed to a concentration on efforts to locate memories of those who had been victimized by child abuse. Regression therapy and the search for repressed memories was *de rigeur* for therapy. The public awareness and the estimated prevalence of childhood abuse suggested an explosion in perceptions of numbers of possible victims, making it more necessary for therapy. The techniques used to explore these memories has given rise to successful lawsuits by third-parties who were directly affected by the therapy sessions.

Elite-Engineered Deviance?

“Defining behavior as deviant is variable with respect to the degree to which it is *spontaneous and grass-roots* or *organized and engineered*” (Goode 1994, 56). The literature provides little evidence of any kind of spontaneous grass-roots groundswell to rein in deviance in therapy. Instead, the social reaction emanated from courts, legislatures, and professional associations which were the guardians of professional standards of ethics. The attribution of deviance, whether of particular therapists or of treatment practices, is most manifest in changes in the ethical standards and in the imposition of laws that affect the procedure of therapy. In other words, the definitions of deviance played out at elite levels. The legal and professional developments occurred during, and may have been encouraged by, an academic conflict among psychologists about the utility and validity of work on the repression of memory (see chapter 4).

The increased attention given to repression by the media was documented in chapter 1. The institution of media helped spark popular, legal, and therapy recognition and interest in the changing cultural norms of therapy practices and in practitioners who deviate from these norms. It reports salient legal issues and plays a role in making salient the cases that reflect these issues through broad exposure. Public attention was focused on the problems that media highlight, including the discovery of child abuse and concerns about sexual child abuse. This attention brings other institutions into play as they examine the issues and problems from vantage of their separate and unique perspectives.

Formal and Informal Labeling of Therapists

State and federal statutes can be used for official labeling. Federal law mandates the reporting of suspected abuse [Child Abuse Prevention and Treatment Act (CAPTA)]

which was originally enacted in 1974 (P.L. 93-247) and was last reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36)]. Many states have similar provisions in their codes.

Formal labels emanate from court cases. The courts act as an audience which applies deviant labels directly to therapy and therapist. These formal norms govern 1) therapists' testimony when called as expert witnesses, 2) prohibition of use by prosecutors of information attained by some therapy techniques which increase client suggestibility and can create false memories, 3) mandates to report suspected abuse or danger to self or others by therapy clients/patients, and 4) the tolling of the statute of limitations for torts experienced when a child.

Chief among the rulings which directly apply to therapists and techniques labeled deviant are the *Tarasoff* and *Ramona* cases. In *Tarasoff v. Regents* (1976) the court mandated a therapist to report possibilities for harm by the client which are discovered in therapy or be held liable for damages which the client causes.

Ramona v. Isabella et al. (1994) first held therapists accountable to third-party tort suits.¹ The court awarded both compensatory and punitive damages.

¹ The cases cited in the text are the omnibus cases relating to harm that therapists can prevent or that they can instigate. There are many cases which have been cited in the articles concerning regression and repression of memory that have provided precedence in suits arising from alleged damage precipitated by a therapist. The following are a few of the more notable that involved liability to third parties damaged as a result of deviant therapy practices:

- A. Couch v. DeSilva (602 N.E.2d 286 Ohio 1991) (mishandled recovery of memory by therapist)
- B. Doe v. McKay (678 N.E.2d 50 (Ill. App. Ct. 1997) (tort for loss of consortium occasioned by therapists' actions)
- C. Dillon v. Legg, 441 P.2d 912 (Cal. 1968) (en banc) (patient acknowledged misdiagnosis that could be used by injured third party to establish liability of therapist)
- D. James W. v Superior Court (93 C.D.O.S.5449 Jul 16, 1993) (denial of immunity from suit about unfounded charges by client against a third party)
- E. Mateu v. Hagen (King County Superior Court, 91-2-08053-1 Seattle) (therapist's use of age regression, bioenergetics, psychodrama, trance work, visualization, and guided imaging was overly suggestive)

In addition to the legal rulings which affect therapy, there are legal rulings which result from changes that have occurred in the practice of therapy. Among these are those which deal with therapists as expert witnesses and those which result from some of the techniques of therapy disclosed as potentially aberrant by the national media [e.g., the *McMartin* case of New Jersey (*McMartin, Virginia, et al. v. Children's Inst., et al.* 494 U.S. 1057; 110 S. Ct. 1526; 108 L. Ed. 2d 766; 1990 U.S.), the *Franklin* case [*Franklin v. Duncan* (WL 684390 9th Cir. 1995)], and the *Ingram* case [*Raymond v. Ingram* 47 Wash. App. 781, 737 P.2d 314 (1987)]. For example, in many jurisdictions testimony will not be admitted that is based on information the plaintiff or prosecutor retrieved via hypnosis or psychoactive drug treatment. Therapists whose testimony is based on knowledge gained from these techniques will not be qualified as expert witnesses.

For this dissertation research, only those rulings which *directly* pertain to the practice of therapy (*Tarasoff* and *Ramona*) were specifically raised in the interviews. Arguably, some other cases have had a salient informal effect on therapists and the practice of therapy. The interviews provided the opportunity for therapists to volunteer which rulings or law affected their thinking about deviance in therapy.

The institution of mental health is also involved in formally defining deviance. Each of the therapy disciplines, in their standards of ethical practice cited in chapter 1, includes an organizational injunction to do no harm (*primum non nocere*). Basing therapy on a false premise potentially harms the client/patient when accepting and

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- F. *Montoya v. Bebensee* (761 P.2d 285, Colorado Court of Appeals, 1988) (duty to care for harm to third party from foreseeable false charges)
 - G. *Tyson v. Tyson* (11986 Wash.2d) (delayed discovery and latent injury cases)
 - H. *W.C.W v. Bird* (840 S.W.2d 50 1992, Texas Court of Appeals) (problems with client's testimony after use of sodium amytal)

focusing on memory which is a product of suggestibility rather than actual events.

Increasing client/patient suggestibility is adding another impediment into his/her life.

This creates a *weltanschauung* which must at some point conflict with reality and serve as a barrier to adapting to present real situations and problems—one of the main purposes of therapy.

In addition to the harm done to the client/patient, having the client/patient act upon findings elicited by questionable techniques to resolve a problem which did not in actuality exist, even in the past, interferes with present interactions with others who were included in the false memory. Third-party lawsuits can arise in situations where therapy clients confront others as a result of the therapy that they receive.

Goode (1997) argues for a contextual construction of problems.

The contextualist constructionist's concern is mainly in understanding how definitions of social problems are generated, sustained, taken seriously, and acted upon; and how certain claims of seriousness are advanced by specific agents and reacted to, or ignored, by different audiences. Goode 1997, 60.

This orientation informs the organization of the next two chapters. In Chapter 3, I examine how the social problem of dealing with mental difficulties has been generated, sustained (or exterminated), taken seriously, and acted upon in the past. In Chapter 4, I examine how regression therapy and repression techniques have become defined as a social problem, how the problem is sustained by those therapists who use the techniques, and how others attack the techniques as needing to be exterminated or modified, and I indicate the seriousness of this problem. After a methodology chapter, the bulk of the remaining chapters are concerned with data on how the audience of therapists view therapy and deviance as well as react to the labeling as a problem.

CHAPTER 3
HISTORY OF NORMALCY, DEVIANCE, AND CHANGE IN THERAPY

Therapy and Change

If the past is any guide to the future, today we can be certain of only one thing: The day will come when people will look back at our current medicines for schizophrenia and the stories we tell to patients about their abnormal brain chemistry, and they will shake their heads and mutter in disbelief. (Whitaker 2002, 291)

Organized concern for mental or emotional illnesses and therapy has existed in America for only a little over 100 years (Napoli 1981). In 1892 the American Psychological Association (APA) was formed, establishing a functional national organization for therapists. While there were earlier attempts at centralization (some of which lasted for years), only after the birth of the APA did America have a national community of mental health specialists that has survived to the present. Since its inception, and even though many of the therapeutic theories and methods advanced (or at least tolerated by the APA) have later fallen out of favor,¹ the APA has consistently received recognition as the dominant organization within the institution of mental health.

Distinctive eras of therapy before that unifying event are difficult to discern. The practice of therapy did not have the organizational structure of an identifiable institution required for tracing what has been labeled deviance as generations progressed. Indeed, there was even less separation of physical treatments for disease and morbidity from

¹ A number of these previously discarded therapies are now at least marginally accepted and some members of the American Psychological Association are protagonists of many of them. A few of these later reappeared in modified forms—notably elements of the water-immersion therapies, electric shock therapy, and many drug treatment therapies.

treatments of mental illness than is presently practiced. Distinguishing mental health treatments from physical health treatments is generally impossible. The medical model of health has predominated, and in early history was the only method in use (Ackerknecht 1955). The breadth and scope of differences between practices wielded by therapists, then and now, compounds the difficulty in distinguishing eras. Presently, institutional rules and guidelines do provide standards for making comparisons. There were no institutional rules and guidelines in place before the founding of the American Psychological Association—there were only centers for treatment, or disposal, of persons who were having mental health problems.

The historical literature reveals how difficult it is to distinguish each historical era. That difficulty extends to discerning which practices were considered normative. Even today there are advocates and practitioners using many of the methodological practices that were in place hundreds of years previously (before falling out of favor, and in some cases being labeled deviant). Treatments still range enormously, from physical interventions (such as administering pharmaceuticals or performing electroshock) to interventions that include more nebulous factors (such as retrieving memories of past events).

Despite this lack of organization among therapists of the distant past and a wide range of tolerance for diverse types of practice today, there is clear evidence of change in the *predominant* theories and methods used in therapy during credibly distinct eras of therapy. Therapy has a history of treatments and theories which have often been reviled or regarded unfavorably by succeeding therapist generations. What may be regarded by later therapists as deviance in treatment practices may have been regarded as a

breakthrough in knowledge. Indeed, some of these practices assumed leading roles in treating mental illness (e.g., insulin shock therapy, lobotomies, and water emersion). Individual therapists precipitated changes in the predominant methods of treatment in their pursuit of solutions to mental and/or emotional problems that hindered normative (or at least functional) adaptation to troubled social surroundings and self identities.

The factors which lead to therapy shifts are historically variable and are complicated. In each era, individual practitioners adapt to these shifts in their own ways. Their professional roles as therapists comport to the possibilities that are in that time socially and structurally confining while adapting not particularly to a theoretical identity but more to the practical standards which work for their clients and for themselves.

Emergence of Modern Psychiatry, Psychology, and Social Work

In the 19th century neurology and psychiatry split into separate medical disciplines. These two were later joined by psychology as the disciplines most concerned with mental health. This provided the infrastructure of the late 19th and the 20th centuries for building and organizing disciplines for the regulation of diagnosis and treatment practices.

Modern psychiatry has been described as dawning at the beginning of the 19th century (Marmer 1994). There was a return to the Hippocratic belief in the biological basis of mental disorders, which was attended by the rise of psychiatry as a scientifically organized discipline with roots in neurology. This somatogenic view focused on the belief that pathological bodily conditions and brain tissue dysfunctions were solely responsible for mental disorder. Mental illness thus became the exclusive domain of physicians. Heredity became the salient variable for understanding mental health issues.

Psychiatry's Emergence from Neurology

While psychiatry had roots developed from humanists like Agrippa, Pinel and Tuke (along with a few other isolated reformers of the nineteenth century) paved the way for the transition of psychiatry into its present form. Their voices spelled the end of justification of punishment for the mentally ill and provided for moral treatment and cure through humanistic techniques.

The term "neurologist" came to refer to organic physicians generally working in hospitals. Psychiatrists took over the neurologists' old position as the outpatient border guard of the medical profession, handling the symptoms and diseases that seemed not quite real. . . . Psychiatry began when a group of enterprising medical reformers argued in the early nineteenth century that madmen ought to be removed from the jurisdiction of the legal authorities and placed under that of the medical profession. Madmen are sick, they said; give them to us and we will cure them. A new theory and therapy justified the shift, and private bodies and state legislatures were soon dotting the countryside with insane asylums. (Abbott 1988, 22)

The Entry of Psychology

By the middle of the nineteenth century almost all American psychiatrists believed that psychological problems had physiological causes (Cockerham 1992). Conventional medical science resisted investigating how physical symptoms could proceed from emotional causes (rather than the other way around) until Jean-Martin Charcot presented a paper on hypnotism to the French Academy in 1882. While advancing a treatment plan which took into consideration factors other than anatomy and physiology, his methods produced problems of their own. Under Charcot patients came in with problems [psychosomatic conversion symptoms, PTSD (post traumatic stress disorder), and other emotional responses to their unhappy lives]. He gave them a certain degree of legitimacy (even celebrity), but:

He took away their dignity and their hope. They were pressed into mass conformity, put into solitary confinement, turned into chronic, even lifelong patients. Through hypnotic suggestion . . . hysterical patients were already becoming iatrogenic monsters. (Showalter 1997, 36-7)

Loosening of the medical model of treatment proceeded steadily but slowly thereafter. The greatest blow to the paradigm of the medical model was the one that set therapy on a path emphasizing psychological concepts of personality, learning, and motivation—psychoanalysis. These concepts were joined to the technique of hypnotism, which had been first advanced a century before by F. Anton Mesmer (who has been deemed the father of psychotherapy by psychoanalysts) (Ackerknecht 1955). The blow was delivered by the writings of Sigmund Freud (originally a neurologist) and his early coauthor, Joseph Breuer (discussed below in Chapter Three). Thinking about the nature of mental illness was revolutionized by Freud and Breuner at the end of the nineteenth century. Their “dynamic” psychology included patients who were neurotics as the psychotics who had traditionally been treated by psychiatry (Horwitz 2002). “Dynamic theories posited that neuroses were continuous with normal behavior” (Horwitz 2002, 1). At the end of the century (1896) Arthur Rufus Trego Wylie was the first American psychologist to be employed in a clinical setting. He later became superintendent of The Institute for the Feeble Minded in North Dakota (Street 1994).

The Entry of Social Work

Psychiatrist John Conolly in 1856 wrote “The Treatment of the Insane Without Mechanical Restraints” in England which was responsible for the growing disfavor accorded that method of treatment on both sides of the Atlantic (Street 1994). Dorothea Lynde Dix, arguably one of America’s greatest humanists of the nineteenth century, was

instrumental in exposing deplorable and brutal conditions of the mental hospitals in the U.S. during that time. “Through her efforts she personally founded or enlarged some thirty-two mental hospitals . . .” (Cockerham 1992). She was the most influential advocate of the principle of public responsibility for the mentally ill and got the mentally ill out of jails and poorhouses into asylums. She also documented filth, brutality, and degrading conditions in existing hospitals (Street 1994). Ironically, the numbers of hospitals that sprang up under her influence and the enormous increase in the numbers of patients decimated the ratio of experienced therapists-and-staff to patients, leading these large mental hospitals to become more custodial than treatment-oriented. Neglect and warehousing sometimes resulted, similar to that found in the 17th century but without the draconian measures.²

Beginning in Boston in 1877, “charity organization societies” began investigating problems of the poor and providing visits and advice to assist them (Kane 1983). Paid positions and educational programs for what became social work practitioners developed from these societies. By the turn of the century, settlement houses (e.g., Jane Addams’ Hull House in Chicago and Lillian Wald’s Henry Street Settlement House in New York) began addressing the social problems associated with health conditions and health problems.

The physician who is generally considered to be the founder of medical social work, Richard Cabot, in the first decade of the twentieth century saw the need for people who would act alongside and in teamwork with the physicians to bridge the gap between

² Among the photos of Richard Avedon (1993) are pictures of the mentally ill in Southeastern Louisiana Mental Institution in 1967. These photos document that *even that recently* warehousing and neglect were found in some of the large mental hospitals.

the world of medical practitioners and their impoverished patients (Kane 1983). At first many of these were nurses, but in 1913 social workers were distinguished from doctors and nurses as those whose field of study was character, human relationships, and community life. In addition to joining hospital staff, other settings soon began seeing social workers as staff members, such as mental health clinics, schools, juvenile courts etc.

Social workers developed organizationally, first as The American Society of Hospital Social Workers, founded in 1918, then in a number of other affiliations including the omnibus National Association of Social Workers (NASW) in 1955. Educationally, stipends were first awarded for the study of social work by the National Institute of Mental Health in 1947.

Although the growth and development of psychoanalysis and social work into increasingly powerful and independent organizations proceeded from the late nineteenth and throughout the twentieth centuries, these developments by no means provided a fatal blow to the medical model for mental health. Indeed, the medical model has become reinvigorated with advances in drug therapy. Psychopharmacology has become a major form of treatment. Further, the Diagnostic Statistical Manuals have provided fixed symptomology for diagnosis, recent advances in brain area mapping have provided new possibilities for treatment, and recent advances in genetics have raised new questions about health in all realms of the body, emotions, and cognitive health. Additionally, recent advances in genetics and brain imaging are only two of the promising areas for medical interventions in mental health.

Variety of Therapies: The 20th Century

All in all, there are at least two hundred therapies and numerous pseudotherapies available in contemporary Western society, all intended to counteract psychological stress and behavioral abnormality. (Cockerham 1992)

By the twentieth century, despite the fact that a large number of therapists were still receiving training in Europe, there was a different motivation for treatment in the two continents. Europeans were more concerned with how to control their populations while Americans were more concerned with how to increase economic productivity (Cushman 1992). Building character “through self-discipline, thrift, hard work, cleanliness and religious instruction” became the European model for mental health while in America the “multilayered relationship between politics and ‘personal growth’” led to stresses on personality, “the sum of personal qualities that caused one to be liked by others . . . to stand out in a crowd” (Cushman 1992, 35).

At the turn of the century and concurrent with Freud’s development of psychoanalytic theory and the importance of confession and suggestion, Emil Kraepelin was developing the classification system for mental illness that is still in use. From his clinical observations he developed a threefold classification (dementia praecox, paranoia, and manic-depressive psychosis) that is the symptomatic system that (with some refinements and changes in terminology) still occupies much of the thought, practice, and theory of therapists today.

The demise of spiritualism and occult phenomena was reported after the 1904 first Congress of Experimental Psychology in Germany. It had been replaced by a scientific approach emphasizing observed facts and explanatory theories (Street 1994). At the 1904

St. Louis World's Fair, mental health was represented with papers by psychologists on the current state and future prospects of psychology, followed by section meetings on General Psychology which concerned experimental, comparative, and abnormal psychology (Street 1994).

The “new psychology” of the 1920s, psychoanalysis, had direct effects on American life. This new psychology “represented a revolt” against the academic psychology with phases of psychoanalysis, emphasis on endocrine glands, and, later, behaviorism (Burnham 1988). In London at the Tavistock Clinic, psychoanalytic therapy for indigent clients received its first client and went on to become known for work in psychosomatic medicine, social psychiatry, and child and family therapy (Street 1994).

During the first quarter of the 20th century, psychology was staking its own domain in the field of mental health. Its development has been examined by Napoli:

More and more, clinical psychologists found themselves in competition with psychiatrists, poorly trained testers, and complete charlatans. . . . To win public support they were impelled to 1) stake a claim to exclusive competence and 2) show their service had widespread application. . . . Contrasting themselves to this source of competition, applied psychology proudly cited their own use of the scientific method, laboratory experimentation, and statistical techniques. . . . [Applied psychology's] realm of inquiry . . . was variously seen as behavior, habits, motives, feelings, or some combination of these (30 & 31). Applied psychologists insisted that hostile emotions and behavior were not directly produced by the environment but grew from within the individual as a result of faulty patterns of adjustment (39-41). Psychiatrists . . . were in no position to treat all of America's behavior problems. Their numbers were small, their training spotty, and their view of the situation myopic. (Napoli 1981, 53)

Psychiatry was confronted with industrial psychologists and industrial sociologists in the 1930s and to maintain its dominance in the field of mental health in the cities

changes were made. The importance of therapeutic teamwork became evident. Napoli

holds that therapeutic teamwork was case oriented:

The concept of therapeutic teamwork . . . grew from the belief that every case required a three-pronged approach. Ideally, the team captain, the psychiatrist, provided psychotherapeutic treatment; the clinical psychologist administered tests; and the social workers developed case histories. In practice, however, the duties of the psychiatrist began to merge. It became increasingly difficult to distinguish between treatment and case history, in part because psychoanalytic psychiatry had an intrinsically historical method and in part because social work was adopting psychiatric theory as the conceptual foundation for its own professional aspirations. (Napoli 1981, 54-5)

Freud did not live to see how psychoanalysis came to dominate the mental health scene and became professionalized.

Psychoanalysis was transformed in the years from 1917 to 1940, from the calling of a self-chosen group of avant-garde psychiatrists and neurologists to a profession with its own institutions for training and certification, separate from medicine and psychiatry, yet with close ties to both. The American insistence on medical training came in part from the wish to attain the scientific authority associated with the medical profession. . . . Psychoanalysis enjoyed an enormous, new, optimistic vogue, vastly expanding its therapeutic domain and its influence in medical schools and in the newly founded National Institute of Mental Health. (Hale 1995, 381-2)

Psychiatrists still headed most mental hospitals but criticisms of the historical, clinical and philosophical grounds of psychoanalytic theory opened the door for non-medical treatments (Hale 1995). The alienating freedoms of the industrial age had progressed in the U.S., bringing with them “moral illiteracy, confusion, isolation, loneliness, and self-preoccupation, leading to the need for the social practice of psychotherapy” (Cushman 1992).

During and right after the war, there was a shuffling of accepted theories on treatments. Inroads were made by psychologists during this period into the professional

dominance of the psychiatrists and neurologists. Medical treatment still had other avenues for approaching mental health. In 1940, successful use of insulin shock therapy was introduced for patients with severe mental illness (Street 1994). In 1947 psychiatrists in Maryland announced that prefrontal lobotomy had led to the release of several patients who had previously been diagnosed as incurable. This practice became widespread in the 1940s, but in 1950 one of the foremost practitioners, Walter Freeman, announced that he would no longer perform lobotomies or topectomies because of their harmful aftereffects (Street 1994). Thereafter, these procedures lost more and more favor, and were replaced by electroshock therapy and psychopharmaceuticals, which are used today to the same purpose for similar patients in some hospitals. Use of insulin shock, electroshock, and lobotomies and topectomies was reduced as drug therapies assumed ascendancy in these severe cases of mental illness. In 1953 and 1954, Thorazine (chlorpromazine) and Serpasil (reserpine) were approved by the U.S. Food and Drug Administration for use as having led to remarkable progress in schizophrenics (bipolar) and some other psychotics. The results were indeed remarkable—for a time. The problems that dopamine and serotonin blockers have caused children and some other patients (see Whitaker 2002) is currently being addressed by researchers, journalists, and even Congressional committees against a well-financed pharmaceutical industry.

While psychiatrists were the primary purveyors of mental health at the start of World War II, psychologists and social workers filled need for personnel and contributed a non-medical, psychotherapeutic professionalism to the mental health institution. This need led the war psychiatrists to abandon “their claim to exclusive rights in this field, falling back to the position that they must only have overall supervision of psychiatric

patients” (Napoli 1981, 143). Behavior modification, derived from psychology’s experimentally established understanding of learning factors, became the arena of appeal during the war years. Carl Rogers’ humanistic psychology, featuring group therapy and nondirective “insight therapy,” provided a non-Freudian approach to psychotherapy (Napoli 1981). Psychologists became even more influential when a psychological board was created by President Truman to deal with propaganda and economic and political activities during the Cold War (Street 1994). During these years, psychiatrists were not the only therapists to engage in treatments which became labeled deviant. For example, in 1951 a Seattle psychologist was convicted because he used sexual intercourse ostensibly to cure the guilt complexes of three of his female clients (Street 1994).

In 1955 a federal commission reported that over half of the 1.5 million hospital beds in the U.S. were used to care for people with mental illness, and declared that mental illness was the greatest single health problem in the United States (Street 1994). Alternatives were sought and patients were increasingly released into their communities. “The mental hospitals released most of their patients from 1965 to 1975, and many closed for good” (Hobson & Leonard 2001, 39). Psychoanalysis was still a potent force in mental health and illness. In 1956 an American critic noted that more people used psychoanalysis as an explanation of human behavior than anything else in modern times, except the great religions (Kazin 1956). Nevertheless its dominance was waning and in 1979 it became but one of the divisions (Division 39) of the American Psychiatric Association.

Between 1960 and 1985 nearly all the factors that had contributed to the rise of psychoanalytic psychiatry were in part reversed: doubts grew about the scientific validity and effectiveness of psychoanalysis; alternatives to

the psychoanalytic psychodynamic style arose; psychoanalysis lost its identification with psychiatric reform; social conditions for psychoanalytic practice changed; partly because of a lack of demonstrable results, government and private funding for psychoanalytic training and research dwindled; some psychoanalysts retreated from the new therapeutic fields they had staked out, among them, psychosomatic medicine and the treatment of schizophrenia. (Hale 1995, 300)

By the mid-1960s, the medical model of health and psychoanalysis was being questioned on many fronts. Leading the attack were R.. D. Laing, Thomas Szasz, and Ernest Becker. Becker (1964, 3) insightfully argued that there was a revolution in psychiatry due to the invasion of philosophy and the social sciences into the realm of mental health and illness, formerly dominated by the medical view of human ills. He argues that “mental illnesses” are “broadly culturally behavioral, rather than narrowly medical, phenomenon.” Psychoanalysts failed to make plain that the world of external objects has to be “created” as well. Becker proposed a transactional system rather than a completely medical or psychoanalytic one.

Increasingly, mental health professions moved toward eclectic approaches beginning in the mid-1960s. Eclecticism emphasized “the idea that methods originating in different schools of therapy may be combined for maximal therapeutic effectiveness” (Arnkoff & Glass 1992, 671). It signaled an openness to change.

Not surprisingly, additional therapies were developed. For example, cognitive-behavioral therapy came of age in 1970s. It is based on establishing warm and supportive relationships where logic, rules of evidence, and Socratic questioning (to encourage patient to reveal, question, and correct the assumptions responsible for his/her bleak outlook and that usually takes six to twenty weekly visits). It is preferred over drug

therapy by many therapists for dealing with mild to moderate cases of depression (Hobson & Leonard 2001, 165-6).

The need to develop effective interventions grew in part out of an expanding need for mental health services. Between 1970 and 1995 Horwitz (2002) estimates that each year about 15% of the adult population of the United States sought some type of professional treatment. Correspondingly, the number of mental health professionals quadrupled during that time frame to meet this demand (see Center for Mental Health Services 1996 and 1998 cited in Horwitz 2002, 4).

Education and training in therapy also changed. In 1968 the first program that replaced the dissertation with further practical training led to a new doctor of psychology degree (PsyD) (Napoli 1981). In 1973 this program was accredited by the American Psychological Association as an alternative to the traditional doctorate (Napoli 1981). "Although the PsyD program at the University of Illinois has since been discontinued, the Illinois program carried the force of a respected faculty in a prestigious university, a rigorous curriculum, and an appearance of solidity that paved the way for other programs to follow" (Paterson 1992, 836). Dissatisfaction with professional training as conducted in traditional PhD programs continued to deepen, however, and insistence on change was expressed in many ways. At the same time, the public need for psychological services continued to grow (Paterson 1992). Medical dominance outside the hospital and the dominance of psychoanalysis as the major form of diagnosis and treatment were being challenged by psychologists and social workers especially dating from the early 1960s. Psychologists and social workers took on new mental health roles, some of which had

previously been performed by medical personnel, after the Community Mental Health Act of 1963. (Abbott 1988, 121).

Although the medical profession's hegemony is being challenged, it continues especially in some areas. Not until 1974 did the first psychologists become trained and authorized to prescribe psychoactive drugs (Street 1994). Several state psychological associations have been instrumental in bringing to their legislators the question of whether specially trained psychologists should be allowed to prescribe medicine.

The lessons from history indicate that therapy will continue to evolve. In the 1700s, structural factors led to a revolution in how therapy was done and who was doing it [as noted by Foucault (1961/1965; 1973/1994) and Street (1994)]. Ideology of The Enlightenment led to humane treatment of the 1800s (Gallagher 1980; Cushman 1992; and Street 1994) and around the turn of the 20th century to dynamic psychiatry and psychoanalysis (Ackerknecht 1955; Abbott 1988; Burnham 1988; Cockerham 1992; Cushman 1992; Marmer 1994; Street 1994; Showalter 1997; and Horwitz 2002). The rise of technology and industry for World War II culminating in the need for psychological input led to the emergence of psychology as a major factor in mental health and illness in the U.S. (Napoli 1981; Cushman 1992; Street 1994; and Hale 1995). Changes in philosophy and social sciences of the 1960s and 1970s led to behaviorism, eclecticism, ascendancy of applied psychology in mental health, and to the further decline of medical and psychoanalytic dominance (Becker 1964).

How therapy is done continues to evolve. Recent controversies over repression and regression therapy, especially those involving childhood sexual abuse may effect that evolution. Labeling some practices of therapy and some therapists as deviant poses a

challenged that therapists and their professional organizations must manage. The interviews conducted for this research are designed to shed light on how therapists are managing that challenge.

The symbolic interactionist roots of labeling theory (Akers & Sellers 2004) sensitize us to the prospect that deviance standards are negotiated. The labeling perspective shares with conflict accounts the premise that more powerful individuals and groups have more influence on those negotiations. Therapists are not powerless, so we might expect them to influence how therapy and mental health are defined by lay individuals. Therapists' own internal debates and conflicts will affect the negotiated definitions.

The methods therapists use and advocate provide an instrumental and evolving infrastructure for lay understanding of mental health. As the major resource for knowledge about the latest theories and methods regarding mental health issues, therapists have attained high status in American society. They are consulted by individuals and organizations for guidance in attaining satisfaction and productive achievement in individual daily life.

Besides direct methods such as openly publicizing emerging mental health theories and stratagems,³ therapists also provide an indirect influence. Through their

³ Section 5 of the American Medical Association "Principles of Medical Ethics" directs psychiatrists (and other doctors) to "continue to study, apply, and advance scientific knowledge (and) make relevant information available to patients, colleagues, and the public . . ." (The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 2001 edition, http://222.psych.org/apa_members/ethics_opinions53101.cfm).

The preamble of the American Psychological Association Ethics Code states that psychologists "strive to help the public in developing informed judgments and choices concerning behavior. In doing so, they perform many roles, such as researcher, educator, diagnostician, therapist, supervisor, consultant, administrator, social interventionist, and expert witness." (American Psychological Association, 2001, <http://www.apa.org/ethics/code2002.html>).

research and experiences with a number of clients or patients, therapists discover and use standards and coping methods for understanding what mental health is and how it can be attained or kept. These standards and methods are assessed by the general public according to how helpful they are perceived to be for clients or patients. When the results lead to a better life for the clients, they are copied and used by other members of society. Those who may have no personal contact with therapists are thus also influenced by these standards and methods. Mental and emotional *weltanschauungs*⁴ and methods for attaining mental health goals are shaped in accordance with these theories and these examples.

Controversies surrounding the repression of memories and regression therapy among therapists, their professional association, and outsiders (the public and law) create confusion. Deviance will be negotiated and defined within this confusion. This analysis now turns to the debate about repression and regression.

⁴ *Weltanschauung*: one's philosophy or conception of the universe and of life (Webster's Dictionary 1976).

CHAPTER 4 REGRESSION POLEMIC

The Debate

The debate over repressed memories and regression therapy techniques to recover those memories provide a point of entry for examining how deviance in therapy is constructed. The use of regression techniques to recover memories of childhood sexual abuse is especially controversial. Articles in journals from many social science disciplines have not only challenged or defended the techniques used to discover repressed memories, but have also questioned whether repression itself is a valid concept to be used in therapy (Loftus 1993; Byrd 1994; Gleaves 1994; Gold, Hughes, & Hohnecker 1994; Olio 1994; Nelson & Simpson 1994; Goldzband 1995). Some social scientists note that there is considerable evidence that what many people think are memories are in fact images of events that never took place. They are *false memories*. There is no corresponding empirical evidence that the phenomenon called “repression” has any reality at all (Holmes 1991; Ofshe & Watters 1993; and Pope & Hudson 1996). Some have criticized resultant lawsuits alleging sexual abuse based on recalled memories since no experiments have demonstrated conclusively that memories can be repressed and then reliably recovered (Lannings 1989; Holmes 1991; Ofshe 1992; Loftus & Rosenwald 1993; and Wright 1994).

My literature review disclosed conceptual differences as to which therapy practices are considered deviant and confronted questions about which therapists will be

labeled as deviant within different therapy disciplines. This dissertation uses interviews of recently certified or licensed therapists (since 1995, since responsibility to third parties was ruled in 1994) to examine the construction of deviance about therapy practices and practitioners.

Freud's Understanding of Repression

Sigmund Freud introduced the term "repression." There has been an ongoing controversy over Sigmund Freud's understanding of repression. He supplied the first seed of controversy in 1893 when he wrote on repression "It was a question of things that the patient wished to forget, and therefore intentionally repressed from his conscious thought and inhibited and suppressed" (Breuer and Freud 1893/1961, 10).

As written, this passage does not imply that repression is an unconscious mental process. However, the passage became critical in later years due to a footnote written by Anna Freud. In the footnote to the passage Anna Freud wrote that "the word 'intentionally' merely indicates the existence of a motive and carries no implication of conscious intention" (Breuer and Freud 1893/1961, 10).

Today, the distinction between conscious and unconscious removal of memory from the client's access (repression versus suppression) is of great importance. In the legal realm, tolling a tort (i.e., determining the length of time remaining before legal remedy can no longer be sought) is governed by the legal distinction between repressed memories and suppressed memories (memories which have been blocked from recall as opposed to those which the individual decides not to remember but has the ability to remember).

Present State of the Debate

Writing in favor of the concept of repression, psychoanalyst David Calof (1993), describes his child abuse clients as having dissociative symptoms such as sleepwalking and memory disturbances and signs of post-traumatic stress, such as flashbacks, sleeping disturbances and nightmares and depression or other mood disturbances. These are but a few of the many symptoms that have been attributed to consequences of repressed memories of CSA (childhood sexual abuse) (e.g., Bass & Davis 1988; Blume 1991; Fredrickson 1992; and Whitfield 1995).

On the other hand, David Holmes reviewed 60 years of attempts at proving the existence of repression. He notes:

Not only do these findings fail to provide support for the concept of repression, but they are the opposite to what would be predicted on the basis of repression. . . . Even if repression does function in the way that therapists who work with recovered memory suppose, is it possible to repress repeated, long-term abuses, some of which began in infancy and lasted well into adult years? . . . Of course, without the concept of repression, the edifice of psychoanalysis collapses. (Holmes 1991)

Post traumatic stress syndrome is often cited as a cause of repressed memories. There are a number of articles in rebuttal. For example, Skow specifies that there were thousands of Holocaust victims who remembered their stress in great detail. There are only a few very vocal orators who make the campus circuit claiming they do not remember (Skow 1994). Rape victims also do not repress everything. Ofshe noted that with combat and savage rapes there is traumatic amnesia but notes that sufferers know they have suffered the experience, but have lost the details (Ofshe 1992). Paul McHugh, director of Department of Psychiatry and Behavioral Science at Johns Hopkins

University, observed (in Wright 1994) that rather than memories being blocked out in cases of severe trauma, children remember them all too well.

A number of individuals who “discovered” repression of memory(ies) of CSA have later averred that their memories were not of actual events but were a product of therapy sessions. One survey found 22% of 630 children in cases of alleged sexual abuse later recanted (Sorensen and Snow 1991). Whatever the reasons for this change in belief, the presence of such a number of retractors provides support to the argument that, at the very least, some previously, strongly believed memories of CSA are false, including those which may be a result of deviant therapy practices (violating the ethical directive to therapists to “above all, do no harm”).

Interactive relationships, social structures, and developmental socialization are essential elements for understanding the analysis of memories—as repressed, forgotten, delayed, deferred, manufactured, or just false—as well as for understanding how these concepts are constructed by therapists. In view of the increased salience of repressed memories in discourses about therapies and the polemic over usage and validity for therapy, this dissertation is relevant as a sociological study on the construction of regression therapies, practices within therapy disciplines, and deviance within therapy practice.

Construction of a New Self

Debilitating mental symptoms that persist into adulthood have been linked to childhood sexual abuse by numerous researchers since Freud initially used the concept of repression. The role of the therapist is to assist in the processes of deconstruction and reconstruction rather than producing a template to match the therapist's own ideology and

experiences. Through the interaction of client and therapist, memories of childhood physical or emotional stress or trauma are discovered. Treatment incorporates these findings. When the memory “discovered” is one that the client may have forgotten, perhaps for many years, emergence during therapy engenders the question of the extent to which the memory was of actual occurrences or was produced or altered in the therapy process.

Contexts of Therapy-Assisted Self Construction

Correlations between a number of adult symptoms and CSA have been statistically examined by numerous social scientists. Regression theorists may suspect and actively probe for repressed memories in clients with any symptom that shows such a correlation (see Pope & Hudson 1996; Weene 1993; Pope & Hudson 1992; Rorty, Yager, & Rossoto 1994; Kinzl, Traweger, Guenther, & Biebl 1994; Wooley 1994; Bordo 1993; and Young 1993). For example, in some studies a high percentage of clients who have bulimia also report having been sexually abused when a child. When a client admits bulimia or exhibits symptoms of bulimia to a therapist, the therapist may suspect sexual abuse of the client when a child and actively pursue whether this client was also so abused. Such a therapist would suspect that the memory of that abuse may be repressed even if not reported by the client. Among these therapists, some can and do lead the client to a memory of an event that in actuality did not occur. They do this by techniques promoting suggestibility which include an air of authority because of the therapists’ presumed status as “experts.”

The most ardent supporters of repressed memory syndrome cite the same few studies of bulimia and neglect to report other studies finding no or little correlation

between CSA and bulimia. Statistical correlation of symptoms such as bulimia with CSA in such cases have been treated as causal. The therapist then participates with the client from an initially questionable perspective in determining new adaptive ideologies, attitudes, and behaviors to alleviate or eradicate the present maladaptive symptoms.

Therapists who discover memories of CSA suggest that a client's previous failure to address his or her troubles resulted from memory repression that was due to the stress or trauma of the abuse. Repressed memories may thus be seen as similar to a virus in the mind. It infects the life of the client and multiplies adverse effects throughout the life course into any of several mental or emotional symptoms of dysfunctionality. Using symptoms as indicators of CSA, these therapists rigorously probe for repression. In doing this, sometimes inapplicable group statistical data are applied to individual clients—finding that statistical support that large numbers of adults with a particular symptom were also sexually abused as children and then asserting that this means that individual clients who exhibit that symptom were also abused.

Some memories that were allegedly repressed were in fact manufactured during therapy and are false memories. Evidence of this can be found in the following ways: Some clients have later recanted the alleged repression and fixed responsibility for their earlier claim of recovered memory on their suggestibility. That the memory was indeed manufactured rather than of an actual occurrence has been discovered in some of the following ways: 1) from data provided by family members who document the impossibility of an abuse occurring in the living time and context of the alleged abuse (e.g., when the alleged perpetrator was not present during that time period or circumstances of household life precluded such an act or acts from being undiscovered);

2) from medical examinations during the targeted time; 3) through court rulings; and 4) from the demonstrable effects of certain discovery and treatment techniques and procedures that increase suggestibility of the client to the point that there is little likelihood that such a memory could be unaffected (e.g., hypnosis, drug therapies, directed imagery, etc.).

Reactions to the Repression Debate

Pivotal cases which have led to legally instigated change in therapy grew out of controversies over repressed memory of childhood sexual abuse. The type of therapy that has been central in the elicitation of memories is regression therapy and the practices which it often entails. I look at two major areas in this debate: The possibility of harm and the centrality of the controversy over regression therapy.

Possibility of harm

Situations we define as real become real in their consequences. (W. I. Thomas 1931/1966)

The pivotal axis of contention about regression therapy has to do with the question of whether a client's images of childhood sexual abuse are accurate memories or inaccurate artifacts of therapy practices. Regardless of which, the images can be real in their consequences for the client and possibly others as well, especially if he/she is encouraged to resolve the memory by confronting an alleged perpetrator. In many instances effects do not stop with the mental health of the client; consequences for alleged perpetrators are dire. They are so even if the images are merely images and not actual memories.

For many therapists the strength of the beliefs of clients is a potent tool for motivating changes in behavior, emotion, and rationality, whatever the validity of that particular belief might be. However, over-reliance on this tool has sometimes resulted in neglect of treatment based on the reality of *present* contexts. The client's *state of belief* in the actuality of past events can result in harmful consequences for themselves and others. Therapists may violate the therapeutic ethical principle of doing no harm by reinforcing and directing treatment toward an occurrence that did not happen, at least not outside of the client's own misconception.

Centrality of the repression polemic

The dissertation explores orientations to therapy practice in three therapy disciplines to learn how the disciplines deal with repressed memories—a concept that is itself controversial.¹ The concept of “repression” as used in this research involves the following characteristics: 1) a/some traumatic or negative event/s occurred to the person in childhood, 2) memory of that/those event/s is blocked from recovery by normal memory processes, 3) the memory affects the person's present behavior, and 4) the way to cure or ease the effects of the memory is to make the event conscious and to confront it in the present.

Some major symptoms of distress or mental illness from these unresolved memories are called “dissociative disorders.” Dissociative disorders are defined as a class of disorders in which people lose contact with portions of their consciousness or memory, resulting in disruptions of their sense of identity.

¹ Sigmund Freud introduced the concept of repression of memories. His changing conception of it and the debate that followed is detailed in Chapter 3.

For over 80 years therapists of different theoretical paradigms have argued about the concept of repression and methods of elicitation. The recent expansion of the controversy is manifested by the spiraling increase in the number of articles covering regression therapy and childhood sexual abuse (CSA) that can be found in professional journals which are dedicated to therapy disciplines. Professional ethics have been reexamined in reaction to this academic outpouring.

The legal profession has also reacted to this controversy over regression therapy and child abuse. In the last few decades there has been a large increase in legal cases involving the terms “child abuse” and “repression of memory.” Those legal issues were reviewed in the previous chapter.

Consequences for Therapists and Clients

The question of whether repressed memories actually exist haunts regression therapy. Finding that memories used for therapy were false memories, which were recovered or manufactured during therapy, would open the therapist to charges of deviant practice and would construct the new self of the client around a falsehood, a weak base at best.

A theoretical argument could be advanced that partially accounts for the recovery of false memories during therapy. The repressed memory of CSA (no recollection) as opposed to one that has been suppressed (recollection that is put aside) is functional for both the therapist and the client. First, potential gains for the therapist are examined, and then gains for the client.

Finding repressed memories increases the control of the therapist. The client may have come to therapy seeking advice or instruction on life techniques that they he or she

is not using, is using inefficiently, or is unaware of (i.e., methods for self-efficacy). By focusing on a “repressed” memory, the locus of power shifts to the therapist. The client becomes dependent on the therapist who revealed this hidden property—the memory which is beyond the scope of self-efficacy—as the root, base, and infrastructure on which all their problems and inadequacies can be rationalized and confronted.

Psychotherapists, particularly psychoanalysts, are taught to encourage uninterrupted narratives, removing themselves to the background, (Holstein & Gubrium, 2000). Even in encouraging these uninterrupted narratives, common therapy elicitation techniques (e.g., silences and turn passing) can reinforce dependence and act to disallow the client’s own perception. If the therapist is passing his/her turn with a silence, the client may come to feel that he/she has not seen or conveyed all that is necessary the topic and may be drawn to confabulate, or search for links that do not convey what he/she had been trying to convey, until the therapist takes his/her turn. Dependence on the therapist’s reconstruction of accepted conversational tactics comes to dominate. The client is likely impelled to trust that there is more to be discovered.

Whatever the therapist's intentions in using these methods, the therapist becomes essential and preeminent in the quest for change. This perpetuates dependence on the therapist. It is therefore in the self-interest of the therapist to find repression. Regression therapy not only keeps discovery of self focused on a particular problem—it also serves to keep the client dependent and in therapy for many sessions.

Therapy may necessitate a protracted period for the therapist to assimilate information and assist the client in organizing thoughts and emotions. The therapist's personal approach to therapy influences the content of sessions through choices of which

narratives to encourage. Only through a number of sessions does the client become aware of the proclivities and understandings of his/her therapist and assimilate them in a joint construction of the client-self. Multiple sessions are thus required.

However, if the memory has been suppressed by the client, this process is less efficient for the therapist. The client retains a greater degree of control and self-actualization. Since the memory has been available for the client to recall when the situation feels right, safe, and/or comfortable, the therapist performs a different role—an adjunct role. In this situation the therapist is a resource for the client's decisions about where his/her life should go rather than a component that is absolutely necessary for personal improvement. The therapist can provide the nonthreatening, comfortable atmosphere that the client requires to decide that it is time to confront the suppressed memories; however the therapist is not the *source* of a recovery of the memory to conscious deliberation.

While finding repression increases client dependence on the therapist, the client gains in two ways. The first gain for the client is that the repressed memory provides a convenient scapegoat for anything not going right in life. If the memory has been unretrievable, persons and processes other than the individual can be held to blame. Any possible lack of self-accountability may thus be rationalized. A new starting point thus emerges that excuses the client from responsibility for previous failed interactions and perceived failures of his or her own self construction processes. This excuses interaction failures and emotional and mental failures dating from the time that the memory first became inaccessible (when the incident/s occurred).

The more mundane gain is found in the legal requirement for tolling the statute of limitations² for discovery of CSA. When the client has suppressed the memory and is only bringing it out when in a “safe” atmosphere for recall and for confrontation, the alleged perpetrator can be held legally accountable, in most state tort courts, for three years after the client reaches majority (tolled after the client reaches majority, not from the time of the incident (Hagen 1991). However, if the memory has been repressed, the accountability is not tolled until the client “discovers” the memory or can reasonably be expected to have discovered it, whatever his/her age at that time (Hagen 1991, and Williams 1996).

Labeling and Imputing Victimization

On the basis of a literature review, this section of the dissertation reveals problematic aspects of constructions of selves generated during the debate on CSA and repressed memories. Experiencing sexual abuse has been deemed a severe psychic trauma (Olio & Cornell 1993). Regression therapists and researchers report that sexual abuse causes an emotional shock to the child's psyche, effacing sexual mores and causing severe suffering (Ashton 1995; Blume 1991; Breire 1990; Herman 1992; Kihlstrom 1996; & Terr 1994).

² *Black's Law Dictionary* defines tolling the statute as a law that interrupts the running of a statute of limitations in certain situations, as when the defendant cannot be served with process in the forum jurisdiction. The statute of limitations is defined as “A statute establishing a time limit for suing in a civil case, based on the date when the claim accrued (as when the injury occurred or was discovered). The purpose of such a statute is to require diligent prosecution of known claims, thereby providing finality and predictability in legal affairs and ensuring that claims will be resolved while evidence is reasonably available and fresh” (Garner 1999).

According to the theory behind regression therapy, this shock in turn creates a mental incapacity for coping with the event(s) of the abuse and causes the consequent repression of the memory(ies). The abuse is deemed a necessary and sufficient cause of the repression. Lenore Terr, a psychiatrist, writes that repressed memories of sexual abuse and other traumatic memories insinuate themselves into the biological and psychological life of a person and the memories themselves come to have lives and transformations of their own (Terr 1994).

Adding to the argument over the effect of (a) trauma(s) experienced when a child is the argument over whether the client should be considered a victim. The importance of this argument revolves on the labeling process.

Calling someone a victim encourages others to see how the labeled person has been harmed by forces beyond his or her control, simultaneously establishing the 'fact' of injury and locating responsibility for the damage outside the 'victim.' The discourse of 'victimization' is thus practically situated social action that promotes practical definitions of everyday circumstances. (Holstein & Miller 1990, 106)

Thus, authors of self-help books and some regression therapists have sometimes become labelers. In regression therapy the labels, "victim" and "victimizer," locate the "fact" of the harm and the resultant mental or emotional problems which may occur as beyond the client's control. Asserting victimhood of the client shifts responsibility for present problems from the client and to the alleged perpetrator who may have caused the repression and resultant mental problems.

Proponents of therapy techniques which do not include regression therapy may be seen by those who do as neglecting the primary (or original) cause of present problems. Those other therapists, thus, may be charged by regression therapists of having blamed

the victim (the client) for problems that were in fact caused by others. A negative consequence of the “victim” label is that victims are often blamed for their own victimization (Ryan 1976). What is missed by such an analysis is that many of the other therapists do not label the client as a victim at all, but as someone who should be instructed and encouraged to take care of their present problems—to develop self-efficacy and ability to fend off adversity.

Labeling a client as a victim of repressed memory(ies) strengthens client dependence on the regression therapist. The use of the label “survivors” for those who aver victimization from CSA becomes a linguistic device. This term is more capable of activating emotionally charged views of the client and the accused perpetrator than would be the case with more neutral labels. Use of the “survivor” label implies that the CSA took place, for how could the client be a survivor if no act had taken place. In most cases, for various reasons, the regression therapist does not seek to verify an actual act. Other possible labels for the person averring repressed memories of CSA (i.e., the “accuser,” “powerless,” “memory impaired”) are more direct in contextual description. For example, a client could be described as an *accuser* who may have been abused when a child and rendered *powerless* (at least until accusations are made), or he/she could be an accuser with a malfunctioning memory. These other terms are sometimes referred to in the literature on regression, but “survivor” is almost invariably the label chosen by those authors who assert the validity of repressed memories of CSA.

Organizations and their agents make it their business to describe our lives and experiences so that they can address, assess, and ameliorate the challenges of daily living. In the process, they become sources of experiential definition--purveyors of identity, so to speak. (Holstein & Gubrium, 2000, 154)

During regression therapy, the life of the client becomes defined within a master identity consisting of a particular “self from therapy”—a master status as *CSA survivor*. In some cases this status becomes so compelling that the client becomes fixated in daily life to the exclusion of other aspects of self. This master status may mitigate and interfere with the formation of a more versatile self that responds to situated contexts and the multiple organizational local cultures, which the client encounters in the flow of daily living. Diversity of response possibilities may be circumscribed.

In this dissertation, distinctions held in different therapy disciplines on these constructions of therapeutic labels of deviance are provided through analysis of interviews with therapists. This qualitative analysis focuses in part on their takes on the constructions of repression of memory, the importance of regression as a therapy tool, and the discovery of repressed memories.

CHAPTER 5 METHODS

The research methodology is qualitative and informed by the work of Holstein and Gubrium (1995). It uses “open interviews” and centers on active techniques rather than highly structured questions. The active interview is “loosely directed” (29). It consists of both subjective and objective elements. The objective element deals with *what* is being volunteered and discussed. It is subjective because it affects *how* responses are interpreted: “The focus and emerging data of the research project provide orientation and framing resources for developing both the subject and his or her responses” (14-15).

The standpoint from which information is offered is continually developed in relation to ongoing interview interaction. ... The subject becomes a narrative resource for both the interviewer and the respondent, a guidepost for how to ask and answer further questions. ... Challenged by the interviewer, pointed in promising directions, and at least partially aware of the interpretive terrain at hand, the respondent becomes a kind of researcher in his or her own right, consulting repertoires of experience and orientations, linking fragments into patterns, and offering ‘theoretically’ coherent descriptions, accounts, and explanations. (Holstein and Gubrium 1995, 29)

The “open interview” can be “constrained by the interviewer’s topical agenda, objectives and queries” (29). Active interviewers “may suggest orientations to, and linkages between diverse aspects of respondents’ experience, adumbrating—even inviting—interpretations that make use of particular resources, connections, and outlooks. Interviewers may explore incompletely articulated aspects of experience, encouraging respondents to develop topics in ways relevant to their own experience ” (Holstein and Gubrium 1995, 17).

One less reactive way to suggest topics is through the use of concept cards.

Concept cards serve as the resources, connections, and outlooks which set loose parameters for discovering orientations. Interviewees can review concept cards and pick those that are within their frames of reference as a means to initiate the “open interviews.” The interviewer operates within this contextual framework to help draw out information. Since an interview is unavoidably collaborative, the interviewer attempts to keep his/her collaborative input to a minimum by advancing queries on the concepts only through neutral probes unless asked a direct question. Interviewees may take the concepts in the directions they choose. The interviewer’s input into that process is limited to probing for the interviewees’ meanings. “Questions, prompts, comments, and clarifications point respondents to particular topics, inviting distinctive narrative treatments” (Holstein and Gubrium 1995, 28).

Open, active interviews are especially useful for conducting narrative analyses.

“The challenge is to identify similarities across the moments [narratives] into an aggregate, a summation” (Riessman 1993, 13). “The stop-and-start style of oral stories of personal experience gets pasted together into something different” (14). “In the end, the analyst creates a metastory about what happened by telling what the interview narratives signify, editing and reshaping what was told, and turning it into a hybrid story . . .” (13).

In my study, that story is the tale of the respondent’s place as a therapist (attitudinally as well as rationally) within the context of therapy practices and in professional circles grappling with the definition of deviance. That context includes legal and societal constraints on the negotiation involved to determine which practices are deviant and how the line between “good” and “bad” therapy is drawn.

This qualitative approach has implications for how to select interviewees, how to conduct interviews, how to analyze information, how to use that information to select additional interviewees, which topics to pursue, and how to interpret the data once it has been gathered. “Investigators must continually modify initial hypotheses about speakers’ beliefs and goals (global coherence) and recurrent themes that unify the text (thematic coherence)” (Riessman 1993, 67). The approach has implications for assessing its utility:

We can provide information that will make it possible for others to determine the trustworthiness of our work by a) describing how the interpretations were produced, b) making visible what we did, c) specifying how we accomplished successive transformations, and d) making primary data available to other researchers ... Narrative analysis allows for systematic study of personal experience and meaning: how events have been constructed by active subjects. (Riessman 1993, 70)

Subjects/Interviewees/Respondents

A strategic sampling approach was used in which the size of the sample and the kinds of information sought were guided by findings from prior interviews. The original design called for interviews with recently licensed and/or certified therapists from the three basic occupational/therapeutic disciplines—psychiatry, psychology, and social work. The reason for the interviews was to explore how therapists constructed deviance.

Approaches to therapy varied greatly within disciplines, indicating that during training the therapists were exposed to a variety of techniques. Disciplinary background did not emerge as being related to orientations to perceived deviance or about repression of memories or the viability of regression therapy. For a study of how deviance was constructed, there was little benefit in locating a set number of subjects from each of the three disciplines. The sampling goal became one of identifying a diverse group of therapists rather than a set number of therapists from different disciplines.

Potential respondents were located through public records of the Department of Health and state licensing boards, internet directories (e.g., National Institute of Health at <http://www.nlm.nih.gov/medlineplus/directories.html> and Medicare at <http://www1.medicare.gov/Physician/Search/PhysicianSearch.asp?>), and library files on commencement exercises by school and discipline. Alumni associations indicated that they would contact individual graduates to ask if they would participate, but would not provide a list. Departments contacted did not provide lists of contact information for graduates. Since I was concerned about the confidentiality of interviewees, I did not use any resource that would connect a particular potential interviewee with my study.

All respondents interviewed were adults. A demographics form contained the question of whether or not the subject was 21 years of age or older. Chronological age of the respondents was not of paramount importance. The time period within the education process—at the end of formal training and while engaging in a career in counseling—was the factor of importance rather than chronological age.

Respondents were not selected on the grounds of gender, race, or ethnicity. While some differences in respondents have been found within the literature on methods and interactional responses, my study was not directly concerned with *who* was being interviewed, other than that they were therapists. Using the data gained from this research, future research on this topic might include a quantitative research agenda to determine the scope of contribution of these and/or other demographic elements to therapy practice and the construction of deviance.

Ten therapists were interviewed. The number was determined during the interviews based on how often the therapists provided similar information. This is called

saturation. Four had backgrounds in social work; four were psychologists (one of whom had a background in educational counseling), and two were psychiatrists. They were practicing in two southern states. The nature of their practices varied. Most were in private practice but some were working within other medical organizations. Other descriptive features will be discussed when presenting the results.

Interviewing

Gaining Access

The potential respondents were first contacted with the letter reproduced in Appendix A. Pages included with the letter were the informed consent document (Appendix B) and an optional questionnaire to attain basic demographic data about individual participants (Appendix C). Those contacts were followed with a phone call. That introductory phone call followed four or five days after the letter was sent. An example of the format of the calls is found in Appendix D.

In some ways the biggest challenge to this research stemmed from difficulties in securing access and cooperation from potential interviewees. The challenge manifested itself in several ways. Obtaining information on which potential interviewees could be contacted (and how) was a difficult task, especially in regard to psychiatrists. It was difficult to discern when some therapists received training and when they were certified or licensed from many of the records which were consulted. One mental health counselor did not believe that she fit the parameters because the letter of introduction referred to her as a Doctor (she was not). She was so reluctant after that point that she was excluded. A licensed clinical social worker stated that she did not know when she could take an hour for the interview since she was working two jobs—at a hospital and her own private

practice—and also had two children. The psychologist whom I had thought would have more knowledge on the areas of my research interest, due to her dissertation topic, said she was too busy in her personal and work life to be interviewed even for just an hour.

Many of the recently trained therapists had relocated to distant sites. Their letters were returned and they could not be contacted by phone or email. Many other prospective interviewees would not return calls (even though an initial contact letter had been sent to provide notice). With psychiatrists, I found that the receptionists and nurses performed a “gatekeeping” function which disallowed contacting the psychiatrists directly or by phone. When I personally handed a sealed letter containing the contact information with the psychiatrist’s name and asked that it be given to him, the nurse tore it open in front of me and began reading it. With many psychiatrists, letters and phone calls were not returned, even when I had been assured that the psychiatrist had received my letter or notification of my phone call. I did not have this problem with the other disciplines.

Sociologically Interviewing the Interviewers of Clients

One question that had to be addressed was, “How do you get therapists to open up to a sociologist?” Their professional function is to get *others* to open up to *them*. I represented a different paradigm and discipline. Many therapists would be more at home performing the role of interviewer than interviewee, and they were well-versed in the art of interviewing and would recognize the techniques that are used to elicit information.

Therapists likely have some knowledge of the sociology as a discipline from their out-of-discipline undergraduate courses. They do not consider deviance in the same way as do sociologists. The interviews used communications tactics that would ensure a common understanding of meaning. For example, use of the word “deviant” was

avoided. In sociology, “deviant” is understood to be a word that has a neutral meaning and does not connote negative aspects.

Therapists are more often focused on dealing with deviant behavior and individual thought processes and emotions than on grappling with larger social and legal definitions of deviance. Their introductory sociological knowledge does not ensure that they will appreciate this line of research. The experiences of the interviewees rests on a person-to-person approach. This perspective brackets understanding within an individual contact level which may have blunted realization of how a sociological approach provides an opportunity for therapists to see themselves in relation to their work and to mental health more generally.

One challenge was to entice the therapists to step out of their chosen role—a doer of therapy—into persons who could relate all the knowledge they had accumulated on therapy and doing therapy. The goal was to elicit their narratives without manipulation.

Casual conversations with therapists and others raised the prospect that the interviews would explore topics that were extremely sensitive for some. Some responses may be emotional or be colored by emotional feelings. Techniques could be used to reduce that kind of reaction, but the analysis would have to incorporate the prospect. For example, probes would have to be worded carefully to avoid emotional responses and to maintain rapport.

Features of the Interviews

Open interviews were conducted. All interviews were confidential. The participants were told that they could skip areas of discussion or terminate the interview at any time—information that also appeared on the informed consent for which they

signed and were given a signed exact copy. The interviews were tape recorded and lasted at least 60 minutes. No interviewee decided to terminate the interview within that span and several extended comments for several minutes thereafter. After the tape recordings were transcribed, they were erased. In the transcription phase, any information that *might* compromise the confidentiality of the participant was excluded. The transcripts were recorded with pseudonyms rather than actual names. All records and data are kept confidential and are controlled and protected by the investigator.

Concept cards were used to introduce topics and to allow interviewees to select priorities. My review of social science journals had provided me with relevant concepts that therapists cover when discussing the present state of American therapy, especially some that related to repression and regression. The topics on those cards consisted of “Accountability, Backlash, Discovery, Epidemiology and Abuse, Labeling, Law and Therapy, Mandated Reporting, Memory and Therapy, *Primum Non Nocere* (Above All Do No Harm), Professional Dominance and Hegemony, Repression, Retractors, Suggestibility, Survival groups, Survivors, Treatment practice, Symptoms, Syndromes, Tolling the Statute of Limitations, Treatment Practices, and Victimhood.” The concepts were typed on 1 3/4" x 3" cards and laminated. Before giving the cards to the interviewee, the deck was shuffled several times to show that they were in no particular order. The interviewee was then told to select the five cards he or she would like to discuss. By the end of the interview most or all of these concepts did get discussed. When prompts were used, they were neutral and allowed the interviewee as much latitude for direction of interpretation as possible. Some of those prompts are found in Appendix E.

Analyzing Interviews

Methods for Analyzing Data

Narrative analysis was the primary tool for analyzing the interviews. It was supplemented by qualitative content analysis. Discourse or conversational analysis was used after several interviews to assess whether the interviews were capturing the information needed to analyze the construction of deviance.

Narrative analysis is used for interpreting data. Narratives are described by Gubrium and Holstein (1997) as “accounts that offer some scheme, either implicitly or explicitly for organizing and understanding the relation of objects and events described.” Riessman (1993) noted, “Narrative analysis—and there is no *one* method here—has to do with ‘how protagonists interpret things’ (Bruner 1990, 51), and we can go about systematically interpreting their interpretations.” I systematically interpreted the narratives my subjects related in their interviews by looking for elements in common with the topics found in my literature review to be of importance for an understanding of the labeling of some therapists and therapy practices as deviant. I also explored narratives related to where the line was drawn between acceptable and unacceptable practices or actions that were the basis for those labels. My rendering of the results centers on four recurring narratives: orientations to therapy; memory, suppression, and repression; accountability and ethics; legal issues and therapy.

Qualitative content analysis sometimes draws inferences on both the appearance or nonappearance of attributes in messages. I used qualitative content analysis on the data to help define the similarities and differences found on the narratives. Discourse or conversational analysis focuses on *how* the interview proceeded that produced the

conversation or discourse. It attends to issues like pauses, repetitions, volume, speed, body language, etc. This kind of analysis provides context for interpreting the narratives. It can also be used to check to see whether the interview interaction permits the subjects' discourse to be voiced without it being constrained by the interviewer. To make sure the interviews were yielding the kinds of stories from the respondents which could be used for narrative analysis, the conversations from the first two interviews were analyzed. I found that the interviews were accessing the kind of data that I needed to perform narrative analysis about the construction and response to deviance (see Appendix F).

Am I Getting Conversations and Narratives That I Can Use?

I transcribed the data from the first two interviews to appraise whether the interviews were collecting relevant data for the research focus. Before the data were collected, I had presumed that I would start by looking at the responses on the concepts, one at a time, and compare them by disciplinary backgrounds of the interviewees (i.e., social workers versus psychologists versus psychiatrists). When viewing the actual data, I realized that the concepts would have to be compared across therapists—a therapist by therapist analysis—because each of these therapists related his/her experiences from a unique perspective that prevailed through most of the interview. How the interviewee responded indicated how he/she shaped the content of his/her answers about the concepts. Each therapist in this set of interviews projected importance to certain topics to a discernable degree, indicating that he/she was intent that I understand the nuances of his/her point of view. That these varied from interviewee to interviewee is one of the reasons for pursuing a qualitative approach.

The first interviewee provided a language couched in terms of moral exactitude. The second responded with very minimal prompts in a language of competent precision. It was clear to me that each of the interviews was a unique presentation and that an examination of the concepts must include how they were told as well as what was told (i.e., narrative analysis should sometimes be supplemented with conversational analysis). Appendix F contains an example of conversational analysis drawn from my data.

The discourse analysis of the first cases also confirmed the utility of the concept cards. The first interviewees selected three of the same concept cards: Accountability and Ethics, Symptoms, and Treatment Practices. I had not asked them to put the concepts in order of preference and was informed that they had not. I did not refer to the cards unless our discourse on a topic came to an end without the topic having surfaced in the course of the interview. This procedure allowed the conversation to flow from the initial question on therapy into lines directed by each interviewee's interests. I first compared their discussion of these concepts and then contrasted them in terms of therapy in general and then as they related to the use of regression and repression.

My greatest surprise in these first interviews was that none of them recognized the *Ramona case until after I explained the Ramona case to them* (to see if they were aware of this lawsuit, but not by name). They hemmed and paused and passed speaking terms in the conversation. They were also unfamiliar with other rulings regarding third-party law suits. I learned that I had to approach these topics differently. Although the therapists were not directly aware of the lawsuits, either through their training or their objectives, they had developed stratagems that would safeguard them from that threat. These became the point of entry for eliciting their narratives about legal issues and therapy.

CHAPTER 6 ORIENTATIONS TO THERAPY AND DEVIANCE

The therapists orient to therapy in various ways. This chapter discusses orientation to therapy in terms of the meaning of therapy for the interviewees, and what they think about deviance in therapy. The therapists' descriptions of their own practices and their thoughts about therapy in general are revealed and discussed. To help order the presentation, the interview data are grouped by the type of occupational credentials.

Therapy treatment practices that are labeled "good" or "bad" were determined by the labels that the interviewees themselves related.³³ Deviance is also determined from an examination of the contrasts in their labels of good or bad practices and therapists. Additionally, I examined the treatment practices of my subjects to help delineate methods that they have found to be normative for their discipline.

The subject of treatment practices would come up from the interviewee directly or in response to a question on what they thought about them. I used the opportunity to question about suggestibility in general and about practices that have often been linked to suggestibility (e.g., hypnosis, drug therapy, guided imagery, and survivor groups).

³ In probing for deviance versus normative practice I had refrained from using the word "deviance" and had used terms like "inappropriate," "non-normative," and "questionable practices." After introducing the concept in these terms, I would use the words "bad" or "good" while making quote marks with my hands and stressing the words so that it was clear that I was using these words as a label of convenience to encompass this concept. None of the therapists interviewed appeared to have a problem with this device for saving time and one even affirmed: "We're going to label it good. . . . Yeah." For fluidity in reading the rest of the text, the quotes symbolizing the stresses made in the interviews are removed.

Interviews with Licensed Clinical Social Workers

Each of the licensed clinical social workers (LCSWs) was able to provide a personal definition of therapy after thinking for a few seconds before announcing his or hers. This is notable in that each of the LCSWs used an interjection (i.e., “hmm,” “uhm,” “I guess . . . ,” or “uhh”) to provide extra seconds for thought before answering.

Although they did therapy every day, these therapists expressed surprise that it had been such a long time since he or she had thought about some of the basic components of the institution of mental health (i.e., what therapy means, what are their feelings on some of the concepts advanced in my questioning et al.).

With the exception of the interview of LCSW Amy, there were usually fairly defined opinions and attitudes toward these topics. Amy’s interview revealed a different aspect of treatment practice. Amy came from the most medical vantage point. Her duties in the teaching hospital where she worked were split between assisting doctors charged with treating physical ailments and resident psychiatrists who were embarking on therapy careers. Her input ranged from making sure that patients had rides home after their hospital stay to alerting the psychiatrists when she detected problems which related to the process of mental health. She dealt with patients before they were admitted to the hospital, through their stay in the hospital, and to adjustment difficulties encountered subsequent to their stay.

In talking about making rounds with medical professionals (i.e., doctors—including psychiatrists, psychologists, and nurses), Amy related numerous instances in which she appeared to have the goals of a prototypical social worker as outlined in the social workers (Working Statement 1981, 6):

1. Help people enlarge their competence and increase their problem-solving ability.
2. Help people obtain resources.
3. Make organizations responsive to people.
4. Facilitate interaction between individuals and others in their environment.
5. Influence interactions between organizations and institutions.
6. Influence social and environmental policy.

She described therapy succinctly and with some finality in terms of healing:

Mike Okay, you work with several different doctors. We'll get to ask some questions about that. It'll be interesting—the psychiatrists in particular. But, let me ask some kind of general questions. What is therapy for *you*? What does therapy mean?

Amy: Hmm. To my mind, therapy is a process by which we heal old hurts that are interfering with our present day life.

Mike: Mental and emotional?

Amy: Probably both.

As “a patient resource manager in a teaching hospital,” Amy says her function and duties are involved in “looking for discharge planning needs, for how we can deliver more efficient service while the patient's in the hospital.” Some of the ways she does this are quite mundane (e.g., making sure the patient has somebody to pick them up on discharge). Some are much more complex and involved interventions [e.g., dealing with more involved services (e.g., HMOs, insurance companies, nursing homes, referrals to outside social workers when needed etc.)]. Others deal with complex issues involving relationships (e.g., family, friends, associates, and employers). From her vantage point,

“the client dictates the course of therapy and if something else is being uh projected onto them, that would be in my opinion bad, practice.”

There was a long pause after I asked Amy “What are good therapy practices.” So I switched my tack and asked her what good *therapy* would be. Her response was in terms of effects on the patient rather than on what a good therapist *does* (i.e., techniques). I guided her to therapy practices by directly asking what a therapist *should not do* as I turned to the bad therapist section of the interview. She again turned the answer to coming from the client (she later would refer to them as patients) and made good distinctions based on basically passive actions by the therapist to finding out where the client is and bad practices as failing to work from the client dictates. Ironically, passivity of the therapist is seen as “good,” contrasted with the peril of bad actions when actually doing something with the patient.

Amy: We’re going to label it “good,” yeah. Umm that would be where someone is able to function either . . . either more effectively or happily in their present day, because, they’ve been able to resolve, issues from the past that have been blocking them.

Mike: Okay. So mostly it’s taking care of problems and symptoms that a person has now? Okay. What is bad counseling, or bad therapy? What are practices that shouldn’t be done. What shouldn’t a person who is a counselor or therapist do?

Amy: Always begin where the client is. Not where the client isn’t. Either uh that would be forcing solution or interventions that 1) the client doesn’t need, or the client doesn’t want, or the timing is not proper for the client.

Mike: So, in other words, you’re kinda telling me that a good practice would be to listen very carefully to the . . .

Amy: client.

Mike: client?

Amy: Yes. The client dictates the course of therapy and if something, else is being uh projected onto them, that would be in my opinion bad, practice.

Mike: Okay, what's, totally unacceptable? What's the line? The person that's gone over the line?

Amy: You mean at it's very worst?

Mike: In counseling and therapy, what would you say?

Amy: Where is the

Mike: "You can't do that(?)," or "You shouldn't do that(?)." Well . . .
"You *can't* do that.

Amy: Well, either telling the client what his problem is before he's been able to figure that out for himself—if it's even true.

Mike: Um hmm

Amy: Or imposing an intervention that's immoral or unethical or, not something that the client is willing to really go along with.

Mike: What would one of those interventions be?

Amy: Umm. . perhaps suggesting sex therapy for um a problem which the therapist is like directly involved. I mean, that is the high end. Immoral and unethical.

Mike: So basically sex with the client or

Amy: Right . . . for his own good.

The use of pauses, turn passing, and insistence on extreme clarity in the questions illustrate Amy's discomfort with the area of good and bad practices. When I asked directly what the line between good and bad practice would be, she answered first by reasserting her insistence that *not directing* the client is being good (even when it proves to be in the right direction) and then by defining bad as forcing interventions on the client,

immoral or unethical interventions, and at last she gave having sex with the client as one of the bad therapy practices (interventions)

The LCSW, Will, spoke of therapy as a process that gets one past obstacles from the past which are impacting the client and preventing him/her from becoming fully alive.

Mike: Usually the first thing that I ask is kind of general: “What is therapy?” and “What do *you* consider therapy to be?”

Will: Uhh. Therapy is a process by which people, examine uh past events in their lives that may be impacting their lives now. Their ability to function, their behaviors uh their thought processes and their moods, uh their emotional world and uh to where they can get some clarity, move past some things, move past these obstacles and be more fully alive.

Will was the most independent of the LCSWs. His practice often involved third-party referrals and one of his groups included a clinical psychologists. For the most part, Will was an “independent contractor” and provided counseling and therapy in a very similar manner to that revealed by my clinical psychologist interviewees.

When asked about substandard treatment practices, Will keyed on suggestibility. He stated that he does not do hypnosis or dream therapy but had done some guided imagery (one of the techniques that risks increasing client suggestibility) but preferred to do conversation therapy to change cognitive makeup.

Will: The suggestibility, how you lead the questioning. I mean that’s a big thing in child, child abuse cases as well, you know. Who’s doing the interviewing. That’s why they have to tape everything now, because that the questions are leading. If you’re talking about, you know, all this hypnotherapy, and again, what are you dealing with to start off with, you know, what is the (?)itic? If you’ve got a therapist, a psychi>: you know, even a psychiatrist in this. . . . Who is> has a certain framework, is looking for certain things. uh it’s, you know, you can, you can go find anything. And if you run up against, you know . . . ? Some types of personality disorders are there everywhere.

Will also expressed concern about the mental health of some of the people who were being graduated from social work universities.

Will: I mean, I looked around my class at [university] and I said ‘50% of these people oughtn’t to be practicing social work.’ Five years. . . . And I don’t know if that’s true or not. but there were some people in there who, uh had to be weeded out. Very needy type of people. I’ve seen it happen at [different university] where they they’ve had to> where on their internships, people would stand up and say, this person is not appropriate to do this work.

Mike: Umhm.

Will: You know. Straight “A” student and everything, but she’s, she’s crazy as a loon.

Will at first brushed aside the question of the line between good and bad practice as being subjective before I assured him that I understood the subjectivity of the question, but that was what I wanted—*his* subjective thoughts on the topic. He then spoke of failure to achieve positive results, therapists with agendas other than the mental health of the client, and confidentiality before returning to not releasing the patient when the therapy is not working.

Mike: I want to ask one question. What is the line between good practice and bad practice? Who are they. How do we determine, bad therapists and good therapists? Should something be done about the bad ones.

Will: You know even that is a subjective thing. You know it’s not like a litmus test.

Mike: I know it’s subjective, and you’re the one.

Will: Huh?

Mike: I know it’s subjective and I’m asking you.

Will: Uh, . uh, yeah, yeah. I would think that if (snort laugh) their patients get sicker (laughs).

Mike: If their patients get sicker, if they do harm—*primum non nocere*?

Will: They . . . yeah. In uh man uh .

Mike: What's a bad therapist? Have you met any bad therapists?

Will: Oh yeah. They're people whose uh, Their agendas are more important than their patients or that it's it's uh, confidentiality >

Mike: We didn't get to talk about confidentiality.

Will: > and that stuff. Uh. Well I'm more interested in the clinical kind of things than the . . . you know. I think that the confidentiality thing, it's it's very important of course. But it's like. . . . Now it's bally to the hip of things. It's ballyhooed way beyond uh . . . you know, I mean it's it's it's it's. . . . That's somehow, that's gotten to be a poke. It's like things in hospitals. A lot of the paper work, regs, and the things that you have to do, are all designed by people who don't do that work. [Will then talked about administration and unnecessary regulations before getting back to bad therapists] . . . Yeah. Cause a lot of people. I mean, you get people in here come into therapy, and there's *not* going to be improvement. You know? I mean, and you see that all the time too.

Mike: And so, you would want to get rid of them or just keep them?

Will: Yeah, just yeah, "Well this is not working."

The two other LCSWs, Betty and Larry, both related the object of therapy to be freedom from something that the client is *stuck in* rather than *healed from* or *got through* an obstacle. For them, the therapist helps to move the client out of the place where he/she is stuck.

The focus of Betty's responses did not appear to come from a particular American perspective. This LCSW included an intercultural standpoint in understanding and treatment of clients. She talked of therapy as an experience of growth that client and therapist are both going through. She spoke of the therapist in the third person as if the therapy is "out there someplace" to be discovered through the interaction of the therapist

and the client. This Oriental concept of “releasing” the self into mental health involved an interaction of two selves—that of the therapist as well as of the client.

Mike: What do you think therapy is? What’s it mean to *you*?

Betty: I guess. . . . Therapy for me personally or for my clients or both?

Mike: What does it mean to *you*.

Betty: Therapy is . . . its just an opportunity where two or more people get together and umm and growth is going to happen somebody is going to learn insightful things about themselves. You know, stuff about themselves and umm is going to learn about things, how it relates to them and how it makes them feel and how it makes them be and behave in the world and what changes they want to make and therapy helps them bring those leeriness to the forefront to help them grow . . . from whatever awareness they are learning. So that to me is what therapy is.

Mike: And so a therapist would be . . . ?

Betty: Like a change agent

Mike: A change agent?

Betty: Yeah somebody who just helps someone move forward out of whatever’s happening with them and move out of that because they’re stuck or

Betty jumped right from my question of what a good therapist would be to therapist skills (communications and listening) and therapist morality and ethics (honest and open). When I asked what a bad therapist would be, she answered, “a therapist who, for their *own* growth and development uses the patient for that.” After reassuring her of confidentiality (that I would make sure that her identity as interviewee would be known by no one but me), I asked her if she had know such a therapist. She related the following, which amplified her position on bad therapists:

Betty: Okay, well not anyone locally but when I lived in [state] there was one person who um dated their patient and the patient had money and influence and all other kinds of other things. And I think it was just purely for their own getting out there and meeting people that they could also treat and whatever and um but, so I would say a bad therapist is someone who dates their patients or who sleeps with their patients or who um who talks about their patients, breaks confidentiality um without anybody, you know, other than a mentor or something. You know?

Mike: Right

Betty: But there sometimes needs to be some help with a consultant or whatever. So a bad therapist would be one who doesn't take care of themselves and who um and who is not in good form for their patients, who is not healthy and whose not modeling behavior that is, that is . . .

Mike: What do you mean by healthy?

Betty: Umm Somebody who's not drunk at night and hung over in the morning and can barely focus on the patient the next day. Someone who doesn't exercise and sleep well so they're groggy and sleepy and not thinking very well. um, You know? Someone who just in general doesn't take good care of themselves um and so they can't be fully present to their patient

The LCSW, Larry, stressed the importance of a religious standpoint. He described therapy in terms being a guide in his relationship with clients.

Mike: Okay. The first thing is what is therapy for *you*? What does therapy *mean*?

Larry: Uhhh. Boy, I guess I'm taking normal people that have to be . . . happen to be stuck in one of life's transitions and sort of providing a safe place for them to work through that and try to get them to a better place.

Mike: Right. Right . . . there's no *right* (laughs) answer for me. It's your answer and-

Larry: I could talk for an hour but an hour is all you got, so. . . .

Mike: Yeah. That's fine.

Larry: I guess coming from my perspective there's a lot of attachment therein, basically, someone who can help a person become anchored in their . . . in that they are a person of value and often go back and explore previous things or previous events where they have not felt that. So it's . . . transference is probably a key thing in my approach to therapy.

Larry noted that he took the questions on “what is therapy” and “what makes a good (or bad) therapist” for granted. After seeing pauses, I decided to change the order of the question and asked about bad therapists first. Larry then answered the question as to what a good therapist does—basically to play a supportive role. He begins his sessions with an eight page introductory form that primarily provides questions to reveal expectations of the client and to let the client know the psychological approach he takes as a therapist. He related good practices to be those that provide unconditional, positive regard to affirm the values of the client. His practice provides a secure place to explore the gap between psychological and spiritual realms. He did this primarily through “discussion.”

Mike: Would it be easier to say what makes a *bad* therapist, an unacceptable therapist?

Larry: (Inhales) I'm probably influenced a lot, by Carl Rogers on the whole, issues of unconditional, positive regard. A therapist has to. . . . A person wants to get from where they are—to some other state other than where they are right now, and *that* involves influence and yet a realization that I don't know their world completely. So a good therapist is somebody that affirms the value of a person, so that that's a settled matter, and they can explore other things that might be a little more threatening to them in any other context.

We discussed authoritarian relationships often requested by clients and then I returned the conversation to the topic of bad therapists. In the following section Larry talks of a particular therapist who was involved sexually with a client.

Mike: Okay. Let's go to what's a bad therapist, what makes. . . . This kind of emotional thing. Have you known people that you considered to be bad therapists, and what was there about them that made them a bad therapist? And if not, what would make a person, you would say, a bad therapist?

Larry: Most of what I get is self-reports of clients' experiences without the . . . without a therapist. Yeah, certainly you get into the extreme. I have indeed conferred in a therapist that entered into a sexual relationship with a client.

Mike: And you said . . . ?

Larry: I inherited that client, so something at that extreme, uhm. Often it's more in the area of, probably, the use and abuse of influence, having an agenda for how they need that person to . . . , what direction they needed that person to go in. So. Ahh, they've usually been in areas pertaining to power and areas pertaining to transference.

He then spoke of abuse of influence and then used his early experience as a therapist to point out the trap some therapist may fall into (letting their own emotional needs lead them into pressuring the client to outcomes) to those which may be more for the therapist's own benefit than that of the client. He then spoke disparagingly of therapists who abandon the client when help is still needed.

Overview of How LCSWs Define Therapy Practices and Therapists

While I decided to ask about “the line” between good and bad therapy practices at an early point in all the therapy interviews, I also returned to “the line” at the end of all my interviews. In many cases, psychologists and psychiatrists as well as the social workers added to their statements. With the exception of social worker Will, the therapists were all asked about good and bad therapists very early in the interview. The flow of Will's interview precluded my asking until near the end. Whether it was an element of the process of the interview or some other factor (i.e., we had talked about

sexual abuse of children before this topic was asked about), LCSW Will was the only one of the clinical social workers who did not mention that therapists who have sex with clients, present or former, are bad therapists.

Each of the therapists had several persons who were resources whom he/she could call upon for support and to help him/her maintain good treatment practices. Amy had the medical staff at the hospital and several social workers that she called upon for specialized service for patients. Larry met weekly with another social worker, a psychologist, and a nutritionist. He also spoke of contacts with clerics who were one of his resources for new clients and in at least one instance had provided counseling assistance. Will shared an office with a psychologist (alternate day occupancy) in a clinic which included other clinical social workers and psychologists. He also conducted a mental health group with a psychologist at another location. Betty was supported by other students and instructors at the clinic where she worked and where she was getting a degree in acupuncture. She also had contact with massage therapists and other alternative health specialists (mental as well as physical).

While my literature review had been rife with expostulations and defenses on what traits a bad therapist has, and often these were contrasted with good therapists, I was surprised to discover that the interviewed therapists did not have such formulated opinions. After I discovered this in an early interview, I rephrased my question and asked about good *practices* as opposed to bad ones. At that point I left open the definition of “practices” (i.e., whether I was asking about how offices were run or what techniques would be labeled bad or good). I was interested in both, but I wanted to find out which ones each therapist would preference in their initial answer. Finally, when asking about

practices, I included that I was interested in finding out what was the *line* between practices that were labeled good or bad. Each of the changes I made in presenting these topics brought more immediate responses and appeared to reach areas which had more saliency for the interviewees.

LCSW Amy did list some of her roles as a resource case manager, but only Betty spoke of good therapists as those who had definable skills (which she enumerated) when she talked of the necessity of maintaining professionalism [my term]. Amy strongly stressed the importance of being aware of and following the dictates of the client in deciding on interventions; Larry spoke of providing a supportive role; and Will said that it is important for the therapist to help in solving the client's problems and stopping the therapy sessions when they are no longer producing positive results.

When talking about bad therapists, all spoke of the fault of giving precedence to the therapists own agendas and/or needs over those of the clients. Betty and Will spoke of the importance of maintaining confidentiality. Amy's definition of bad therapy practice was that it is the opposite of the definition of good therapy—*not* following the dictates of the client/patient—therapy processes *must* involve and spring from the client. For Larry, the paramount difference from statements of the others was in emphasizing the importance of continuing the therapy support, and not abandoning the client prematurely. While Larry advised caution in not letting the patient go too soon, Will advised caution in not letting the patient go soon enough.

The social workers who had been interviewed were essentially trained to assist in the practical concerns of their client/patients. To become Licensed Clinical Social Workers they also had been required to pass a national examination. Three of the

LCSWs were occupying primary therapist roles and the other was performing roles and tasks within a teaching hospital. These tasks involved supporting doctors charged with physical problems and supporting the psychiatrists who were often residents assigned to the hospital. One aspect of her support took the form of alerting medical personnel to the mental health needs of the patient for coping with the world external to the hospital environment as well as within it.

All of the LCSWs had support people to assist in their practice as needed. Those in private practices performed functions described similarly to those of other primary therapists. They acted as the primary mental health resource for their clients on a one-on-one basis and led mental health group sessions. Each of their offices was in a clinic which contained other therapists and available support personnel.

Two of the LCSWs oriented to therapy related that clients were *mired* in situations and conceptual binds that were affecting his/her mental health. Another was concerned with *blockages* restraining the client from mental health. The fourth was oriented to treating mental illness as an *injury* and herself as a component of the healing process. The LCSWs in private practices all used brief therapy consisting of only a few therapy sessions. Each had treated clients in group therapy sessions as well as individually.

Along with Will, Amy and Betty noted that character flaws were additional barriers to good practice. All had, in at least one instance in their careers, experienced the actions of a licensed clinical social worker that they labeled “crazy.” In each of these cases, they were appalled that such a person could be licensed. Since this research is concerned with the labeling of practices as deviant or normative and leaves questions of

character for others to pursue, the interviewer did not probe for details or seek other instances of character flaws, which are not directly proscribed by professional ethics or the law.

The LCSWs correlated bad therapy with doing harm to the client (i.e., *primum non nocere*). For Amy sexual abuse of patients by the therapist, cultivating extreme dependency on the therapist, and manipulation (even when it results in a good outcome for the patient) were the things that harm patients. Larry discussed harm that came from counter-transference. Will and Betty more directly related harm to not being sensitive (“present”) for the client/patient. All of the social worker interviewees advocated some kind of constraint by licensing boards although the form that this might take varied, greatly.

To get to actual therapy techniques, I had noted that my literature review had brought up the practices of hypnosis, drug therapy, and guided imagery and, in turn, asked what did each think about those practices. Will had used guided imagery at some times in his practice, but he preferred to use talk. He strongly cautioned that use of these techniques raise the issue of suggestibility and that use of them opens the therapist to accusations of managing the client rather than helping them solve their problems. None of the others had used any of these techniques. Betty and Amy also were concerned about suggestibility in relation to these techniques but accepted that they were used by others. Larry’s theoretical perspective precluded use of hypnosis or guided imagery. Betty was particularly concerned about the over-prescription of psychotropic drugs but like the rest said that they were useful in some instances.

Interviews with Psychologists and an Educational Counselor

The clinical psychologists and the educational counselor spoke of using a cognitive-behavioral perspective on therapy. All, however, were eclectic in their selection of particular approaches and goals. These were tailored to the context of the therapy sessions and the content of the social and physical environment of a particular client.

Rick, a psychologist, got several of his clients from referrals by clergy. He differentiated between an ideal type of therapy and the way therapy is practiced. Nevertheless, his theoretical perspective was very similar to the other psychologists but focused more on fitting client selection according to his religious framework. He did not believe that there was a conflict between his religious beliefs and his theoretical training but did give examples of times when his religious beliefs had affected client selection. At first, he appeared taken aback by my probe about therapy. He chose to reframe my question “What is therapy?” into “What therapy should be?” He answered that it should be a way of producing wanted and healthy changes in life.

Rick: In essence, therapy I believe, not to get too Clintonian, but I guess part of the reason I’m having trouble answering your question is it depends on what you mean by ‘is.’ So I’m going to answer instead, “What therapy should be.” Therapy for me should be, a, mode by which a professional assists, someone in, producing wanted and health changes in life[?].

When I asked how he (a therapist) does that, he discussed theoreticians from the cognitive behavioral perspective and then a theoretician from the solution oriented approach. In the therapeutic discipline blank on the demographic data form he had

written “predominantly cognitive-behavioral, informed by other approaches, including solution oriented.”

Hypnosis was a technique that Rick had used to help a client do things that the client wanted to do but had resistance to other therapy techniques. Rick remarked that he had some training in hypnosis and the client had suggested trying it. Rick did not find it to be effective. He said that with more training he would consider using it in the future for changing expectations, but not for changing personalities.

Rick: It’s that ‘hope’ concept. “I can’t stop smoking, I can’t stop this,” or “I can’t get along with my wife.” “Yes you can!” [laugh] You know?

Mike: Yeah

Rick: And if that ends up being a tool that somehow, [raps on table] the ritual and all that of it, uh tends to be more convincing than my just saying, “Well if you try this technique . . .” Then it’s something used for positive value and a gain and service—fine!, It’s a valid therapy. Uh there’s a cliché for that. But [laughs]. Uh, in that context, I could see using it. My belief in hypnosis as being . . . a *thing*. Uh it was some type of, you know, quasi-magical thing that really has a lot of effect on its own. It’s limited. But I do know that people, uh are convinced and sold on ideas of different ways, and if hypnosis can be used in a way of, of increasing their, expectation of change, buying into that suggestibility, sobeit. . . . I don’t use it. I guess what I’m trying to maintain here and make clear here is that I don’t have an absolute prohibition against the idea, if I thought it would be helpful to do. I just haven’t found a case where it *is*.

Rick did not use guided imagery about memories but he did use imagery in relaxation techniques, “imagining themselves.” He did not use pharmacology because it was not available to him. He did see it as a tool helpful for therapy, depending how it is used, but did not go into detail as to when it is misused.

Rick was very succinct in his statement about when a therapist has done bad practice: “You’re going too far, when, you lose track of who the therapy is suppose to be about. It’s not about you, it’s about them.”

When I asked Rick what makes for a good therapist, he first responded with personal traits that a therapist should have and then working *with* the clients instead of trying to *fix* them and finally respect for their values. Rick was the therapist who rejected potential clients on the basis of his own values. Therefore part of his approach involved his ability to show the client that he shares their values.

Rick . . . [exhale]. Well certain obvious things—intelligence, uh uh insight, understanding, study—all that kind of good stuff. Uh, but I think the basic, uh, . Respect for your clients as as a partner in the process. Uh, you’re not, *fixing* them. If you view it that way, you’re going to be far too uh aggressive, and you can either . . . can push them in directions that they, they don’t want to go. uh You’re kind of helping them fix themselves. so a kind of respect for them, and uh, which includes uh, a respect for their values. Kind of goes back to the question about, How do you build the trust. uh you know, where possible, kind of showing you know that you share their values. uh

Mike: yeah

Rick:: Just part of how I end up getting a lot of referrals.

Bad therapists are defined as ones who have their own agendas and “wants everybody to fit into their mold.” He thought that everyone has his/her own world outlook and philosophy, but therapists should make theirs “up front,” “so that they can know whether they (clients) match you and find somebody else if they don’t.” Rick’s religious outlook and ideology were very important for him.

Rick: I don’t pretend to be unbiased. uh I’m in favor of, faith and values and strong marriages and that kind of stuff and if you want somebody who’s gonna, tell you how to get out of your marriage

without any guilt.> I can recommend you to a few other therapists. You don't want to be working with me.

Being “up front” and selecting clients with similar values were the way Rick avoided being a bad therapist and having his personal agenda affect his clients. “Agenda” for Rick had three components: philosophical (melding professional and religious ethics); financial (e.g., keeping somebody in therapy when they really don't need to be); and emotional (e.g., inappropriate relationships). The interview flowed into the authority that a therapists represent and the need to listen to how the clients talk about their and problems. These are examined for logical errors and fallacies that the client is telling him or herself and, as a therapist, Rick would focus on solutions for the client.

Rick's practice was slow at the moment. He did not accept clients from HMOs and clients were responsible for dealing with insurance companies. He said he would work with clients with insurance, but required them to pay up-front and collect the insurance remuneration themselves. Since he did not collect fees from third parties, he did not feel that he needed to spend much time on diagnosis. He would go straight to problem solution. If a diagnosis was needed by the client for insurance purposes, Rick would consult the DSM IV. When I asked what was the line between good and bad therapy. He said, “good therapy is about them, bad therapy is about you.”

Karen, Ph.D. in educational counseling, defined therapy in term of the privileged responsibility of helping balance the clients' feeling and “head” aspects. She referred to “solution focused therapy,” but indicated it was an insufficient label for the type therapy she did. In addition to focusing on problems that the client was presently having, she added that her work was eclectic and involved helping people get balanced in their lives

by working on “the *feeling* side of them,” not “just in their *head* all the time.” Karen also described therapy as a privileged position with responsibilities.

Karen: Well it’s a very privileged position I have in terms of . . . in terms of people trusting me with their stories and with their issues and their problems and concerns and helping them believe that there is a way to live a better life, be truer to themselves, live in—I’m trying—harmony and community better, be at more at peace with themselves, make changes that they want in their lives.

Ethics was the key to good treatment practices for educational counselor Karen, a Ph.D. in educational counseling. She also mentioned respecting the confidentiality of the client to the extent legally possible. Karen talked about ethics and laws throughout the interview and sometimes it seemed that she was waiting for me to express something to give her a cue as to what her answer should be.

Approach to therapy and techniques were not so important to Karen as living up to professional ethics. She felt that different approaches which might be inappropriate or ineffective for a particular therapist might work for another. This was the moment I chose to ask about the *Ramona* case (amplified in Chapter 9). I concluded a short synopsis of the case by noting some of the practices that were discussed in the case and noted: “They used certain practices—hypnosis, Sodium Pentothal, directed imagery and uh a lot of things that had to do with suggestibility. Do you use any of those in your practice?”

Karen: (Laughing) Right, right. No I don’t do hypnotherapy and directed imagery. I’m not sure what you mean by the term. Let me put it this way, is your question what do I do about repressed memories?

Mike: Yeah that, should do.

Karen: Ye(laughs)ah, uh I *typically*, everything's individual. I mean that there's not one thing I do in my life, probably, that I do in the same way every time—not even how I brush my teeth. So, I do believe that people can repress memories. I think it's a phenomenon, I just accept it as such. Do I work, to pull those out of people? I don't. I think they are . . .

Mike: You don't probe?

Karen: I may ask them some questions and I'll test, I'll watch reactions, I'll listen to words, I'll, you know, watch, you know.

Mike: But you don't open it up?

Karen: Let's see do I open it up? If it's appropriate. Am I a sleuth about them? No. No, there's a reason that they're sort of latent and I think it *can* be harmful. I mean, if it's *relevant* I work with it, but.
 . . .

After stating that she did not use any of those techniques, she assumed that I was asking about how she approached repressed memories. She believed that people can repress memories and believed that repressed memories can be harmful. Karen would ask some questions about the memories if the client brought them up, but would not probe for them. She showed some uncertainty about the relevance of these memories for diagnosis and/or treatment by ending her statement on their relevance with a subjunctive “if” and the open-ended qualifier “but. . . .”

Of all the therapists I interviewed, Karen was most guarded in her answers. As the interview went on, she would volunteer information. In the early stage of the interview she would use stalling tactics such as repeating the question as if she had not heard it, laughter, and long pauses as if passing her turn to speak, even to respond to the question. One example is that she took a comparatively extremely long time to select five

cards from the concept cards. She reacted to the cards as if they were a test. Finally she indicated her quandary:

Karen: I know what I am going to do, just decided what I am going to do with these. [A few words were accidentally erased from the tape] . . . process it and one of the things that get sorted are people with tests like these are quick to make judgments or they think about the possibilities forever. (Karen laughs) I know. I know, but I'm just thinking. . . . You've got someone who's gonna try to think like, "Well if I put these, then what will that *mean*." Rather than "Oh this, this, this, this."

She was also judicious in defining a good therapist. The following is an example:

Mike: Okay, what makes for a good therapist?

Karen: Well, lots of things. (laugh)

Mike: What's number one?

Karen: Yeah, what's number one?

Mike: What is the one thing you would say if that person doesn't do that thing, then they're not a good therapist.

Karen: To be ethical.

Mike: To be ethical?

Karen: Yeah, cause I think. . . . Take ten therapists with the same client. We can approach things ten different ways and then we can all be good or we can all be horrible. (laugh).

For Karen, following the dictates of the law and the ethics of the profession determine if the therapist is good or bad. She indicated that she hoped that the legality and professional ethics would be the same in a particular case, but the final determinant of the line between good and bad practice was "the law!"

The other psychologists, Gail and Zoe, spoke from an educational perspective. This was discernible by the text of their discussions as well as from the fact that Gail was

involved with children with problems often regarding intellectual barriers and that Zoe was primarily involved with students at a university. Throughout their interviews, they would demonstrate facility in the transmission of knowledge—what they knew about a subject. This perspective is associated with the educational system more so than with one of the other institutions.

Gail said. “I don’t really feel like I have a certain orientation toward therapy.”

During other elements of the interview, I would pose a question and she would give remarkably detailed and inclusive answers that were obviously not memorized but internalized—illustrating a firm understanding of the topics. Her answer for this question appeared to be less formed and more in the process of being thought out as she spoke it. This is notable in the uncharacteristically uneven flow of the answer illustrated by the second part of this exchange:

Mike: In, your words, what is therapy? What do therapists do?

Gail: I think therapists work with people to consider situations that are creating some sort of stress or unhappiness and explore options for making changes, so that they can feel better.

Mike: Where do you fit in therapy?

Gail: I really, it’s hard, I’m kinda eclectic. I guess that more uhm . . . Sometimes . . . , Depending on the problem, you know . . . this depends on the problem, so like your, your typical behavioral kinds of things . . . or your anxiety kinds of things. I’m more cognitive behavioral. If it’s a relationship issue—I’m more interpersonal. If it’s more of something like, uhm your recurrent problematic patterns, like you know, someone who’s got more of a personality disorder (which I really don’t see much here now, but I use to)—uhm I might do more of a mixive, interpersonal and insight oriented kind of work.

From answers to this and other questions, it became apparent that for Gail therapy is primarily what a therapist *does*. A therapist works with people and explores options for making changes so that they can feel better. She had not put an answer in the blank of the demographic form which was for Theoretical Perspective, but she described herself as eclectic in her approach to therapy during the interview.

Good treatment practices for Gail were those which provide interventions. For her, interventions are “suggestions” that are made for the clients and with their input.

Gail: Treatment practices would mean: what kinda interventions are your gonna put in place, what kind of suggestions are you going to make to parents, or things that you are going to suggest to kids or what sorts of options are available to them for getting the needs met. Because we are a multidisciplinary setting, I really think that treatment practices is having a wide range of things that patients have access to.

Mike: What types of interventions do you do or do you suggest or. . . . What do you do?

Gail: Well, a lot of times we’re going to work on things that improve communication, or things that will improve expectations, behavior and discipline at home, and we’re kind of just making some things clear that haven’t been, and helping kids to understand what’s going on that’s creating behavior problems and what kinds of incentives and consequences are available when they make different kinds of choices. A lot of times parents are coming because they’re having a difficult time managing their temperament and their child. So, knowing about the treatments we have like things that they can get from censoring litter treatment and all possible help with medication. We also talk about the options they have and their feelings about pushing, or not.

Rather than speak of specific treatment practices or techniques, Gail related them to the unspecified ways used for clarifying causes, incentives and consequences available for choice about clients’ problems and that are used to work on improving the clients’ abilities in communication, expectations, and behavior. While she did not provide any

information on guided imagery or hypnosis, she was very much in favor of her clinic's biomedical connection and its multi-faceted approach to the practice of therapy. She went into detail in describing that:

Gail: This is a, you know, biochemically, medical facility, and I'm very much in support of it. I do think, that it's uh, probably over-prescribed at times, and I think -

Mike: Here, or . . . just in general

Gail: umhm, I don't think here. I think that in general. I think it has been carelessly prescribed or I should maybe even say carelessly monitored. I feel like, by the time a patient here, has been prescribed medication, we've done a pretty exhaustive assessment, and uh, we're getting information from families and parents and our intensive zone and observations, and seeing them multiple times and so I feel pretty confident. I also think when we prescribe medication, we do follow-up assessment, we get teacher feedback, we get parent feedback, and we have parents keep journals. . and so on, I think when, when we're doing it, it's a- . I think sometimes people use it as a way to treat, for instance, behavioral problems, and while a lot of kids *have* behavioral problems, medication is not gonna address them. Uhm, you need a multidisciplinary approach and, for a lot of the kids that have the disruptive behaviors, they need . . . they need their own strategies, they need medication, they need to learn arousal techniques (which is a big piece that I've learned from our occupational therapist that they provide the kids) just learning how to modulate your own arousal level . . . for different situations, to rev yourself up or rev yourself down.

Gail: So, It's *very* interesting [the study of arousal techniques]. I mean, and a lot of the kids we work with have a learning disability, have attention difficulties that are secondary to having *learning* disabilities because when you're working, when you're in an area where you're already . . . stressed, and you have to work extra hard to keep up with everyone else, your stamina is gonna be less at the end of the day than the other kids that didn't have to work as hard, and that's gonna create *attention* problems. And so if you can, you know, boost your system by having medication, it's gonna make the learning easier. And I'm very much in support of that. But I do think, sometimes, that a fifteen minute interview might be all that a, physician needs to give someone *medication*.

While Gail favored medical interventions for stress, she did not believe that it is the cure-all for behavioral problems. She tied the use of medication into enabling the social interventions to do their jobs. Her idea of treatment was indeed eclectic—testing, interviewing, and observation to determine if medication might help; then medication (carefully prescribed and closely monitored); then the less “stressed” client is able to take advantage of the social techniques (occupational therapy, psychological testing, cognitive psychology et al.); and finally, a lot of feedback during these phases of treatment. Interestingly, the doctor who owned and worked in the clinic was a pediatrician and not a psychiatrist.

Bad therapy practice was not working with the client and the over-prescription of drugs. good therapy practice was a teaching enterprise—helping clients understand what’s going on that’s creating behavior problems, revealing incentives and consequences that are available for different kinds of choices, managing temperament, and discussing the options that they have. It also involved respecting the confidentiality of the client.

Gail would not volunteer any information unless I directly asked for it. She would then give exhaustive answers, which sometimes included examples. In contrast to Karen’s reticence on the topic of what makes a therapist a good therapist, Gail responded immediately that a good therapist has knowledge on the subject that will help patients manage their problems, has traits of warmth and empathy and who is supportive and available. Other elements of a good therapist that she stressed were making sure the treatment is effective and worthwhile, staying aware, watching what the client is paying, doing follow up with families at their homes, and maintaining discipline accountability to

patients. In direct answer to my question on a good therapist she had first mentioned the following:

Gail: Whatever issues that come up in therapy, always trying to stay empathic and tuned in with the family in the face of even their extreme anger. I mean, I think that people. . . . I certainly couldn't speak to what someone that's maybe sociopathic or like that, but in general, I think that people. . . . Anger and just stress. . . . I think you can do a lot to help them with managing that, even in very unpleasant situations based on how you are with them. If you're non-defensive, if you're warm. If you're supportive even in the face of having to do something really yucky.

During the course of the interview, Gail related that bad therapists were those who have sexual relations with clients or interns, who violate patient confidentiality, and doctors who over-prescribe.

Zoe discussed therapy in terms of helping clients to adequately function in day-to-day life. On the demographics form, Zoe had written that she came from a cognitive-behavioral theoretical perspective but stressed throughout the interview that she was a counseling psychologist, not a cognitive psychologist. Zoe described therapy without having to reflect beforehand. Therapy was helping people to become able to "live their lives in a more fully functional manner."

Mike: For you, what is therapy?

Zoe: Ah, for me, therapy is helping people, to become more, ah able to live lives, live their lives in a more fully functional manner. Uh therapy can be anything from helping a person who, is, very low, in their functioning and day to day life. Like unable to, work on a regular basis or carry out their day to day activities on a, daily basis. To help them to become . . . adequately functional. *Or*, to enhance the functioning of an individual who is already pretty functional but, ah would like to enhance some aspect of their, lives, their interpersonal relationships their assertiveness, something along those . . . something of that nature.

More than the other psychologists, Zoe talked of therapy as more inclusive of life process. She averred that even people who were leading basically functional lives could gain some help from a therapist.

In addition to problem solving, Zoe said cognitive psychologists use systematic desensitization, relaxation, coaching, modeling (all of which she used), and also cognitive restructuring and imagery techniques. The only types of guided imagery that she used was during relaxation exercises (ask the client to imagine a calming scene) and for development of social skills (a rehearsal to overcome social deficits—“imaginal role playing”). When I asked about suggestibility she said,

Zoe: I don't have a firm idea about it, but hypnotherapy—I've always been a little, leery, about. Because, uh hypnosis relies obviously on some level of suggestibility.

Zoe: One session of anything is not going to really . . . going, to . . . do anything—'a;' but 'b' I think, I'm just not convinced that the . . . that there is uh research support, for a hypnotherapy, type of approach, with, a wide variety of problems. Maybe there's research support for it being effective with *some* types of problems. Maybe it's completely dependent on the level of suggestibility of the individual but, I'm still [exhale] with things that, circumvent conscious thinking and things that don't build skills, that help to make change. . . .

She had witnessed one session in which psychiatrists had used Sodium Amytal.

She felt that intervention had “yielded no more than I got in clinical interview, frankly.”

Zoe: If you're not clear on what the clients wants and you're, you're using suggestibility to suggest things that *you* think are right for the client. I think that is, ethically inappropriate. Be less than ethical

Mike: Even though your heart's in the right place?

Zoe: Your heart may be in the right place but you are not the one to decide what . . . how to live the client's life according to their values. So, unless you *know* what they want uhm and assuming

what they want is healthy enough, for them. I mean you have to help a client evaluate sometimes the. . . . If a woman in an abusive relationship comes to you and wants to be able to better, tolerate being beaten, you have to evaluate with her, if that's a good choice, or not, for her physical safety. But . . . other than life and limb, threatening, stuff. . . .

Several times within the interview, Zoe expressed the importance for therapists to stick within their levels of expertise—not to go beyond what they were trained to do in therapy. Therapists should not accept clients for treatment in areas where they have not received appropriate training and gotten some supervised experience.

Her response to the probe on the line between good or bad practices was that good practice helps people meet healthy goals and bad practice prevents people from meeting them or pushes them into unhealthy goals. For Zoe, good therapists internalize professional ethics, keep their skills up to date, work within their areas of competence, and:

Zoe: You have to let help clients to gain functionality in a way that's consistent and consonant with who they are as individuals. I don't think it's up to us to decide what the clients goals are, I think it's up to us to help them formulate *reachable* goals . . . and healthy goals.

According to Zoe, bad therapist are those who do not do those things. She was the only therapist who spoke directly of the possibility of changing bad therapist so that they would be able to do good practice. She said that the state licensing boards provide an outlet for professionals when there's a professional in distress or "impaired." They provide a way "of making it stick that a person, comes back into the fold [laugh] when they need to be; or how they need to be functioning to be able to effectively provide services."

Overview of How Psychologists and a Counselor Define Therapy Practices and Therapists

All of the therapists had expressed the necessity of on-going training. One psychologist (Zoe) had stressed the duty of the disciplines to insist on professional ethics and provide assistance for “distressed” or “impaired,” psychologists (and by extension, all therapists). Jack discussed the duty of the therapists to engage in self-reflection about their roles with the client and to make sure that their agenda do not affect the treatment.

The clinical psychologists all used cognitive and solution-based treatment in their own practices. The particular techniques of therapy were unimportant to one (Karen), as long as therapists abided by the ethics of their discipline. In conjunction with doctor-supplied medical treatment and when interacting with other specialists, another psychologist (Gail) used a variety of unspecified psychological techniques and tests as a part of her work with clients. The goal was to help them recognize and achieve the clients’ own social goals regarding interpersonal communication, understanding of societal expectations, and achieving proficiency in behavioral interactions. Another clinical psychologist (Rick) was open to using any technique that provided a “positive” value, gain, and/or service, even if it meant “buying into their suggestibility.” “Positive” was not directly defined, but since this psychologist is strongly attached to his religion, connections from the tenets of that religion were likely the basis of his use of the concept “positive.” The fourth (Zoe) was the only clinical psychologist who listed actual techniques (i.e., systematic desensitization, relaxation, coaching, modeling, cognitive restructuring, and imagery techniques for relaxation).

Only one of the therapists, psychologist Rick, had used hypnosis, but he had not achieved the result he had hoped. He had not used it again, but did leave open the possibility that he might try it again, after further training. Guided imagery was done by the clinical psychologists to facilitate client relaxation. One therapist said she also used it as imaginal role playing for developing social skills. There was a wide range of responses about the use of psychopharmaceuticals. Karen laughed and said that of course *she* did not use them. Given her partialities for law and ethics, use of drugs—and perhaps even consideration of the use—was something reserved only for M.D.s. Rick thought that prescribing was a tool that can be used for the “therapy resistant” clients. He said he did not have the option of prescribing available for him and he was uncomfortable about psychologists being allowed to prescribe. He was unresolved on whether they should be able to prescribe even with more training. For Gail the prescription of pharmaceuticals was a familiar and necessary facet of her work on a team that includes a pediatrician. She was concerned with over-prescribing of drugs by M.D.s in other settings. When I asked in particular about prescription of psychopharmaceuticals, Zoe related a case she had observed involving a client who was deemed overly defensive. She felt that this intervention did not achieve more than she had been able to do during the clinical interview. Nevertheless, she understood that this may have been an isolated incidence and remained open to its use, so long as it was within the therapist’s area of expertise.

All the clinical psychologists stressed that the therapist should never enter into a sexual relationship with their client and Zoe extended that to banning *any* social relationship beside that of therapist and client. All therapists except Rick mentioned and stressed the confidentiality of the client. However, they also revealed that they would

breach the confidentiality if they considered that harm would come to the client or others by maintaining it. Whereas Rick felt that spending time on diagnosing problems detracted from treatment, Gail was very much in favor of doing a number of psychological tests on clients to determine their diagnosis right from the start.

Whether practices are good or bad was defined by Karen in terms of whether they fit within the legal and ethical codicils of a particular discipline. Gail felt that the line between good and bad practices depended on whether the client is or is not helped by the therapist's 1) working to teach, 2) revealing choices and management techniques, and 3) is exploring options. She judged as inherently bad those therapy practices which came from any other agenda, or which were not working for the client. Rick's perception was similar—bad was any practice that focused on a therapist-defined agenda rather than the therapy being about the client. For Zoe good practices were those that helped the client achieve healthy goals (e.g., mental and emotional goals). Bad practices do not help, or push the client away from healthy goals.

Conceptions about good and bad therapists varied widely for the clinical psychologists. In brief: Karen stressed that a good therapist abides by the law and the professional ethics of her/his profession; Gail stressed having traits of warmth and empathy, being supportive and available, maintaining discipline accountability (professionally ethical), doing follow-up visits, and being knowledgeable on subjects which will help patients manage life's problems; Rick stressed personal traits that give rise to an ethic of working with the client instead of fixing them (working from the client's agenda rather than the therapist's), being up-front about biases, and sharing

values; and Zoe stressed internalizing professional ethics, keeping up with the latest skills, and working only within one's areas of competence.

Bad therapists, for Karen, are those therapists who do not abide by the law or the professional ethics formulated by the national associations. Gail felt that bad therapists are those who have sexual relation with clients or interns, who violate patient confidentiality, and those who over-prescribe drugs. Rick talked about bad therapists as those who allow their personal agenda to affect the client rather than following the client's agenda either philosophically, financially, or emotionally. For Zoe, bad therapists are simply those who are not good therapists. She considered a bad therapist to be a "professional in distress" or "an impaired psychologist" and felt that licensing sanctions provide insurance that bad therapists are excluded until they can function to "effectively provide service."

Karen had focused on her privileged responsibility [taken in context to mean "greater authority"] to help clients achieve balance between mind and emotion. This was done by working within the professional ethics and laws which govern Karen's discipline, and this could be done by virtually any technique. Gail focused on working with people after psychological testing. Under the leadership of a pediatrician, she, another psychologist, and a social worker approached therapy as parts of a team. Rick focused on selecting clients. He based this on whether he would be able to assist the client in achieving "positive" value, gain, and service. This was done through use of any "teaching" technique that fell within Rick's qualifications. While he was insistent upon working toward the client's agenda, he was willing to use even suggestibility of the client as a tool for achieving the client's agenda. Zoe focused on helping clients to adequately

function in day-to-day life. Of the psychologists, only Zoe itemized a number of techniques that she used to in therapy. These included systematic desensitization, relaxation, coaching, modeling, cognitive restructuring, and imagery techniques for relaxation.

When diagnosing, none of the clinical psychologists had used any of the techniques which have been found to involve risk for increased client suggestibility (guided imagery, hypnosis and drug therapy). Rick and Zoe had used imagery for relaxation and stress removal (e.g., “imagine a place where you felt very relaxed and at ease”) not for imagining other past events. Zoe also used imagery as a tool for role playing (e.g., “imagine how you would apply for this job” or “imagine how you could interact with this person in a constructive manner”).

None of the psychologists had prescribed medicine. Rick and Gail had referred clients to psychiatrists when they thought that psychopharmaceutical intervention might be necessary. Gail performed tests designed to determine whether a patient might require intervention by the therapy team medical doctor. Zoe had witnessed a drug intervention and felt that the results of that particular intervention were no more than equivalent to those achieved in a clinical interview. None of the clinical psychologists felt that there was a problem with psychopharmaceutical interventions except for over-prescription of drugs and the possibility of increasing client/patient suggestibility. Their objection was not to the use of drug therapy—they were more concerned about the potential for misuse.

None of the psychologists had referred a client to a hypnotist. Only Rick had used hypnosis but was unsatisfied with the result. While Zoe had seen a client who had gone to a hypnotherapist, the report she got from the parents was that it “didn’t work at all.”

She said that she was not surprised because she had reservations about any treatment that involves only one session. Her reservations also extended to questioning the efficacy of all treatment practices that “circumvent conscious thinking and things that don’t build skills.”

All the psychologists specified that a therapist had gone over the line into bad practice if he/she engaged in a sexual relationship with a client. Zoe expanded this to include others who are under the therapists authority (i.e., psychological students or interns). All except Rick mentioned violation of client/patient confidentiality as a bad practice except in cases when disclosure is legally required. Karen particularly proscribed neglecting to follow relevant law or violating professional ethics. Failure to terminate the therapy when the patient is not being helped and failure to conduct follow-up studies were stipulated by Gail as bad practices. Not being up-front about biases and violating Christian values was cited by Rick as bad. Zoe considered bad therapy to be a continued use of practices that do not help, or that push the client away from healthy goals.

Other than the general proscriptions to ensure that therapists’ own agendas are subservient to the clients’, the psychologists varied greatly in their conception of the line between good and bad therapists. Legal elements were of primary importance for Karen. Professional ethics and religious values concerned Rick. An ethic of professionalism through educating and working with the client was stressed by Gail. Internalizing professional ethical standards and maintaining the latest skills were emphasized by Zoe.

Applying her concepts to individuals, Karen felt that professionally formulated ethics and relevant laws provided the line between good versus bad therapists. According to Rick , a therapist who applies his/her own agenda on the client would be over the line.

Gail related going over the line to particular acts (i.e., sexual relations with patients, violating patient confidentiality, or over-prescribing drugs). Zoe centered on bad therapists as those who were in “professional distress” or were “impaired psychologists,” and who were not effectively providing service to their clients.

Interviews with Psychiatrists

The psychiatrists who were interviewed spoke from a medical perspective when defining therapy. Yet, they balanced their replies with a more psychological (social) perspective. They also were forensic psychiatrists. The psychiatrists viewed the therapist’s job to be an interaction with the patient that is designed to treat a disorder to be cured. Peculiarly, throughout the interview they referred to the patient as having a disorder (a social control and medical concept) but they did not speak of the physical side of mental health unless directly probed.

Ben considered therapy as analogous to treatment of a disorder. His practice was in a teaching hospital, dealing with a geriatric population. Limitation of function and dementia were the major disorders he treated. Ben did not relate a particular theorist or theoretical perspective for the supportive therapy he practiced, stating that “It’s a fairly general concept.” When asked “what is therapy,” he said:

Ben: I consider therapy uhhhh . . . to be, uh analogous to treatment . . . of a given disorder. There are different types of therapy. When I first debuted on my inpatient unit, I used supportive therapy. Uh Where we are uh nurturing, on the unit, and provide support that may be lacking otherwise . . . for a patient.

Ben had selected the card “Treatment Practices.” After finding out Ben’s opinions on the DSM IV, I got to this card, about half way through the interview. He asked if I could be more specific. I related that the literature I had read showed that this

was an area that “was in some kind of context, but it's not important what the context was that I saw it in. The fact that *you* selected it means it has significance for you and that's what I'm after.” He indicated that he understood and said:

Ben: True. In practice. Well, the reason why I uh. . . . There's a big shift in psychiatry right now—it's been going on for a little while now—it's actually a shift away from therapy and towards a more uh psychopharmacological treatment approach, and so that's what caught my eye when I saw that card

Mike: Really?

Ben: Yeah yeah and the uh of uh uh being able to delineate what's going on at a more physical level with . . . >

Mike: (inaudible) schizophrenia?

Ben: We've had some uh revolutionary changes in treatment modality for a number of our diagnoses that we, before, did not have any uh real effective means of uh addressing, and that uh I think that's been a big part of what's been going on lately.

Possibilities of gene therapy were in the news when Ben was interviewed. I asked what he thought about it. Ben said:

Ben: We're looking at familiar components of these disorders and it's one of the things we always ask about. Do you have a family history for this? Do you have other family members that suffer from this? Uh, so in looking at that even now . . . it's always going to be problematic at an ethical level and we get to the point we are trying to alter things that's always going to be a concern.

Ben: Yeah, my profession's always been accused of trying to make everyone the same and not allowing for individuality or a freedom of expression and uh, well, that would be a nightmare if we started mandating that everyone have particular genes and we didn't allow for the variability that uh allow us to adapt overall.

He then discussed stigma associated with mental illness. He said a good therapist is careful with how a patient is diagnosed since both laymen and therapists may perceive

and react on the basis of that stigma. After noting that, he gave an example of negative connotations associated by other clinicians to a person diagnosed with borderline personality disorder. He noted further that the diagnosis is carried in future medical records and that the patient may internalize and also stigmatize him/herself in relation to the diagnosis. These negative possibilities are mitigated by a good therapist by being very cautious about applying diagnosis labels.

He said that the patient should be put above all else, emphasizing money as a possible negative agenda. This included avoiding some confrontational styles of therapy which can overwhelm a fragile patient, doing more harm than good. In answer to the probe, “How do you feel about hypnosis,” Ben said:

Ben: It’s interesting, especially as a forensic psychiatrist, uh I’ve seen hypnosis done, and it’s interesting. There’s always concern about possible of false memory and of uh suggestibility, but I can, I can see where there may be some utility in it, because there’s a very strong defense—if you’re overwhelmed with a particular memory—to suppress it. It’s a very primitive defense mechanism, but it’s, it’s pretty effective. And if that information is vital, for whatever reason, be it uhh for you to understand yourself more, in order to grow as a person or, be *that* important for legal reasons or to find the truth about something that happened to address wrongs that have been done in the past. I can see the utility in that, it’s just uh the information. I’m not sure how reliable it is in all situations. I think there’s a great deal of contamination that can take place, with retrievable suppressed memory.

When I asked about psychotropic drugs, he said that he had seen interviews when patients were affected and that the same issues (suggestibility) arise. When I then asked about guided imagery, his answer indicated that he understood the term in the context of distraction rather than recall of past memories.

Ben: Suggestibility. Yeah, you always have uh biases of the interviewer and uh question selection, and there are a lot of opportunities to *steer* answers and lead the patient in a particular area.

Mike: Okay. What about guided imagery? What do you think about that?

Ben: The guided imagery, I think is actually uh. That's more interesting to me. I think that could be very helpful, for uh for a patient. And uh, uh being able to distract yourself from things temporarily, and, and uh, use that type of imagery, I think could be very beneficial.

The psychiatrist, Ben, said that good therapists are empathetic, capable of establishing a good rapport with the patient and are good listeners. good therapists provide enough time and opportunity to find out what is bothering the patient. Basically, being a good therapist is being a person who is supportive and nurturing in a general way.

Mike: What's required to be a good therapist?

Ben: For the supportive therapy I'm talking about, it helps if you're empathetic . If you can establish a good rapport with a patient. If you're a good listener. Give them the time and opportunity to tell you . . . what's bothering them and what difficulty they're having, and be able to meet and compensate for some of those difficulties.

Mike: Ahh. and how is that different from general (laughs) therapy.

Ben: It's different in that uh it's not as much introspection. You don't . . . evaluate their pattern of behavior and the path as much. You don't look for deficits that are going on where you're trying to create awareness in the patient of those deficits. It's more of uh just being a good person, being supportive and being nurturing in more of a general way.

Jack primarily treated hospitalized geriatric patients but was also involved in outpatient treatment (“18 up to. . . No age limit on the top”). Jack described his theoretical perspective as psychodynamic (“It’s a kind of a mini-branch of psychoanalysis”). Jack saw the use of psychotropic drugs, guided imagery (to access memories), and hypnosis as useful and sometimes essential tools of therapy. He had used

drug therapy and guided imagery to access memories but stressed the need for diligence in refraining from implanting memories while the patient is in such a suggestible state.

Jack: Uh, well, interviewing is one of the techniques that I that I . that we rely on in psychiatry. Now, that obviously has it's own set of limitations, that go with it to help with some of those limitations, we've done things like sodium Amytal—truth serum interviews. Yeah, and sodium Pentothal. That also is something we've done to help.

Mike: Guided imagery?

Jack: Uhm that is helpful to some degree, I think it's a > Again it's almost like a slippery slope. There is some > Whenever there > I> The guided imagery is okay and I've had a little experience with that. I think the place where you start to get into the slippery slope is when you start asking pointed questions, about memories. Things that you> If you know of what you're looking for, you have to be careful on how you look for it, because you can often steer the course of where you are looking. Not even purposefully, but if you understand where you're . . . what you're looking for.

Mike: I understand that you're much, much more suggestible, under sodium Am>

Jack: Correct. and so you may not even mean to, but you may implant some ideas. If you ask a question like 'Do you remember X.' Well if they didn't ever have that memory but you've now, kind of planted, that seed in their mind there are some, scenarios where that may become implanted.

Mike: And under guided imagery you're actually suggesting that they . consider that as a fact?

Jack: As a fact.

Mike: What about hypnosis?

Jack: I think hypnosis can be used in terms of ge> uh recollections, repressed memories. Hypnosis is an effective technique too. In my mind it's similar to the sodium Amytal—the truth serum. I don't see that it does *magical* things to our brains. Um and I don't see that it, it changes something. The way I see it, hypnosis is basically an aaaaa, heightened sense of relaxation and that it may

often help to lower the, the checks that we have in place, that maybe keep some of the memories out of our consciences. Uh, same idea as the truth serum. It's not really truth serum, it just simply lowers your inhibitions and lowers some of your, hesitations, recovering some of those, thoughts, or going through some of those things. Ah. I kind of view hypnosis along the same lines, but it can be very effective in some people to help to lower the inhibitions enough that they may be able, to think, about certain things that, when they're not relaxed, the mental angst, if you will, is just too much. That the brain simply won't allow those thoughts into consciousness. and so that's why they don't have any independent recollection of them.

When we were talking about using memory as a tactic for therapy, Jack discussed some of the techniques that he uses. One of the things of interest is the shift of case from first person singular, to first person plural, to the indeterminate "you." After starting in the active "I" he switched to the plural "we" (psychiatrists, including him). When he talked about "get into the slippery slope," he switched to "you." He returned to the first person singular to express his opinion on hypnosis.

Of all the therapists, Jack was quickest to respond to my question about therapy. He paused only a second and his delivery was quite fluent, which indicates that he may have considered the question more recently than the others.

Jack: Uhh. The coming together of two people, with the idea that one . . . that the exchange of ideas and feelings and emotions would help, or improve, the emotional well-being of one of . . . or both.

Even though his answer was relatively fluid, I found it interesting that a psychiatrist would not include the physical element within his definition. During the interview, he did speak of the dominance of the medical aspect of his treatment (e.g., treatment with drugs).

When questioned about good and bad therapists Jack had definite opinions and discussed them at length. The gist is that becoming enmeshed with the patient keeps the therapist from being objective in their treatment. “No sexual involvement” was a given, but the “no involvement” injunction had a broader meaning for Jack.

Jack: I think that, intentional or not, I think some of the bad things, or hang ups which therapists can encounter, be encountered, is, becoming enmeshed—with the patient is one. If you lose your objectivity, as a therapist, I think you lose, uh most of your ability to assist your patient to become better.

When asked about good therapy, Jack said “it’s basically opposite of what we we’re saying. I think being able to leave out our baggage. To get a better understanding of what the patient needs, not what we need.” He restated these in positive terms and then added an element he thought was very important—self-knowledge.

Jack: I think it’s important for a therapist or psychiatrist to be able to understand some of their own meanings and motives and needs, be it through therapy of their own, or just through some self-reflection, of having some understanding when they hit issues in therapy with some of their patients that maybe they realize that, ‘maybe I’m overreacting here’ or “my reaction isn’t really . therapeutic.” Taking a look at it once you’ve stepped out of that role as therapist and being able to look at it—say “Wait a minute. What’s going on here? Why am I acting like this,” uhm would certainly be effective to help, to reduce that.

Overview of How Psychiatrists Define Therapy Practices and Therapists

The interviewed psychiatrists practiced forensic psychiatry as well as psychopharmaceutics and therapy. In each of these areas, the psychiatric focus involved a different perspective. In roles as forensic psychiatrists, their duty was to provide the courts with information on the patient’s mental health and abilities. In doing this, they were confronted with strictures of the legal system, techniques of psychotherapy and of

medicine, and the ethical standards of their profession (which sometimes conflicted with the others). When acting as a medical doctor, providing psychopharmaceuticals, they were concerned with the systemic needs of the body when mental symptoms indicated that a physical lack or imbalance might be present. As therapists, their concentration was on the agenda of the patient and how they could help the patient achieve realistic goals, or how they could help them discover which goals were unrealistic.

Ben chose to use guided imagery in the context of distraction rather than for memory retrieval. He had observed other psychiatrists incorporating the use of drugs as a tool for memory retrieval during the treatment phase. Jack, on the other hand, had used psychotropic drugs and guided imagery to access memories. Both he and Ben had also viewed hypnosis and felt that it was a useful tool, especially for forensic pursuits. These psychiatrists emphasized the importance for therapists to realize that use of these techniques increases of patient suggestibility. They note the questionability of information recovered through their use and they stress the necessity for diligence in interpreting the findings.

Empathy, rapport, listening skills, and self-knowledge are the traits that the psychiatrist attributed to good therapists. They indicated that bad therapists are those who allow their own agendas to take precedence over the clients' (e.g., pursuit of financial gain, applying their own "baggage," and act without sensitivity to their patients' suggestibility and fragility). They also spoke of bad therapists as those who breach their patients' confidentiality.

CHAPTER 7 MEMORY, SUPPRESSION, AND REPRESSION

Because of the controversy over memories and their role in therapy, the therapists were asked to talk about memories, suppression, and repression. The controversy was thought to provide fertile ground for learning about the construction of deviance in therapy. LCSW Will had clients who alleged they had discovered a memory of childhood abuse. Although he advised extreme caution and suspicion as to whether the abuse had actually occurred or whether they “will bring that up as uh something else,” his treatment would mirror that of many of my interviewees who were less skeptical:

Will: Well you’d be supportive of them. uhh with empathy. Allow them to have their feelings. You know, therapy is a safe place for people to explore stuff like that. . . .

Will: Mainly about the emotional impact of it you know, “If you start to feel the trauma again, if something” And see what’s happening with them physically. You know. If they start going through, you know.

Mike: Acting nervously?

Will: All that kind of stuff, and uh you know, just kind of be there for them and help them to experience. It’s like to unrepress the stuff and uh again. You gotta be carefully with this. You can’t just have a I mean I got some people that they’re so suggestive that I mean and not clients of mine now but, they’ll say if you suggest *anything*, they’ll run with it. They’re border-line.

He then gave an example of a psychiatrist at a hospital he had worked out who was “real big into multi-personalities.” He said the patients:

Will: They [the clients] were just more than happy to act out for the doctor, “anything you wanna see.” . . . And when they shut it

down—when he left, all of a sudden all of the personalities went away.

Mike: So you think that that was the therapist?

Will: Well, you know, he would diagnose them and they would take it and run with it.

Will: It's it's personality disorders running amuck. So, you gotta be careful with. . . . There are no cookbooks, you know, for this thing. And a lot of it is uh. . . . Again, if stuff comes out—to be there—they have a safe place to bring that stuff forward.

Will: I try to keep things: “This is my practice, you know, uh how you dealt . . . who cares about a psychologist.” I said, “I use this. I’m not the guy who goes into all that area.” You know?

Will did not probe for memories and his treatment of memories basically involved providing a safe-haven where the client could talk about *anything*, even a memory that may or possibly may not have been of an actual occurrence. Nevertheless, his statements indicate that memories of childhood sexual abuse, real or not, were not part of his treatment plans.

LCSW Larry on the other hand had a lot to say about memory, suppression and repression. During discussion of these topics, I got the impression from his frequent taking of deep breaths and numerous pauses that he was working hard to “get it right.”

The following are two brief examples:

Larry: I don't use hypnosis. I will do some (I guess it would . . . might not be) accurate to call it repressed memory work, or whatever, but I'll do some family of origin work-

Mike: You do memory retrieval?

Larry: (Breath) I have *never* set out to do that.

Larry: I will continually take people back to understanding, trying to understand why, you know. What holds the problems of the

present in place and often, it is. . . . I'll do what they call—I don't know if you've heard of it—Redecision Therapy. But I'm doing a lot of work in attachment theory and certain decisions that were . . . certain generalizations made by the self, about the self, and about the other interrelationship, growing up.

Larry also talked about his belief in, and use of, Attachment Theory, which includes operating under the assumption that people store memory episodically and semantically. When I asked if he thought that people stored memories *somatically*, he would take several noticeably deep breaths during his discussion. Examples are

Larry: I *believe* . . . that person, (breath) retains that memory as clearly as if they'd experienced it, that morning. . . . And certainly, in that *case* (and I've just come to believe that to a lesser degree, we are less and less refined in our capacity to *repress*) and so, I think I have some (breath) somatic memories

Larry went on to describe an event in his childhood which he remembered in terms of bodily factors (e.g., tasting the blood today when he thinks about the fearful incident in which a bloodied nose had resulted). When I asked him if he had an opinion on a difference in the concepts of suppression and repression he replied:

Larry: (Short intake, longer exhale) Yeah, I would. I'd probably see that as on somewhat of a continuum as opposed to being absolutely *discrete*. I guess I'd also just say out of *pickiness* that attachment theorists would shun the word *regression*, as far as therapy, and I guess in the rough sense of taking somebody back. But, they don't-

Mike: You call it a reconstruction, or . . . ?

Larry: They just see that as too Freudian, that people become fixated at certain stages and, I guess they see life as a series of attachment relationships not being stage oriented, but probably much more of a continuum. Or Freud would speak of *regressing* back to a fixed stage in which there was a particular life task to perform. Attachment theorists would make a pretty strong break with that, but I'm thinking with what you mean with *regression* is, (breath) is

taking back to a time prior, that you think still is influencing them and they think doesn't have anything to *do* with it.

Of the therapists I interviewed, LCSW Larry, psychologist Rick, and psychiatrist Jack most closely fit the psychoanalytic model. Nevertheless, Larry's discussion above illustrates that he takes great pains to distance himself from it. I include the lengthy section below without my benign words and interjections of encouragement (i.e., "Um hmm" and "Right") that were designed to indicate that I was hearing him and wished to continue his speaking turn. This tactic will also be used throughout the rest of this paper in instances when these words add nothing beyond indication of attention and/or turn passing.

Larry: I think maybe—on practical differences in my approach, which is centered heavily on Attachment Theory—things that might not be regarded as a trauma worth looking at becomes significant. Let's just say that at a time that I was humiliated and sort of vowed in my heart, "I'll never open myself up to feeling that way, again." And so, I would be continuing to talk that out, that it might be a minor thing. It didn't involve physical harm to me. It didn't involve what, for many people might have seemed too much of a loss of identity, but it became how I was going to shield myself when I feel *feeling*. And I can remember exactly where that happened, so it's not *repressed*. (breath). But I've focused on it from a cognitive point of view, and I'm not focused *in* on the sort of the identity-maintenance decision that I *had*, and so, later on I marry someone who is asking me things because she wants to call me out and know my heart and know what's going on, but I have, at a subconscious level, purposed that I am (breath) *not* going to sh- sh-, you know, I'm going to play my card close to my vest. I'm not going to do that and so, I think that some of the obstacles that need to be removed in marital therapy would not fit under the classic definition of *trauma*, and therefore get overlooked. But they are, to a lesser degree, how someone has guarded their heart from a painful outcome, and is stuck with a decision that's no longer relevant in the present. Mine is more from the standpoint of intentional limitation of attention. Yeah, you've created a grid by which you are going to interpret events and you cut yourself off

from being able to attend to other data that, say this does not fit that circumstance.

While it is possible that an element of the Hawthorne Effect (the subject's response is influenced by awareness that he/she is being studied) may have a bearing on Larry's exposition, the detail and personal level of his monologue indicate that this is an area that he had previously considered. He had come to his own conclusions (and rationalizations?) even before he became aware that this was a part of my research. He was able to use psychoanalytic techniques for discovery [primarily] and treatment [to a degree] while at the same time reducing susceptibility to negative labeling by those who believe that the suggestibility inherent in regression therapy precludes its use in these areas. Secondly, a new vocabulary has emerged that links psychoanalytic discovery techniques with behavioral treatment procedures.

Betty found that during massage sessions and during acupuncture people brought up repressed memories which were described as body memories (memories immutably and completely etched within the structure of the body even though they have not come to consciousness since the time they were allegedly etched there):

Betty: "You know, the things that they hadn't talked with anybody about..

Betty: I've heard stories from massage therapists with some people who have gotten massages where that type of stuff happens and then I've also seen it happen with acupuncture. We've hit acupuncture points that have brought back floods of emotion or memories or what have you. Though I don't think in acupuncture it's as if they're feeling the exact same feelings. But massage . . . I've heard many people talk about—I've never witnessed it, but I've heard *many* people talk about—, "Gosh as soon as we touch, you know, this one point it's like [exhale] everything returned, you know." So I've heard stories about that from massage therapists in people who have gotten massages. That there is memory in different parts of your body.

Mike: And it's complete, whole, and . . . ?

Betty: Yes

Of those I interviewed, Betty was the therapist who had most often encountered people who averred repressed memories. Nevertheless, she felt that the memories cited should be looked at with care. Her style of dealing with repressed memories was such that she did not dwell on the memory, but just let the client talk it out. She then would move them out of it, back to the coping with their present circumstances.

Betty: I mean I think someone's attitude towards life *colors* the way that they remember things. And that it *colors* the way that they recall things and that they would then tell you about them. . . . So somebody's current attitude, their way of looking at life, their perspective. uhm *definitely* colors the memory. Definitely will color how they will recall it and then how they retell it.

Betty: You know, so, they're gonna experience their trauma, whatever trauma it is, differently. And then they may relive it. They, may, re-experience it at a later date, given the newer ways of feeling and coping with the experience. So, uhm, as you get older. you may, re-experience it and then you re-integrate it in a new way because you look at it from a different way.

Mike: So how would you treat that?

Betty: I move them forward. I move them forward.

Mike: How would you do that?

Betty: They . . . they can talk about it . and then they can, talk about how it relates to their relationships now, that they're in. And then they can talk about it some more and then how it relates to their work-life now. and then, but con> but constantly bring them to the front, to the to the current time, of living and dealing with what's happening with their lives now. And see how that made them feel then and then see how they feel now and see if they're connected and see. . . . But not always go there, stay there, and blame everything then now . . .on this. I move them out of that. I move them.

LCSW Amy had not had a patient who had discovered repressed memories. The parameters of her function as a ward manager precluded much exposure to patients who might ever recovered memories. The only time she did speak of memory was in a negative way, when criticizing licensing exams which tend to preference memorization of facts over screening for sanity and actual competency for doing therapy.

Amy: Yes. But there's nobody to say whether or not you personally [as a social worker] are a nut. And if you have any business dealing with people on a professional level. Right now it is, 'what is your grade on this exam. How well do you memorize facts and, how much money will you send us, and . . . period—that's it!

Karen, the education counselor, did deal with memories. When I noted that the Ramona case had involved practices which had to do with suggestibility in recall (i.e., hypnosis, Sodium Pentothal, and directed imagery) and asked if she had used these techniques, she jumped directly to the question of what she does about repressed memories. She said that though she does not probe for memories she might open them up if she felt it was appropriate. She definitely does believe that sometimes memories can be repressed. The one time a client brought up the possibility of a repressed memory Karen informed her that that would not be the focus of her work. Karen felt that the limited number of sessions could be, and was, spent on more relevant matters.

Karen: No, I don't do Hypnotherapy and directed imagery. I'm not sure what you mean by the term. Let me put it this way, is your question what do I do about repressed memories?

Mike: Yeah that, should do.

Karen: Ye(laughs)ah, uh I typically, everything's individual. I mean that there's not one thing I do in my life, probably, that I do in the same way every time. Not even how I brush my teeth. So, I do believe that people can repress memories. I think it's a phenomenon, I just accept it as such. Do I work, to pull those out of people? I don't. .

. . . Let's see do I open it up? If it's appropriate. Am I a sleuth about them? No. No, there's a reason that they're sort of latent and I think it *can* be harmful. I mean, if it's *relevant* I work with it, but . . . >

Mike: How would it be relevant?

Karen: < and since in *all* the years. . . . Oh, oh, wait, let me just finish. In all the years that I've done therapy, I think that only one time did somebody come to me and say, "I was lying down the other day, and the ceiling fan was on. And all of a sudden I got this . . . inkling of a remembrance of being at my grandfather's, and I just had the feeling that something happened there. And I don't really know what it is but I want to find out." And she was *wondering* about had she been sexually abused by her grandfather . . . and she really wanted to go for it, she really did, she wanted to uncover it. And I worked with her, for as long as I felt comfortable, and told her that *that* would not be the focus of my work and that I wasn't going to do hypnotherapy with her. And that it's not in my area of expertise. But, I didn't necessarily, I mean she was very functional in the present and I just didn't believe that there was any benefit for *that* particular person to, you know, to become an archaeologist into her past about that. Now that might've, had she presented some other time (her) life. . . . I wouldn't say that I would never ever work with her on that, but for the reasons that she came in, I don't think she came in just to talk about the ceiling fan, I mean. I don't remember whether we worked on other things first and then that came up or whatever, but it really. . . . In relatively brief psychotherapy, you have to make choices. I mean, we had a limited time in sessions. We could work together and we just didn't think it was *the* most relevant thing to her. And it proved to be *not* the most relevant. She kind of decided "Okay, maybe I don't have to live with that." If it came up again some other time and she wanted to explore it, heck. . . . I don't particularly appreciate the viewpoint of psychologists and psychiatrists and anybody else saying that they're always totally fabricated. . . . I don't believe that and I think that there have been some harmful things written in my profession about the non-validity of repressed memories.

She was aware of a difference between suppression and repression. I then asked about PTSD (post traumatic stress disorder). Karen believed that PTSD can be a result of having been sexually abused or having suffered some other extreme stressor(s). She said

the PTSD from war experience was the not the same as from childhood sexual abuse.

She also said there were other stressors, such as that involved in writing her dissertation could lead to PTSD.

Karen: Nope. Sometimes people who have been in sexually abusive relationships *do* develop post traumatic stress disorder, but I don't know that I can make a connection. . . . Yeah. So yes, I think sometimes people do develop post traumatic stress disorder, as a result of whatever traumas they've suffered, and granted it was first written about in terms of people in World War II; but, there are lots of other reasons that people develop post traumatic stress disorder. I think I did about my dissertation. (laughs loudly) yeah (continues laughs). Just *doing* one.

Gail spoke openly and in depth in response to probes on topics that she knew, but would not speculate about less familiar ones. She would continually use techniques which pass her turn to speak or would directly say she did not know about that subject. Repression was one of these topics. She does not probe for memories, does not use regression therapy techniques, nor does she use treatment techniques that might lead the patient to be suggestible or consider themselves to be a victim. She is very much in favor of responsible medication of patients and works with a pediatrician (the director of her clinic) who performs the functions of a psychiatrist.

She had previously worked with a number of patients who had post traumatic stress disorder (PTSD) from war experiences. On one of the few occasions that her thoughts and feelings on a topic was not concise and clear, she linked statements about that PTSD to the fact that she had worked with children who had been sexually and physically abused and also in a support group composed of women who had been sexually abused. She left moot the question of whether she believed that these were the same PTSD. While interviewing Gail, I noticed that she would answer any question I

asked fully and thoughtfully, but she did not volunteer any information which was not actually asked about. There was one occasion when she went against this practice—she voluntarily expressed her concern about third-party providers (i.e., HMOs, Medicare, and insurance companies)—that they have produced a greater impact on the institution of therapy than even the fall-out from the repressed memory polemic.

Gail: HMOs and Medicare, and I think insurance companies, try to prescribe what they think is mental health care and what should be adequate for different kinds of problems and how to decide if something is effective or not, or what they'll pay for, and it [sic] certainly understands, coming from a business aspect, that you try to make things really quantifiable, but I think it's had much more of an impact on treatment than regression.

Rick felt that memories were important, but “One of the things I try to teach my clients is not to be a slave to their pasts.” He would say to some clients that it “only effects you to the point that you're still keeping it alive . . . which of course is memory.” I asked him if he used the Mental Status Exam (MSE), a cognitive function exam that includes testing short- and long-term memories. He had administered it when acting as a consultant for hospital long-term care treatment, to provide a “baseline.” However, he said he did not use it with his own private clients. His clients were either able to pay for the sessions or “had looked far enough ahead to get insurance to pay.”

Rick: By definition that means they're, typically functioning at a level, to be able to hold down the bills and yadda yadda yadda. That already tells me a lot about what the mental status exam would tell me [laughs]. . . . They're able to do you know the executive planning. . . . They're able to do short-term and long-term memory. They're able to do, uh simple comprehension and language skills and all the . . . a lot of the stuff which is in the mental status exam. So, uhm, that . . . the MSE is getting, very basic, core, cognitive processing functions that. . . . It may be a little bit sloppier but that I can almost, assume as a matter of course

that ‘there, walking in the door, is a private-paid client. They’re [The elements of memory are] in place.’

Rick had not had a client averring repressed memories although he had hypothesized about it. He carefully phrased his answers to the probes on repression. This was indicated by his shifting perspective in the citation below. He began by qualifying his belief in repression with the preposition “if.” Then he said that he would not be dealing with whatever was repressed [the memorable objective reality of the past]. Then he indicated that it was important to look for a memory which is itself a part of the client in the present moment, if only in that it is being kept alive [whether of actual happenings or not are of limited importance—important is that it is being kept alive]. He would look not at the memory but at *the present reality of its being seen as repressed*. Whereas the literature favoring regression therapy indicates that repressed memories can only be brought back with the help of a professional that the client trusts and provides a comfort zone in which the memory is discovered, Rick felt that the memory would come back on its own and would do so because of *discomfort* in life. Key to his looking at repressed memories is that “They’ve brought it to you.”

Rick: If classic repression exists, uh and if it exists in a client that I was seeing, by definition, I would not be dealing with whatever was repressed because what’s uh, what’s at issue to me is what you have alive at the moment and that’s that. You’re keeping alive and remembering at the moment you’re dealing with. . . . So by definition, I *wanna* be going looking for that which is repressed. There is, there’s a few inherent *implications* of that and apparent assumptions uh that it’s something that’s really important. You get uncomfortable enough, it’s going to come back on it’s own.

Rick: Certainly. and that’s part of how it will come back on its own. that’s> as you confront that mind-set, and, not going You get this mind-set “Oh, well you were obviously, abused.” You get this mind-set “Well what’s logical about that mind-set, why is it

important for you yadda yadda yadda. Why, don't we get rid of it yadda yadda yadda." and in the process, uh if it's salient, saliency and impressive, they'll go "Well, actually I go to this mind-set *because . . .*" and then you're off to the races. But they've brought it to you.

Zoe described herself as an empiricist. She did not believe that enough supportive data existed on regression therapy to use memories as an intervention technique.

Zoe: I'm an empiricist. Basically, if the data isn't there to support that a technique is effective, then, I don't think that's something that we should be doing as a profession. And as far as I know, there isn't a . . . there isn't enough data in support of that being an efficacious intervention to support that being done.

She went on to talk about repression as a defense mechanism that cannot be tested. From what is known about memory and from her own clinical experience, Zoe felt that people do not forget being sexually abused. She felt that rather than repression that dissociation¹ might be what is occurring in cases where repressed memories are alleged. Where repression involves not being able to remember something or things which happened, dissociation for Zoe involves not remembering because the individual is overloaded with things to remember and is episodic rather than continuous. Her explanation of this distinction follows:

Zoe: I guess the other part> like these regression, therapies are, repressed memories, things. uh. Repressed memories are (we just talked about this in class the other night [Zoe teaches at a university]). Repression is a defense mechanism . . . we can never, say does or does not exist. In reality it's an untestable . . . it's an

¹ Dissociative Amnesia (formerly Psychogenic Amnesia).

A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance . . . or a neurological or other general medical condition . . . (Hales, Yudofsky, and Talbott 1994).

intangible sort of thing. And I'm very uh, based, on what we know about memory. These repressed memories should not be, especially repressed memories of sexual abuse. . . . Uhm. Although I've worked with a lot of sexually abused, children—I have extensive experience with that—uhm, which maybe even further my feeling, but not from an empirical stance but just from a clinical . . . observation stance. Uhm, People, for the most part, do not forget that they were sexually abused. It's, a *huge* part of their lives. I think you might see dissociation occurring.

I then asked her about suppression. She said that in contrast to repression that suppression is a conscious choice to not think about something and is tangible enough for consideration. When I asked her how she treated memories or if she did, she said that she did not look for memories.

Zoe: I mean I ask a client for their past, but, you know, “What was your childhood like?” or Your relationships with your parents or significant people in your life but, uhm. . . . I'm looking for more, maybe, present day problems. And I look to see how the past may have influenced that. Especially in terms of interpersonal relating . . . but, uh, I don't find the need to dig terribly much. [laugh] There's usually plenty, right there in front of you. That you don't have to dig.

I probed whether she had ever had a client averring repressed memories and she cited a case she had supervised with an intern. When I asked how she handled that case she said:

Zoe: Well. I think what happened is the client, only came for a couple of sessions, and so it was kind of a moot> We didn't really get to bring that to fruition to see what would come out. But, in part what I wanted the supervisee to do, was to determine, what context, that this memory came back to them, what, how did . . . when did they first become aware of this, memory.

She thought what was happening in recovered memory therapy was that “some therapists are *seizing* on anything that remotely resembles survivor status. And, I think they are *convincing* clients that they were sexually abused. When, in fact, I doubt it. I

doubt it.” When I asked what should be done about therapists who do this, she said laughingly “Oh lordy. [Sigh, laugh]. Hang them by their toe-nails [laughing]” and then more seriously:

Zoe: I guess the deal is that, I think a lot of time those therapists are people who have had . . . who are emotionally unhealthy themselves. And they are practicing in that state. . . . I heard stories about someone who practiced in the town I used to live in. Uh, hated men. And every client she had who had a man in her life, the man turned out to be the seat of all evil and . . . et cetera. Uh. And I think it’s kind of the same thing with these uh people who bring out these. These are either people, I think, who believe that everything that ha> *bad* that comes out of a person, came about because of sexual abuse or because they were sexually abused themselves and they see that in everybody. I don’t know what is happening but. . . . In general, this whole recovered memory thing, as *much* as I’ve worked with sexually abused, children and adults, survivors, [clap]. I’ll be darned if any of them have any [laugh] problem whatsoever, being cognizant of that.

Zoe supported the finding of the literature review that the topic of repressed memory is *hotly* contested. She cited an occasion when Elizabeth Loftus [first president of the American Psychological Society] was asked to present her research on memory to a regional psychological conference. The Repressed Memory Foundation “contacted, us, threw a big fat fit—that we weren’t balancing by presenting the other side of the debate.” The conference organizers had decided that there was not a comparable level of research offered by the foundation. The escalating nature of emails and other contacts made by an individual from that foundation resulted in the conference actually hiring security. This was the first and only time that particular regional conference had felt the necessity of providing security.

Psychiatrist Ben in his primary role as a geriatric psychiatrist usually dealt with memories in a different context than the social workers and psychologists. Some of his

clients' problems were that they did not have memories except for old memories. Some would conceive of themselves as living in the time of the memory rather than in the present. Although he did not do a lot of therapy (dealing more often with forms of dementia) he had experience and opinions on regression and memory.

Ben: I don't use it. I don't use it much. You have to understand, too, that I don't do a great deal of therapy, given my role in what I do right now. When I encounter regression it is usually the patient spontaneously elects to regress, and it's often debilitating for them and counterproductive for them. and so I'm usually trying to get them out of regression. So it's almost against my nature to want to induce it.

Mike: So if someone, says "I have this memory, I need to talk about that just popped up." . . . In other words, you don't solicit memories?

Ben: I investigate areas that the patient has concern about. And if it's a past memory that they've recently uncovered, I'd certainly discuss it with them and look into it. I wouldn't purposefully uh have the patient uh try to regress themselves in order to recover new memories.

I asked Jack what he thought about using memory as a therapy tactic. He thought that memory had pluses and minuses.

Jack: Uhm. It has it's pluses and minuses. Memory is obviously going to be one of the cornerstones I think, because it's—Unless it's documented somewhere—but, uhm I think that's going to be a difficult thing a lot of times.

Although Jack said that repressed memory syndrome was not in his area, memories of the past were important enough for his therapy for him to advocate memory retrieval methods (see Chapter 5, 'Good' versus 'Bad' Treatment Practices). He related his experience with a woman who had retrieved memories of childhood sexual abuse while under the care of a counselor.

Mike: The repressed memory syndrome, what do you think about that?

Jack: Uhm. That's not my area of specialty.

Mike: Have you ever treated, a patient who had memories that fell within this.

Jack: In, kind of an ancillary fashion. One of the forensic cases that I reviewed was a patient that, I wasn't in—involvement in that aspect of the case, but that they were dealing with some repressed memories, that actually had been recovered, and .

Mike: Were they recovered during therapy?

Jack: Yes. And that was the issue (laughingly) *actually*. The best of my recollection it was a patient that had . . . a history of abuse as a child.

Mike: An unrecorded history?

Jack: Unrecorded history of abuse as a child. and as an adult. began to experience problems in relationships, and things like that which led them to pursue therapy. During the therapy (I don't remember how long they had been in therapy. uhm and I can't . I don't remember the time line, but somewhere in there) it started out as dreams, if I remember (breath exhale), that started coming back to her and she was wondering during therapy with a therapist whether these dreams were dreams or whether they were recollections of previous of experiences, because it was her, as a younger . . . as a child.

Mike: Was the therapist doing dream analysis?

Jack: No. er at least according to her, they hadn't. They were talking about their dreams a little bit but not in any kind of formal, uh dream analysis. Uhm and then, at some point during there, she s>, the memory started becoming more intrusive images. It started happening when she was awake uhm and then eventually, I think, they started focusing in on those. Not just the dreams but actually the memories of the intrusive thought that were starting to . interrupt her day. And then eventually led to these uh recollections of what these rep> what she called, and the therapist had identified as repressed memories.

Mike: What kind of therapist was she?

Jack: All she told was she was a counselor. She was . . . I know she wasn't an M.D. but she was some sort of mental health counselor.

Mike: And so. How did you get involved with her.

Jack: We were viewing a case from, from legal charges that she had had, subsequently. It's kind of unrelated to that but, as part of my evaluation I will ask them about, previous psychiatric history of counseling, and things like uhm and that's when she started opening up about all this. And so I just went into as much depth as she was comfortable so I >

Mike: What do you mean by legal charges?

Jack: She had been charged with a crime. It was unrelated to any of the memories or anything like that but, she had been arrested for a crime that she had allegedly committed. uhm and then her attorney had brought her to us, to evaluate her for competency to go to trial.

Mike: Okay. And as part of this you contacted the mental health counselor?

Jack: No, this is strictly on her [the patient's] reports and in her recollections of what happened.

Mike: And how. I don't understand the connec>, how you got these or whatever, you know. "She had this mental health counselor and then uh uhmm then at some point, I guess later, you were>

Jack: Right. I think it was just . . . a few years, two, three, maybe four years after this whole, the issue of uhm when she and the therapist labeled them as recollections, or repressed memories that had been . . . recollected. uhm Somewhere after that was when the alleged crime committed, was committed. And that was when they sent her to us. It was two separate issues, but just because when she came in to me I try to do a thorough exam she was . . . that was one of the issues that came up.

Mike: And uh did you ask her about this? Did you do a discovery on this issue.

Jack: Some. I tried to do some. Just based on, because of the fact that if she had these repressed memories, one of the issues that might come up would be post traumatic stress disorder. And so that would certainly have relevance to any kind of crime, perhaps, that she may have committed. So I did ask her about it.

Jack's experience with the patient originated after she had been in therapy a few years before. She had recovered the memories with an unknown therapist at that time. His function was to find out whether the client had post traumatic stress disorder for the court. His examination came from a paradigm in which he was not responsible for the patient's therapy, but to reporting her mental condition to the court.

M.S.W.s on Memory, Repression, and Regression Therapy

The clinical social workers' experiences with averred repressed memory and suppressed memories ranged from no contact (Amy) to multiple contacts. Of those who had contact with clients/patients who did aver these memories, each would provide the client/patient with a safe place for talking about them but would at some point acknowledge that the event the memory evinced either did or might have happened, but that circumstances of the present should not be held hostage to those memories. Instead, the therapy of the social workers dealt with the practicalities of mental health within the present milieu.

Ph.D.s on Memory, Repression, and Regression Therapy

Gail had said that she does not look for memories or repression and does not speculate about what she would do with a patient who mentions a repressed memory. She does not use techniques which would be likely to discover repressed memories. Karen does not focus on memories. On the one occasion when repressed memories were brought up, she concentrated on present problems rather than the repression.

Although psychologist Rick thinks that memories are important, to date no client had averred repressed memories to him. He hypothesized that if or when a client brought repression up, he would look at what is repressed. At the same time he revealed that

therapy in relation to the memory would be approached as something that the client is now making a problem. He would look at its importance for the client and would not have the client confront the alleged perpetrator. Instead he would have the client confront the memory as a problem that needed to be taken care of.

Zoe said the question of whether there actually was repression was something that could not be supported by data. In the only case she had been involved in, she was more concerned with the context in which the memory first came back and probe why that memory, true or false, occurred to effect the client at that time. She felt that some therapists are seizing on anything remotely resembling survivor status and are convincing clients that they were sexually abused and had forgotten. She gave an example of a therapist she had known who was a misanthropist and related anything bad that was happening to the women under her care to something a man (or men) in the client's life had done to the client.

M.D./Ph.D.s on Memory, Repression, and Regression Therapy

Psychiatrist Ben was concerned that regression is often debilitating and counterproductive for his patients. In fact when it is broached, it is because of spontaneous election to regress and usually Ben tries to get them out of regressing. He does discuss any concern a patient has about a memory and would look into it, but would not try to get the patient to regress to recover new memories.

Jack did think memories were an important tool for therapy and in some cases he would advocate memory retrieval. However, the only case he related was one in which another therapist (a counselor, personally unknown to him) had worked with a patient and uncovered memories of childhood abuse. His function in this case was to find out

whether the patient had diagnosable post traumatic stress disorder for a court. As such, he was not responsible for the patient's therapy. He was just trying to do a thorough exam on relevance for the court and asked her about it to see if it had any relevance to her competency for trial on the alleged crime.

CHAPTER 8 ACCOUNTABILITY AND ETHICS

Amy had put Accountability and Ethics as one of her five choices for topics of discussion. When I asked her about it, I was surprised that her response was directed at *patient* accountability and empowerment rather than therapist accountability. I questioned

Mike: While we're on accountability, uhm, you talked about helping or insisting upon the client becoming accountable.

Amy: Umhmm.

Mike: What is the accountability of the therapist or the counselor?

Amy: Not to foster dependency . . . >

Mike: Okay

Amy: > from clients.

Mike: Okay. What about. So they have an accountability to clients. What about to society or to peers or . What kind of, you know, accountability do you have to them?

Amy: To adhere to the highest standards, not to uh to abuse the patient's rights or privileges. A resource that that can be talked through.

Mike: Okay. In terms of ethics, I've looked at NASW, I guess that's what it is, uh statement on ethics and, incidentally, what you're doing now is, I think in the preamble, is "you will provide public information" >

Amy: Umhmm

Mike: > and that sort of thing. So it's appreciated.

Amy: Umhmm

Mike: I was glad to see that in all the therapy disciplines

Amy: Umhmm

Mike: And uh, ethical standards—you've given one, not to sleep with your client or to uh in some way abuse sex with the client.

Amy: Umhmm

At this point I decided to move on. In addition to not fostering dependency on the therapist, she had spoken of the injunction to not have a sexual relationship with any of the therapist's clients. Near the end of the interview, Amy spoke of her training and mentioned that, among others, it had covered ethics, "but even those were pretty much essays."

Perhaps Amy's position within the medical team (she needed a physician's approval for many of her interventions) and the case manager perspective of functioning as augments of patient welfare sheltered her from having to consider *therapist* accountability and ethics. She was the only one of all my interviewees who interpreted this card to refer to *patient* accountability. From her responses, she revealed that she had not considered the ethics portion of the card.

With Larry, the interview was almost half over before I asked him what the card "accountability" involved. This appeared to mark a transition point in the interview. Up to that point Larry had been leaning toward me with his elbows on his knees. He took a deep breath and sat fully back in the comfortable-looking office chair and stayed in that position for most of the rest of the interview—as if on guard. He said that part of the reason that he partnered with other therapists was "to have somebody to bounce

something off of." He used other members of his office and even outside members when he got into situations where "‘I’m not sure how this is playing out’ or ‘I’m not sure what my role is in this.’"

He again mentioned bringing in a lady in a church ministerial position when confronted with the situation of the woman who wanted to recover memories about a sexual abuse that happened in her youth. After following the discussion into other areas, I noted that he had talked about accountability to clients to "give him [sic] the best therapy that works for him." I then asked about accountability to peers. Larry: "Well, in my initial accountability to peers is my partners and we meet every other Wednesday for an hour." He talked about the arrangements that he had with his business partners for several minutes and described the Wednesday meetings and consulting:

Mike: What's the nature of your partnership meeting?

Larry: It usually goes from details of the financial aspects of the business and so forth to getting more into therapy issues. . . . Three therapists will consult, for example to do that, and in the office. . . . The reason we set it up that way is in the off-weeks that often any two or three of us who are in the mental health field will meet and discuss therapy issues.

Mike: Uh hmm.

Larry: And I brought them in just to check blind spots for me. I recently told a certain very complicated or conflict resolution issue that involved three generations. I brought therapists from the outside to review my written work and to interview the parties because I felt stuck. And so there's that kind of accountability of submitting your work to somebody else to tell you if you're missing something and hoping that they find something because (laughs) you want to be unstuck more than you want to be defended. (laughs).

We were nearing the end of the hour allotted for the interview and I had related the gist of the Ramona case and its ruling effecting accountability to third-parties when he mentioned that he had the two ethics classes (one in 1995) and that this case and topic had probably been discussed but he did not directly remember either. He did have this to say regarding harm to clients:

Larry: The idea being that therapist is sort of a co-author in shaping the client's view of life and if that emerging view of life can be proven to harm someone else, the therapist becomes culpable in that process.

While noting that the therapist is involved in shaping the client's view of life, Larry said he guarded against the possibility of counter-transference (unconsciously projecting his own emotions, thoughts, and wishes from his past onto the client's personality, "thus expressing unresolved conflicts and/or gratifying the psychiatrist's [sic] own personal needs" (Scheiber 1994, 218). When I noted that the standards of ethics for the different disciplines were very similar, he replied:

Larry: Yeah. But that's ethics. Practice—there are very different flavors in practice. In my field, the NCE, the National Counselor Exam, I think, is administered to all three disciplines within Line Statute 491 that we're under, and that seems to provide some common thread throughout.

Overall, Larry's remarks showed that accountability was an area that he had previously considered. He talks of a "balance" that is to be struck between ethics and the practicalities of doing therapy, which apparently hinges on doing one's best and refraining from doing harm. The way he becomes accountable to his clients is through a system of backing up his decisions with advice from others and the way he is

accountability to his therapy and business partners is through taking advice and offering advice to his team members.

With Will, toward the end of my interview the subject of Accountability and Ethics came up. Will related these topics to injunctions from the state licensing board.

Will: You know, you have a state board--there's a certain thing. That's legislated and uh there> I was empowered by the state and it's also it's empowered to uh be punitive if necessary, you know, to sanction. and uh . . . >

Mike: Yeah. I'm aware of it. In fact

Will: > and all that. But it regulates the ongoing uh, professional life of the profession, if you will. You know. How much educ> continuing education you need.. Uh, the ethics. The ethics are legislated. and uh so, you know, it's it's . raises the level of accountability and, empowers the profession. The more you've got of that the more powerful you, you know, you are.

Being accountable to the licensing board was advocated by Will, but he also returned to the subject of the responsibility of a therapist to end the therapy sessions when there is no further improvement and not lead the client into expensive future sessions.

Will: You know people are ethical and up front that that would you know that: "We've done all we can do," or "I don't see any. . . . Is this really working for you?" I can give it to you simple: "Is it working for you?"

Of the social workers, Betty appeared to have considered these topics the most. Early in the interview she had described the need for a good therapist to be moral and ethical. Much later in the interview she spoke of the words that a careless therapist can use, which are at the wrong time or which are the wrong thing to say to *that* patient. Betty often referred to the responsibility of therapists to avoid carelessness and

negligence—to be their “best” possible (totally “present” for the patient). She also contrasted the responsibility of the clinical social worker to that of the other mental health counselors to connect the patients to social services.

Mike: I've noticed that many of uh . that, several of them which I was looking through the DOH licensing, would be licensed as both if they were mental health counselors.

Betty: Yes.

Mike: I guess for the mental health counselors cause, they wanted to accentuate the fact that they were doing actual individual therapy more than uh the uh social, uhm services >

Betty: Yeah. Yep, yeah.

Mike: > element of

Betty: Yep, connecting them with resources and you know, they're doing some of the concrete services as opposed to some of the inter, interactional, you know, therapy.

The subject of accountability and ethics did not come up in my interview with Karen until we were talking about certification and licensing. For her, therapists are held accountable by "being aware of the legality and the ethics of my profession." When I asked her if it forced her to be aware, she said that she would anyway:

Karen: But its another reminder. I'm very aware that people can complain to the licensing board or file suit against (voice breaks) me. So hopefully I'd be an ethical practitioner anyway, but being held accountable by law and by license probably helps that, even more.

When she was asked what is the one thing that a therapist must do to be a good therapist, Karen had said, “To be ethical . . . We can approach things ten different ways and then we can all be good or we can all be horrible.” When she was asked about the

line between good and bad practices near the end of the interview, she said, “The line is the legality, and hopefully the legality and the ethics are at the same place.” When I asked her what would be the minimum that would be necessary for a treatment to be above the line, she exclaimed, “The law!” The only ethical principles which she talked about in particular were doing no harm to the client, the legal duty to report abuse, and the legal duty to warrant (i.e., to report specific intentions that are a specific danger to a specific person). Several probes failed to ferret out what in particular a therapist should be accountable for and what ethics in particular she referred to when she said “the law.” She said that in a particular situation that she thought might involve an ethical or legal question, it is her duty to talk with people whose job it is to interpret the law (i.e., colleagues, supervisors, and then the university attorney).

I tried a different tack for this topic by asking her if she knew of persons who did not live up to the standards of good practice. Then she expanded her definition to these specifics: poor judgment in prescribing medications and crossing the boundaries of friendship and therapy (i.e., sexual relationship). Her remarks on confidentiality stressed that the client holds the confidentiality and that the therapist does not. She stressed that she uses the protective measure of always recording her practice and never writing a case note without remembering that they may be used in court someday. That her interest was in the legal arena rather than the ethical is shown by the fact that she used the word “law” thirty times and the word “legal” three during the interview.

Gail picked the accountability and ethics card to discuss effectiveness of treatment, assuring worth of treatment even in terms of payments made, following-up the

treatment with home awareness, partnering with peers to make recommendations, and helping the client to achieve maximum input in their lives.

Gail: When I picked that card I just thought about that in the sense that I think of law. I went to an insurance conference last week, and we just really tuned in to feeling like you have to make sure that you're treatment is effective and worth while, and watch what your patient's paying and, and aware, because we do treatment. We're very sensitive to that. Especially in my area a lot of psychologists will do evaluations that don't necessarily do a lot of following up with families at home (who are) somewhat implementing treatment recommendations. And so I think, discipline accountability. Even partner with someone that wants you to make recommendations, helping maximum input into their lives, and, with this school even when we're not counseling. So, I was just tuned into that since I've been here. That's one of the things I feel proud about, about my work here, is that we have the ability to do that.

Rick said that a therapist is accountable to the client, who is the boss and consumer, except in *Tarasoff* kinds of situations (duty to protect). I asked him about religious ethics and professional ethics. He cited a concept, which he believed from Catholic thought, which covered this for him.

Rick: “The truth cannot contradict truth. Whatever source it’s coming from.” So, good sciences, good ethics, good religion, good-anything, eventually leads the same place

Rick: Misunderstood. If there appears to be a conflict, between, two sources, of truth. -got something wrong with one of them. You know?

Mike: Yeah

Rick: You know.

Mike: yeah

Rick: So, you either misunderstood, the theology or, you misunderstood, the ethical principles. Uh and that’s—I don’t try to.

Having said that, Rick mentioned that he was not a member of the American Psychological Association “precisely because of their ethics.” I asked about the American Psychological Society, which includes APA members, but is more research—oriented. He said he was not a member of any of them. His problem with the APA was that

Rick: My problem, in short with the APA is, that, . . . like far too many other professional organizations, they stray *way* beyond, their areas of competence. And, get into things where, they, should not be speaking. And then, uh regardless of, abortion, regardless of the abuse on abortions, whether you’re pro-life or pro-choice, the APA shouldn’t have a position on that, you know. . . . And, you know, the APA would be a lot more effective if it concentrated on what it does, instead of trying to morph into some type of political activist organization.

Zoe noted that the ethical standards of therapists are similar but not necessarily in agreement to the level of staunchness to which she holds the injunction against entering into a social relationship with a client “Until death you do part.” She had ethical “concerns with suggestibility—to be “straight forward” with the client and refraining from using suggestibility to suggest things that *you* think are right for the client. She felt that the ethics of confidentiality should be secondary to protecting the client from self-harm or harm to others. She was also glad that every two years four hours have to be in the ethics or forensic area. Finally, many times she spoke of the ethics of staying within your realm of expertise in therapy gained through formal training and your supervisor’s experience. Zoe related, “ I think it’s ultimately the training programs . . . [educators] should take more responsibility for screening out people who are psychologically unfit to serve as therapists or counselors.”

In his role as a forensic psychiatrist, Ben had encountered therapists who "have crossed the line—taken advantage of their therapeutic role in sexual ways." He acted as an evaluator and sometimes sanctions were administered, including loss of license to practice and even loss of affiliation with the local medical board in psychiatry. While it was his impression that it would effect licensure in other states, even this psychiatrist, who was part of a training program for psychiatry, was not sure.

When I asked if he had ever reported another therapist for breach of ethics, Ben said that he had not. He said that in one instance he had considered doing so in a confidentiality matter, but had not.

Ben: I think if you talk to any clinician, they know of people that have done things that they shouldn't and have . . . and haven't really been reprimanded sufficiently and they're still engaged in those activities and you know it's a sour taste in everyone's mouth. And at the same time you don't want an outside organization you know imposing it's will on, on you. You want to keep your autonomy intact.

When asked about accountability and ethics, Jack spoke of stepping over the line with some therapy practices.

Jack: Right. There's probably no great black line but (snort laugh) I, in general . . . again, very bad to have any kind of relationship with patient, or patient's direct family members at any point. Just given the nature of what we do in psychiatry, it's just too. . . . In a relationship the idea would be for an equal balance of power. And I see that if a patient has come to you in the doctor/patient relationship, be now or ten years ago, that balance of power has been tipped and it's not even.

Professional ethical guidelines prohibit a relationship with a former patient. This involves being available as a therapist for the future and not providing conflicting

messages about the therapy of the past. From his psychoanalytic perspective, Jack's embracement of the prohibition had a logical element as well.

Jack: By nature what we do is talk about how past relationships and experiences that are affecting our current situation. And so I don't see it as fair for us to say 'Yes, what happened to you as a child from your parents is affecting how you act now, but what you and I went through ten years ago isn't affecting you, right now. That it's not.' . . . [It] sways your decision making. So I don't see that as a fair exclusion. So I generally feel there's a lifetime

Jack felt that there are a number of practices which a therapist or a physician can do that are bad practices. Exploiting the patient for physical or monetary gain—creating dependency. Another was neglect of issues which would help the patient. Although he did not use the word “agenda,” he spoke of applying the therapists own “baggage” to the patient. He also was concerned about breach of confidentiality but recognized that the new climate that required reporting to HMOs and insurance had created a “tricky” issue.

Jack: For example having a patient continue in therapy when you feel like you're not really improving that patient.

Jack: I have run into patients, and physicians, psychiatrists, that will continue patients in therapy, even though they are not really doing therapy and it's. . . . They've almost kind of turned the tables and they're—they've created a dependent situation. So the patient is almost dependent upon seeing the psychiatrist. So they know that they will continue to come.

Jack: I think neglecting an area, that, would help the patient uh because of some of my baggage. that I bring into the therapy room with me. For example: one of the issues that always seems to come up with some of the residents that I train, is sexuality issues. If a patient comes to them and is having some issues with their own sexuality . . . the example that's always, brought to mind is somebody that has been married for a little while and is now thinking that maybe they have some homosexual tendencies. They come to therapy thinking that they'll fix this. that they can just get through this and get rid of

these crazy thoughts. Well, that shouldn't be the goal of the therapist. The goal of the therapist should not be to get rid these homosexual tendencies. The therapist needs to have a thorough understanding of that patient. That doesn't mean that every patient that comes to us is going to become a homosexual, but, it means that you need to talk to the patient and find out what it is that they actually. . . .

Mike: Where they fit?

Jack: Exactly. Where they actually belong and where they feel like they belong. It's not what I think they need to do, it's what they think they need to do. So I think—be it through omission, voluntary omission, or from a lack of knowledge—I think bringing our own baggage into the therapy room and then directing our treatment. I think that you are allowing your own personal beliefs, to interfere with what you're trying to do in terms of helping that patient. They don't live by our code. Nobody lives by my code except for myself and so it's unfair.

M.S.W.s on Accountability and Ethics

The responses of the LCSWs to the subject of accountability and ethics was interesting in its scope. Amy was concerned with helping patients become accountable for themselves. She did not have ready answers to probes about therapist accountability and virtually ignored probes on ethics of therapy practice. This topic appeared to provide a transition point in the interview with Larry. His change of posture and responses suggested that he felt that this was an area which required caution in his responses. He introduced the subject of [what I term] peer review. Will provided two directions in his responses. He was very much in favor of attention to the state board and was adamant about the responsibility of the therapist to put an end to therapy sessions when there is no further improvement. Betty, on the other hand, appeared to have considered this topic in some depth. She referred to it in several places during the interview before and after

being probed about it in general. She included referral of the client to sources of help outside the therapy sessions as a responsibility of the therapist.

Ph.D.s on Accountability and Ethics

Educational counselor Karen had fit ethics and accountability within a legalistic and ethical framework. To be a good therapist, to determine whether therapy practices are good or “bad,” or to determine where the line is between good or bad treatment—all were determined first by the law and then by the ethical standards of the professions.

For Gail effectiveness of treatment, worth of treatment, partnering to ensure being as accountable and ethical as possible, doing follow-ups to ensure treatment was effective and enduring, and helping patients achieve maximum input in their lives were all ways that ethics and accountability were practiced. She did not refer to accountability to the law. She was concerned with accountability to patients and to her clinic coworkers.

Rick talked about being accountable to the client and to those who might be harmed by the client. He was also accountable to his religious beliefs. He felt that the national organization, the APA, had transcended the ethical mandate of therapy and was intruding in moral areas where it did not belong.

Zoe spoke of the injunction against entering into a social relationship with a client in perpetuity, guarding against client suggestibility, being straight forward with the client, maintaining client confidentiality unless self-harm or harm to others might ensue, staying within ones realm of expertise in therapy, and keeping up with the latest techniques and standards of ones discipline. She also mentioned the accountability of the discipline

training programs to take responsibility for screening out people who are unfit to serve as therapists or counselors.

M.D./Ph.D.s on Accountability and Ethics

Ben spoke of the lack of sufficient sanctions for therapists. He noted that therapists who should change their practices have not. Jack felt that exploitation of the patient in any way and neglect of issues which would help patients were of major importance. He also spoke of the ethical problems related to confidentiality due to the new social climate that therapy is confronting.

CHAPTER 9 LEGAL ISSUES AND THERAPY

The attribution of deviance, whether of particular therapists or of treatment practices, is manifest in changes in the ethical standards and in the imposition of laws that affect the procedure of therapy. This is often a reflexive process, but recently, laws are influencing therapy practices more than practices are leading to change in laws. Forces outside the institutions of State and Mental Health have upset the balance. One of these forces is the public exposure of the fact that psychological theorists are engaged in a polemical disagreement about repression of memory and regression therapy. A related force is the drive to codify heightened ideological concerns about child abuse. Combining these two forces became one of the main thrusts for the implementation of ground-breaking legal rulings which are now in some ways effecting the practices of mental health providers.

My research focuses on three legal issues: licensure and certification of therapists; the *Ramona v. Isabella* case (which first provided for therapists' tort responsibility to third parties); and the federal law mandating the reporting of suspected abuse, first enacted in 1974 [Child Abuse Prevention and Treatment Act (CAPTA), (P.L. 93-247) and last reauthorized on June 25, 2003, by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36)]. Additionally, the subjects are probed regarding any other legal issues that they might consider important for their practices or for therapy in general. While referenced by name by only two therapists, the *Tarasov v. Regents of the*

University of California case (1976) (which provided for therapist liability in cases where possibility of harm from client has been revealed during therapy) was the only other case which was mentioned.

I was interested in how much vulnerability therapists felt from the new legalities which were affecting many of the therapy practices, as outlined in professional journals, and that often have been associated with regression therapy and repressed memories of CSA. One of the criteria for potential interviewees was that they had been certified or licensed since the *Ramona v. Isabella* case in 1994. As such, they were among the first cohort of therapists that would have to consider the legal ramifications that it entails. I was interested in discovering whether the therapists had done anything in setting up their practices that was directly or indirectly related to these legal developments.

Reflexively, I was also interested in how therapist attitudes, reactions, and innovations, influenced by consideration of the legal ramifications, might in turn possibly act to influence further certification, licensing, and legislation changes. The legal response to the discourse on repression and regressive therapy has already played a role in changing the language of recent state laws on tort (i.e., for the first time recognizing third-party lawsuits against therapists), tolling the statute of limitations (e.g., according to whether a memory of child abuse has been suppressed or repressed), legally acceptable treatment practices (e.g., under what circumstances can a client testify after hypnosis, psychoactive drug treatment, guided imagery etc.), and on the use of therapists as expert witnesses (e.g., confidentiality requirements and personal agendas).

I used the qualitative research method of open interview with four Licensed Clinical Social Workers with MSW degrees, one Educational Counselor with a Ph.D.,

three Clinical Psychologists with Ph.D.s, and two psychiatrists with M.D.s and Ph.D.s. This method allowed maximum disclosure with minimal chance of contamination by the interviewer.

The interviewed therapists were very reluctant to define fellow therapists as deviant. Even when they would cite a breach of ethics that they knew about, they moved to address how that bad behavior might be changed rather than focusing on what should be done with the therapist. The behavior was deemed deviant, but none of my interviewees would label the therapist as deviant on even the techniques. It was the result which was so descried. Faulty or inappropriate socialization of the therapist had produced an outcome in which the client's suggestibility was exploited. This was related as a *fixable* problem.

The national organizations and, to an extent, the courts were looked to for definition of who is deviant. The national organizations could, and on occasion had labeled some therapists as deviant. The sanctions imposed could range from a nasty letter of condemnation to a temporary suspension of certification. An examination of lexis/nexus and other internet search engines found no criminal indictments that were based on harm done from a therapist's deviant use of the client's/patient's suggestibility. No indictments were exposed in the hundreds of articles of social science journals reviewed in researching this topic, nor were any revealed in the popular media. However, in civil court, tort sanctions were imposed on some therapists.

Certification and Licensure

Each of the clinical social workers felt that there should be at least some change in licensing and certification of their discipline. Amy was concerned that the laws

governing her profession were not being stressed enough during training. Amy noted that the LCSW national licensing exam was comprised of two parts: a laws and rules exam and the national clinical exam. At the university, she said, laws were not covered so much as ethics, social welfare and family counseling. Her mental health concern as a social worker appeared to be entirely encompassed by her desire to perform the duties and responsibilities of a ward resource manager. When there were problems which the patient had or might encounter, she would *recommend* to the attending physician a course of action which that doctor could act upon or ignore.

Larry was basically satisfied with the way certification and licensure is now done but felt that there should be some strengthening at the national level and supervision at the local level. This LCSW noted that “good as my heart and intent was prior to my formal training and licensure,” he was not as fit, suitable, and capable as he presently deemed necessary to be guiding the mental health of others.

Larry: So I clearly think there should be rigorous licensing procedures. The technical difference between certification being some body, body of people that's familiar with the standards of the profession are saying to a state agency who licenses you that this person is fit and they are suitable, and their licensure being the actual government body recognizing that capability and formulating how you exercise it.

Larry: In my field, the NCE, the National Counselor Exam, I think, is administered to all three disciplines within Line Statute 491 that we're under, and that seems to provide some common thread throughout. Feels like . . . you've got the national, you've got the state, and then you've got the various associations sort of bridge that. I like how that is right now. I don't think I can give a more definitive answer.

While in general Larry thought that there could be some strengthening of standards at a national level, he was satisfied with the way the social work discipline approaches certification and licensure now.

Will was much less satisfied than the other LCSWs. He felt that the dynamic controlling the direction of the discipline was the influence of the power of money. He was concerned about the present condition of licensure:

Will: You have the LPCs, the licensed professional counselors . . . which includes a lot of things. Ahh, I don't know the whole . . . they went through, a number of years ago, a big grandfather deal. They wanted to expand their trip. So they grandfathered in everybody and their dog with a B.A. or, uh, I don't even know what their criteria are, but I know if you are, if you have an M.A. in psychology, which is about as you know, 'Whatta you do with that?' Well you become an LPC. You get *that* certification, licensure and that allows you do to some>

Mike: You can get licensure too?

Will: Oh yeah. LPC, licensed professional counselor. They have a uh I mean that's uh I don't know the whole origins of it, but it allows people with education degrees, probably even sociology degrees.

Will was also concerned that training to be a social worker has become more academic than clinically oriented. I asked Will if he thought this is a problem?

Will: Uhhh, Not necessar> I think it's probably the whole, you know, that, that doesn't guarantee anything. My understanding was that psychiatrists have very intensive, psychotherapy, you know, they go through all this . . . big type >

Mike: They have lots of hours

Will: > trip and everything, but I doubt if clinical psychologists go through. . . . I mean they may test them. I mean I don't know. But I know social workers are not required to do that. The> there's supervision, is the main thing. And, hell, it's like anything else, you know, you get a degree or you get a license and all that does is put you in the ball game. . . . Then you start learning (laugh).

Throughout our discussion of certification and licensure, Will noted the influence of money on what is done, whether the subject be regarding who got/gets certified and licensed, whether there should be supervised therapy sessions during training, who gets third-party payments [i.e., from HMOs or insurance companies], or whether psychologists should prescribe medicine. One example follows:

Will: You know, you have a state board—there's a certain thing. That's legislated and uh, there. I was empowered by the state and it's also . . . it's empowered to uh be punitive if necessary, you know, to sanction, and uh and all that. But it regulates the ongoing uh, professional life of the profession, if you will. You know. How much educ . . . continuing education you need. Uh, the ethics. The ethics are legislated, and uh so, you know, it's it's . . . raises the level of accountability and, empowers the profession. The more you've got of that the more powerful you, you know, you are.

Mike: Umhm.

Will: Uh, it comes back to the money.

LCSW Betty was the most positive about the need for national licensure of all mental health social workers. She used the national licensure exam of acupuncturists with state licensing [due to state laws for different professions] as an example which could be set up. She felt that the professional associations should do this with some regulation from a government organization, such as the Department of Health.

Betty: I think social workers should be nationally licensed—doctors—, and, maybe they need to just take a refresher course or whatever in the state they're going to be practicing, so they know the laws of that state. Because the laws are different, in some ways . . . for each of the professions.

When Karen was in a Northeastern city, this Ph.D. in Educational Counseling had been certified by the National Board of Certified Counselors, but there was no state licensing that state. She had become licensed subsequently, when she relocated to the

Southern state where she now practices. I asked her if she thought that there should be national licensure in addition to discipline certification and she responded emphatically:

Karen: No. No, I think licensure by state is okay. I think it keeps people a little more accountable to the laws of the state. First of all it's got a little bit more teeth. I mean they pull my license if the national board of certified counselors pulled my certification and my licensure board found out about it. I mean if I didn't tell them about it. There's a chance that I could practice but . . . , if I get my license pulled in [her present state], I can't practice. I mean licensure's got higher standards and stricter standards by law than certification. So I think it's important. I think licensure by state is okay.

Gail expressed dismay that people were calling themselves psychologists without even having a degree in psychology, whether Ph.D. or PsiD.

Gail: I find myself extremely dismayed, by, what the range is of people that can call themselves, psychologists. I mean, I'm not even anymore[?], but I do know, uhm, I remember reading recently, I don't even think you have to have a uh, uhm,

Mike: PsiD?

Gail: Yeah, I don't think you do to be a psychologist.

I asked if she thought that just anybody should be able to do therapy. Gail thought that there should be licensing which shows that the therapist has gone through course work, supervised clinical experience, and mentoring. She would like for there to be a way to tell exactly what one's specialty in psychology is so that clients could select the type of psychologist background matches their problem. She rued that some psychologists who are proficient in testing or other psychological areas are doing therapy when their training might not have involved counseling.

Mike: I want to get back to licensing and, certification. What do you think shou-. Do you think>

Gail: No. I think that you should have to be licensed and I do think that it's . uh, it's an important part of training that you have . in your course work and, clinical experience that's supervised and you know and a lot of mentoring. And what I would like, eh that I don't like in my field of psychology is that you can get licensed, but, in psychology you can have a range of, training backgrounds to get licensed as a psychologist. And I really think . you know, just like if I'm going to a physician's assistant versus an RN, you know, I might already know some of what those training differences are, and I might be comfortable going to one just as another, or there might be things where I'd go to one and not the other. But I *know* what each of them is, and I think sometimes uh, it's a problem . for instance when you have the term 'psychologist' but someone's training can be really variable. and your not necessarily gonna know . what their psychologist, are they, do they have a doctorate in counseling, do they have . uh uhm a Ph.D., you know?

Mike: Yeah

Gail: Exactly what is their background.

Mike: Do they give Stanford Binet tests. or-

Gail: Um hmm. Exactly.

Rick had quite a different idea. Similar to Will, he considered the economics of his profession. Rick said that licensing was primarily a restraint of trade. He preferred a system where word of mouth would provide information for clients to make choices as to which therapist to use. He felt that licensing does not work and might give people a false sense of comfort that the licensed are proficient in therapy when some of the legal cases have provided evidence that some of those licensed are not.

Rick: In essence, the whole licensing procedure is simply a uh uh uh uh a fancy legal restraint of trade practice. Uh uh. If you're good, you're good, if you're bad, you're bad. And hopefully people will figure it out at some point. uh, does licensing work for me? Can I charge more because I am? Surre! uh uh At a, personal level, would I like to see licensing go away? I, I'm poor enough already, I probably would be poorer without it. [laughs] But at a certain philosophical level. I think it. It a.) really doesn't work and b.) I

think in certain cases it might give people a false sense of comfort. You know the , the, the *Ramona* case, the *Tarasoff* case, all the others you talked about, presumably *were* with licensed professionals.

He felt that if licensing was no longer required that there would be abuses for a while, but then people would learn to ask around to determine who is good at helping with the problems they have.

Rick: I, think, if you took away licensing, today, uh tomorrow and for, probably for foreseeable future there would be a lot of abuse. Because people have been so trained *to* have somebody else protect them and take care of them that they're they're they're not, *use* to it. Uhh, probably won't be in either one of our life times that things would get back to normal. But over-time, people would learn that, -you ask around. and you find out and you get, good word of mouth. and you don't trust somebody, just because they call themselves such and such but because you heard good things about them.

The benefit he saw from licensing was that it provided an extra push to continue the therapists education. Because licensing requires a certain number of courses each year, licensing reinforces necessary continuing education despite individual difficulties that might other wise lead a therapist to skip those courses.

Rick: As silly and trivial as it becomes in civil service, I have to say, one of the good things about licensing is that they are able to enforce, *certain* standards. But again, if in some way that people know those standards are enforced, it helps the matter. And they are able to enforce, certain things like, doing continuing education. you know ah, even though some of the courses you go to are really a joke. uh uh, just there to get you an hour or so[?]. At least, keeps you at least pretending to be looking [laugh]. If you're . . . if you're either busy or broke or whatever and for whatever reason you know want to get to it otherwise and say "Now need to get my fifteen hours in this year. Uh in fairness apply it to me. You know, I got my fifteen hours this year and because I needed it for the license, you know, and I didn't have the uh the money's been tight and probably wouldn't have gone otherwise.

When I asked about certification and licensing, Zoe first talked about the need for continuing education to make sure that people keep their skills up to date. She was pleased that with the requirement to take thirty hours of training programs every two years, but thought that licensing boards do not have enough information about the mental health of therapists except in very blatant cases.

I hypothesized that a psychologist who had been censured by the licensing board of one state could just go to the next state and become licensed there. I then asked whether there should be some kind of national and Zoe supplied the word “registry.” She said “I think they’re, I think they’re talking about doing that and yet. . . . I think we do need to, to do that. By the time you get your license revoked, there is some *pretty* heavy duty evidence, that you should [laugh] have your license.” She noted that in addition to the licensing by state that the APA has an ethics board.

When I asked about supervisory responsibility, Ben mentioned that the American Psychiatry Association is self-monitoring, “keeps itself in line.” We had been talking about doing no harm and I asked him what is the job of his profession at the national, state, and local levels.

Ben: Well, at a national level I think there needs to be uh um, a code, there needs to be a central, uh uh

Mike: Like its ethical code?

Ben: Exactly. That everyone agrees to and that everybody can abide to. Exactly. And then as you get smaller and smaller you get more and more local. I think uhm you just need to consider the ramifications of applying that code to that particular area. And you need to adjust things slightly. So, within the framework of that code, there may be some particulars that that code wasn’t aware of because of your area that you do business in.

I mentioned that psychotherapists in New York City, for example, do not have to be certified or licensed and asked what he thought about accountability and sanctioning across the entire institution of mental health.

Ben: Certainly. Well, you know you're talkin' to somebody who's spent four years in medical school and four years in a residency and another year of additional training outside my residency. So of course I'm going to want other people to have adequate training and supervision before they attempt to do the same thing I that I've been trained to do, and it's not just cause I get a M.D. that everybody else should have to do it. But I think that it is really important that I was instructed . . . to supervise what I'm doing. Because I'm impacting other people and there is. . . . It can be done inappropriately and can actually cause harm, if you do it inappropriately so I want that accountability across the board. Uhm, there are difficulties that are enforced in that accountability and holding everyone to the same standards.

Ben: I'd love to have some type of some type of national requirements for, for training and supervision and making sure, making sure everyone is abiding by some principles that would make sure that the therapy is done appropriately. There are some limitations in asking for that. It's gonna cost people to go through that training at the same level I did. There's, there's some major sacrifices in doing that and we're already at a deficit for mental health as far as care givers are concerned. We're putting more requirements and demands for the training that's involved and, and the way that people are doing the therapy is limited more. I'm just concerned that you may uh cause that deficit to increase.

Mike: Yeah

Ben: Less people willing to help in the mental health area. So I think you have to balance what I want as a, as a trained and supervised clinician, the realities of a . . . out in the field, and the support that we have to provide mental health treatment.

I related that New York City and some other places did not require certification or licensing for psychotherapy and asked what Jack thought of certification and licensure. He considered its importance from the standpoint of the juncture of the body and the

mind. That same perspective is shown in his discourse on psychiatrists as therapists who have both the medical side and the therapy side covered by training.

Jack: I think if anything, I'd have to say more toward having it regulated in some form. The reason being that> I mean, there's well documented studies that therapy can change brain chemistry, the same way that our medicines, medications do. So, it's not just, 'I think a lot of people have this benign idea that, or this idea that it's a benign thing that you just talk to people and you can't do any damage.' But that is definitely not the case. You can do just as much damage as giving somebody the wrong medication and not following them. And so I think that having it regulated would be an important thing to prevent, just that. from somebody who just needs to make some money going out and hanging up a shingle and becoming a psychotherapist (breath) uhm and they can do more damage than, good.

Jack: Right. Well I think as a psychiatrist. there are some, good things obviously. I mean this is what I do (both laugh) so I, I feel, I felt for me at least that this was the best choice. For me, I think one of the stronger suits of psychiatry is we consider not just the, the therapeutic> the therapy side of the patient. Uhm but we also look at the biological side. So, I'm trained as a medical doctor, so I have a good understanding about diabetes, high blood pressure., surgeries, ah and other issues like that. But we also receive the training in term of the therapy side, and so I'm able to kind of help assimilate the two. And so, from my standpoint, I think that's one of the definite positive suits of psychiatry, is that we're able to . . . we're trained as medical doctors, and *are* medical doctors, and are able to therefore, assimilate the two—go the therapeu> the psychotherapy side and the medical side.

To the probe who should regulate these two sides, Jack felt that this was tricky since states have different laws. He did advocate national regulation of therapists in all disciplines, but appeared to be formulating his opinion as he discussed it.

Jack: I think,> that part gets a little tricky because I think some of the states have different interpretations of some of the laws. And so I think if the national organization. . . . You're going to run into some problems. enforcing those, because some of the states may interpret those mandates a little differently without. . . . I think that ideally that would be the best—would be to have a national

mandated system where you set the standard and then that way, because patients realistically do> uh

Mike: Who would administer it if you did?

Jack: Well, (laugh) there'd need to be some sort of national . uh> like our APA is a national organization but I think I>, What we were talking about earlier is very true—they don't have it, a record of enforcing. many of the issues. or problems that come up. Uhm they're notorious for having, you know, you may get a reprimand from them for something. But that's about it. Uhm and so, I think having some sort of national . agency that would be able tooo enforce these rules. and, to dole out the punishment, when, necessary. I think would certainly make it an easier, system, to navigate through. Because you would have. ultimately, one body that was doing this.

Jack: Right. Well, again I think there needs to be some kind of national, regulation of that. And >

Mike: By whom? I'm a sociologist. (laughs)

Jack: Right. Well. I think there should be some sort of inac> When it comes to> If you're regulating all therapists, I don't think the American Psychiatrist Association would be the correct board. Because we. . . . They're not all psychiatrists. So I think just by sheer definition that wouldn't work. I'm not saying that the APA should not be involved because I think what they should do is to regulate their own groups of psychiatrists. Just because it's in place, a well established organization, and it has a set of ethics and it has some standards and things which we get regulated through.

Mike: There is also the NMSW and the APA, psychologists. Do you think maybe these should get together and create a board?

Jack: Yes, I do. I don't think that>. Well, I wouldn't even say that I don't think. I don't know that consolidating the groups into one giant thing would work so well. But I think having a national board that would consist of, you know, several members from each, coming together ahm to regulate those kinds of things because it is a commonality for all of them. I think that would certainly be acceptable, and actually preferable . . . because you'd have input from all the areas of therapy.

LCSWs on Certification and Licensure

Each of the clinical social workers felt that there should be at least some change in licensing and certification of their discipline. Amy was concerned that the laws governing their profession were not being stressed enough during training. Her solution to this problem would involve change at the educational/organizational level. Larry was basically satisfied with the way certification and licensure is now done but felt that there should be some strengthening at the national level and supervision at the local level. Will was much less satisfied. He felt that the dynamic controlling the direction of the discipline was the influence of the power of money. He expressed a certain resignation to this state of affairs. He did believe that there should be more supervision of the neophyte clinical social worker during early therapy sessions. Betty felt that the organization of the clinical social workers would be strengthened by using a plan more similar to that of the medical model, in particular of that of acupuncture. Of the social workers interviewed, she provided a more exhaustive view of clinical social work as a discipline with important functions being formed at each level—local, state, and national.

Psychologists and a Counselor on Certification and Licensure

The therapists with Ph.D.s in psychology or counseling also varied little in their responses. Karen had thought that each state should license therapists. She had said that she believed that national certification according to discipline worked. She explained her preference by noting that each state had slightly different laws which affected therapy.

Gail had felt that there should be licensing in all states. She said licensing let's the client know that the therapist had gone through a certain type of course work, been supervised during early clinical experience and had been mentored within her/his

discipline. She wanted the licensing to reflect the areas of expertise and rued that having the academic credentials (Ph.D., PsiD, or M.S.W.) did not show what areas of training had been focused upon.

Rick did have a different idea about licensing. He felt it was an inefficient and counterproductive restraint of trade. His ideal type would be one in which people were socialized to use word of mouth to determine who was a good therapist and what areas were covered by a particular therapist. He was in favor of certification that tells what training had been undergone and said that licensing did perform the function of impelling therapists to continuing education in their field.

Zoe also talked about the need for continuing education and the role of licensing and certification to make sure that skills were kept up to date. She favored a system in which the licensing boards could find out more about mental health therapists before cases became blatant. That would allow problems, whether problem therapists or problem techniques, to be revealed so that measures could be taken to rectify them at an early stage and keep therapists helping their clients. When we talked of the ease with which a problem therapist could merely move to a different state when she/he had lost their license or censured or expelled from the national organization, she revealed that she favored a national registry of problem therapists and said that there is talk about doing that within psychology.

Psychiatrists on Certification and Licensure

The psychiatrists also expressed basic satisfaction with certification and licensure. As with the social worker therapists who had M.S.W.s and national certification and the therapists (psychologists and educational counselor) with the academic credential of a

Ph.D. and national certifications, these psychiatrists with M.D.s/Ph.Ds did not have ready responses to how certification and licensure should be done and at what levels.

During their discussions of certification and licensure, all the therapists, of whatever academic or medical certification and state and/or national licensure themselves, did not speak of an expanded role in sanctioning by any of the boards. Several expressed an interest in some cross-disciplinary ethical guidelines at a national level, but did not have a particular format for how it should be organized and their response indicated that they had not given this possibility much consideration.

M.D./Ph.D.s on Certification and Licensure

The psychiatrists also expressed basic satisfaction with certification and licensure. As with the therapists who had M.S.W.s and national certification and the therapists with the academic credential of a Ph.D. and national certifications, these psychiatrists with M.D.s/Ph.Ds did not have ready responses to how certification and licensure should be done and at what levels.

During their discussions of certification and licensure, none of the therapists, of whatever academic or medical certification and state and/or national licensure themselves, spoke of an expanded role in sanctioning by any of the boards. Several expressed an interest in some cross-disciplinary ethical guidelines at a national level, but did not have a particular format for how it should be organized and their response indicated that they had not given this possibility much consideration.

***Ramona v. Isabella* and Third-party Suits**

There is an increasing number of tort cases in which the diagnosis and treatment practices of mental health providers have come into question. My search of the literature

revealed that *Ramona* was the first and most publicized lawsuit affecting culpability to third-parties. The publicity brought a heightened public awareness of therapy, and had implications for LCSWs. This ruling was the first allowing third-parties to demand compensation for tort harm when therapy practices have been instrumental in leading to damage to someone other than the therapy client. Loss of consortium (i.e., alienation of affection), damage to reputation, or preventable damage to third-parties discovered during therapy (i.e., client is likely to cause physical harm to another individual), are all torts for which the therapist is now liable. Except for the latter,¹ the *Ramona* case was the primary legal ruling that established liability and outlined what some of these practices may be.

When I asked about the *Ramona v. Isabella* suit, LCSW Amy said that she had not heard of it nor of third-party tort liability. She was not at all concerned about her own liability since the nature of her job as a case manager insulated her from suits in most instances.

Amy: Umm. Well, as I said, I don't know anything, about it. I'm kind of skeptical, we're, you know, very litigious society. And a lot of people who are guilty as sin, so to speak, are getting pretty huge payouts. [laughs, joined by M]. Um. Perhaps that's why I'm doing case management now and. . . .

Mike: You're pretty well insulated from that, you feel?

Amy: Yes.

¹ The *Tarasoff v. Regents of the University of California*, 1974, case had rejected the claim that confidentiality limits the liability of therapists who have reasonable cause to believe that the patient is dangerous to himself, others, or personal property.

When asked his reaction to the *Ramona* case and third-party lawsuits, Larry spoke of ethics classes at that time but had a hazy recollection of it and did not speak on the important area of accountability to third parties.

Mike: At any rate, now therapists are accountable to third parties. Did you know about this? There are some other cases since this.

Larry: It probably isn't very professional to say, I usually get my clues on recent case law by watching 'Law and Order' because they usually duplicate [both laugh] .

Mike: They use some of those [cases].

Larry: You can look at everyone you've seen and that theme comes out. But if it was in 1994, I mean, the name *Ramona v. Isabella* is ringing a bell, but I couldn't have named the case. I was taking two ethics classes, one of them in '95 so they probably covered that but [laughs] I don't

When asked directly about concern about third-party lawsuits, Larry spoke of his religious stance toward life and therapy, of being cautious, and of not letting concern about them influence his life outside the therapy sessions.

Mike: Yeah. So, this has not been a matter of concern?

Larry: At the risk of sounding other-worldly, I seek not to do harm—I seek to do good, and I hope that God protects those who put their hearts in the right place. I'm pretty cautious by temperament. I guess, I feel intuitively if you're treating yourself and that person with integrity that you can't stay up at night, having done nothing—worried that you haven't covered yourself. It's very difficult to cover that person of what you need if you don't expose yourself on some area. They could walk in and ultimately I could be quiet or be . . .

While the *Ramona* case was hazy for Larry, Will said that “all of this” was coming back after I revealed some of the details regarding the case.

Will: You know, you're talking about> Well, the suggestibility—how you lead the questions I mean, that's a big thing in child, child

abuse cases as well—who's doing the interviewing. That's why they have to tape everything now, because that the, the questions are leading. If you're talking about all this hypnotherapy. And again, what are you dealing with to start off with, you know, what is the (?)itic? If you've got a therapist, a psychi . . . you know. Even a psychiatrist in this . . . [case?].

Will was not much concerned with the possibility that he might be affected by this case since he used brief therapy. In regard to therapists now being more susceptible to tort suits brought by third parties, he laughed as he said, "That's why I carry lots of liability." Will had also seen economic power at the heart of licensure.

Betty was finishing her training for acupuncture and had not been doing much social work with clients at the time I interviewed her. When I mentioned that she was subject to the ruling on third-party suits that the *Ramona* case had opened, she said:

Betty: I think that I've probably stayed away from clinical social work because of all the legal stuff. Real serious, private practice, clinical social work. Uhm because I don't feel equipped to do some of the stuff that I hear people doing with people. Uh I haven't gone to> I've gone to, minution(?), I've done family therapy workshops, I've done some eclectic type ahm workshops, but I've never done something like just hypnosis, or just guided imagery. . . . And I've never done anything, uhm privately, because of the legal stuff.

When I asked her what she did with her patients who said they had been victimized in childhood, she had this to say:

Betty: I don't . . . I don't buy into victim stuff. I do a lot of uhm, reframing, you know. Help them reframe the way that they look at . and ahm deal with and, and the way that they, uh incorporate whatever bad thing's happened to them. I just, I just move them way out of, staying in the victim role and staying in the 'everybody does everything to me role' and, cause I> They need to move into taking responsibility for their choices the day that they come to see me.

At this point Betty talked about how she gets the client out of feeling that he/she is a victim.

Psychologist Gail was not sure whether she had heard of the *Ramona* case. After I gave a synopsis of it, she said:

Gail: I haven't heard about that case before.

Mike: Do you know about third-party law suits?

Gail: Uhm

Mike: Or did you know before I talked about it?

Gail: No.

Of all the therapist I interviewed, the thing most notable about Gail was that she would answer fully and very cogently any direct question, but she would not respond with any information not directly asked. She could not be "baited" into showing interest in elements of the third-party culpability (which subsequent statements showed she had thoughts about and that she was indeed interested).

Rick had a vague memory of the *Ramona* case but did not remember more than that it was about repressed memories that were found not to be repressed. He felt that the problems that *Ramona* made salient were a nonissue for him because of the way he practiced therapy. He provided an example of a client who had been multiply abused as a child. His tack was to work to get her to stopping taking responsibility for what others had done to her. He was very emphatic that the way he practiced therapy could not convince someone who had not been abused as a child that they had been. After I reminded him of some of the details of the case and that this case made therapists liable for third-party suits, he said that his therapeutic approach would not produce tort liability.

Rick: Well there's, there's something implicit, uh in what I'm . . . in my approach that probably come through from everything you're hearing. Before I said ultimately your accountability is to the client, with certain exceptions. (clears throat), your accountability also is, to, truth. It's not pushing an agenda. I like to think the kind of work that I do won't produce those types of thefts.

Mike: Umhm

Rick: So then it's> In essence it's a nonissue. I'm not trying to fit somebody into, [clears throat] a> my mold. If you're having such and such symptoms and obviously there's this [raps desk] and "Damn it, [rap] I've gotta convince you [rap] that that's what's going on" and, "who cares what your family or you think, or" There's a certain, brusqueness that produces that which, I find, anathetical to the type of therapy that I *do*. I have a client, currently, who, absolutely *was* abused. No question about it. She uh uh uh uh was subjected to, uh uh sexual contact from her father, from, a, step-brother and from an older cousin. [clears throat]. Uh, she's very open in therapy, and uh, she doesn't even like the word abuse. She likes calling them "the relationships" now. In my . . . that's the place where, where work needs to be done to kinda get her to, you know, to separate and divide and to stop taking on the uh, uh uh, the responsibility for what they *did*. And yet, still. . . . You know, even with a client, with a client who was abused and there's no question about it. Where I'm kind of respecting their pace and their, way of moving. *That* type of approach is never going to take somebody who was never abused and convince them that they were.

I had thought that Zoe would be familiar with the *Ramona* case since in addition to having therapy clients, she teaches psychology at a university. As I refreshed her memory she remembered that Ramona had sued the therapist and the clinic for tort damages but did not remember the outcome of the suit. I had started saying, "Whether the client had been abused or not, it was deemed impossible . . ." meaning to conclude "that she was not influenced by the therapist," when Zoe interrupted:

Zoe: She believed that. She was by the time they were finished.

Mike: She was going to believe it.

Zoe: Umhm. That's why you have to be so careful when you're doing child sexual abuse interviews. Because children are *so* suggestible.

Mike: Absolutely. And if you're trying to remember yourself, you know.

Zoe: Well we all know you reconstruct memory in the way that it makes sense and if someone is providing you with context . . . >

Mike: You confabulate.

Zoe: Right.

We discussed anatomically correct dolls for trials and the novelty of the sex parts for the child. Zoe mentioned that training on how to do those interviews has now become standard practice to make them really be court-admissible. About harm to third-parties from therapy itself she said that she considered herself to be low risk. She does not push her clients to confront others and if the client decides on her/his own to confront others, she helps them project possible incomes, both negative and positive. Besides not probing for memories, Zoe prepares her clients for confrontations by role playing and clarifying how the client feels toward others. She also prepares significant others for signs of change in the client.

Zoe: I don't worry much about that. Maybe . . . maybe in part because I'm pretty adhering to ethical, standards—I consider myself a 'low-risk' person, cause I go the conservative [laugh] route, when I treat. Maybe because in my therapy with others, I try to consider other people in that person's system, and, >

Mike: You feel that's their support system or>

Zoe: Yeah well they could, they could just ruin everything I do in therapy with the person, by not providing a supportive context. So I have to help that person, i-mag-ine, or or, generate how might others' react to any changes in behavior . . . or help prepare other people they're close to for those changes.

Mike: Do you have them con—your clients—confront people? In their, >

Zoe: Uhhm, I don't know so much as, as confront, as discuss things with them. Uhm. Like, I never>. Like for sexually abused adults, I have seen uh, more often than not, what I advise them to do—one of the many things I advise them to do—is to write out letters, stating how they feel about the abuse, to the abuser. But whether they want to go and confront that person is really their own decision. It's never been something I really pushed for. And, this is, I mean these are, clients where—it's never in a recovered memory—it's. . . . They've always *known* that they were sexually abused or

Mike: Suppressed? They said it's not time to think about it cause I'm not strong enough or whatever?

Zoe: Well, or they, they've had problems throughout, their adolescence because of it and into adulthood, but. they've just now got to the point where they're ready to address it. So. Uhhh, if they want to *confront* them, I would . . . I would role play with them, ways to do it, and help them uh project potential outcomes because, that could either work out nicely or poorly. I mean you never know that. So be prepared for any set of circumstances. But, I don't really worry about third-parties.

Psychiatrist Ben had heard of the *Ramona v. Isabelle* case and third-party lawsuits, but was able to conversed about it only after being informed of some of the details of the case. He recognized the gravity of expanded vulnerability to third-parties, but felt that this was just an extension of the possibility of suit. He opines that therapists can learn to deal with so that fear of suit would not interfere with their practices.

Ben: For me I mean it's something that I'm aware of. There always was a possibility of litigation. There's third-party liability but we have liability, you know, in a number of ways. We have legal liability and we have civil liability. I can be sued for any number of things that go on in a course of treating someone. So it's something that we're aware of and we attempt to protect ourselves as much as we can but you can't let it limit you. If you're that uhm afraid of it, you shouldn't probably be in the profession at this point and so uh

Ben: I mean they're extending it more than it have been in the past when they allowed third- parties to file suits but the liability has always been there. We're a very litigious society and it's one of the more

negative aspects of what I do, is that there's always a possibility. So it's something you learn to deal with. You do the best you can for your patients you abide by your beliefs and your ethics and provide the best care you can for your people and try not to let it influence you.

Jack appeared to be more familiar with the *Ramona* case than any of the other therapists. He said that he had heard of it and was trying to remember the details. As I attempted to fresh his memory, several time he said, "Right," in agreement and when I mentioned that Ramona had sued for tort damages his response was even more supporting: "That's right." In conclusion I said:

Mike: So. Third-party suits. Now you're susceptible to third> that's the first time that a therapist could be sued by anyone other than the client, or the patient >

Jack: Right

Mike: > or the—an agent.

Jack: Or an agent for them.

Mike: Have. . . . Do you ever think about that or . . . ?

Jack: Uhm, somewhat. I mean, it doesn't open up the door, for legal actions to be taken against the therapist or organization. However, ahm . At some level, when you recommend, as a therapist to a patient, to take a course of action—confront her father, for example—there is some responsibility in that.

Mike: Do you have your patients confront people or, >

Jack: Not typically. What I will do is talk to them and, in terms of our therapy we try not to make, suggestions for them to do—concrete suggestions for them to do. What we often do is try and lead them down a road and . . . so they can make their own discoveries and their own decisions, as opposed to having us make the decisions for them. We often will try and make ahh make the patient make their own decisions. We can help them, guide them down the right road but they ultimately need to be the driver.

Mike: What do you think about uhm while we're on this, the patient as victim, or victimhood, you know. What do you think about that situation? Are they? Do you see patients as victims? . . . of, I don't know, of whatever social interactions or how . . .

Jack: I guess it depends on what you are defining as a victim. I've certainly seen patients like we've already talked about with post traumatic stress that have been victims of crimes. uhm I do see patients that have, assumed almost, a victim role, if you will. They've had enough bad things that have happened to them that they sort of take on the role of, perpetually being a victim—putting themselves in situations where they're going to be, abused or mistreated or taken advantage of. uhm That's not uncommon, actually, for us to see. uhm I guess eh I . . . Is that answering your question, or I I I don't know.

I briefly related Gail's stance (as one psychologist) on victimhood in which she said that she never lets her clients see themselves as victims. When I asked what he thought about that, he enthusiastically (rapidly and smoothly) agreed with her assessment.

Jack: Right. Actually it's pretty similar, uh, again the problem is that the patients is to assume this from a victim and so our job as their therapist, or psychiatrist, is to . change that. the best that we can. or get the patient to change it. And so, that is definitely the approach in theory that we would take, is that we don't want the patient to see themselves as a victim because, that identifies as more a passive role. Ummm and that 'things just sort of happen to me'—the whole idea of learned helplessness, almost fits them to a victim role.

Mike: Ummm

Jack: And so it's something that we would certainly . try and discourage from a patient, to assume a victim role because it does make them more passive. What we enc>, instead, *try* to encourage is for them to discover within themselves the idea that do have some control over the situation. Yes, it was a horrible thing that happened to them. uh and yes, maybe they couldn't have prevented it. But, what they do from now forward is within their abilities. And that is what we try and focus on. Is getting healthy, and feeling better about themselves.

LCSWs on *Ramona v. Isabella* and Third-Party Suits

None of the LCSWs remembered the *Ramona v. Isabella* case. When I gave a synopsis of the case, all but Amy had faint recollections about it but had not felt that it affected what they were doing in therapy. Amy felt secure behind the medical curtain (since the doctor must make final decisions on matters which might lead to culpability to third-parties). Because they used various types of goal-oriented, short-term therapy, the other three LCSWs did not feel threatened by third-part suits. Larry trusted his morality to keep him from harm. Will trusted his type of therapy while carrying “lots” of liability insurance. Betty put her trust in turning conversation to problems the client was having coping in the present and getting past the victim role.

Partially, the social workers were insulated from the effects of the *Ramona* case and had not dealt with the liability to third parties based on that knowledge. The magnitude of the tort award, that I had related, brought exclamations of “Wow” from two and the others indicated awe. Since they had said they recalled something about this topic from their ethics classes, somehow it failed to make an impression at the time that would lead them to consider it during their practice of therapy. One can only speculate as to the reasons for the lack of awareness about such an important piece of jurisprudence. One possible alternative might be that the nature of their socialization as social workers (which looks for problem oriented solutions for mental difficulties) combined with the fact that it was not social workers who had been sued and mitigated thoughts of liability for them and reduced its saliency for setting up practices that would be protected. Despite her interest in the legal elements of the field of therapy, Karen did not have some recognition of the *Ramona v. Isabella* trial even after hearing a brief synopsis of the main

points. She asked for some clarifications about the suit and then the interview was shifted to some of the treatment practices that the suit had entailed. She also thought that third-party suits would be insurance companies or protective agencies concerned with mandatory reporting of suspected abuse. She had not considered that therapists are now accountable individuals for tort damages.

Psychologists and a Counselor on *Ramona v. Isabella* and Third-Party Suits

One of the clinical psychologists (Rick) had said that he had heard of the *Ramona v. Isabella* trial and liability to third-parties. Rick recalled only that it was about repressed memories which had been found not to be repressed. Gail flatly stated that she had never heard of the case nor of liability to third-parties and did not consider herself to be at risk of tort suit. Surprisingly, Karen who was interested in ethics and laws and mandatory reporting had not heard about the *Ramona* case. She had considered accountability to third-parties to be limited to accountability to insurance companies for treatment that had been done or protective agencies in reporting suspected harm or threat of harm. She did not have an opinion on its effect on her practice. Zoe, who taught psychology, did not remember the case by name, but remembered it as I started my synopsis. She did not know the outcome of the case, just that there had been such a case. She considered herself to be at low risk for suits for tort damages because her type therapy is not confrontational, prepares clients to realistically consider the logical consequences of their actions, and she involves the clients' significant others when significant changes are expected in the clients' behavior.

Psychiatrists on *Ramona v. Isabella* and Third-Party Suits

Of the psychiatrists, Jack, evinced some knowledge of the *Ramona* case, but was not so familiar with it that he did not have to be reminded of some of the details. The psychiatrists were relatively unconcerned about the peril of third-party suits—medical liability insurance was seen as a necessity in this litigious society and they indicated that the *Ramona* case did not greatly increase their risk..

All Therapists on *Ramona v. Isabella* and Third-Party Suits

One therapist from each of the disciplines had indicated that, though rarely, they sometimes discussed a client's memories—a type of psychoanalytic approach—but only at the client/patient's request (LCSW Rick, clinical sociologist Larry, and psychiatrist Jack). While this may have put them at some risk for tort damages, they did not have the client confront the accused perpetrator, primarily because their types of therapy expressed self-efficacy (not victimhood), problem solving, personal growth, and situation management in the present environment.

Mandatory Reporting of Abuse

Amy had reported suspected elder abuse through the abuse registry. The cases that she had reported involved elders who were neglected (e.g., soiled, hungry or not brought for essential medical treatment, such as dialysis), but she had not seen evidence of physical abuse. The ward she was assigned to did not have a pediatrics wing, so she had not seen and therefore had not reported any type of child abuse.

Larry on the other hand had reported abuse. He had reported several times in the past but found that he was discouraged when in a non-therapeutic role.

Larry: (breath) I've had several. I have found that I want to look a person in the eye and tell them, "I need to report this, and I'm going to do that." And, prior to my being in this field, where maybe you're encouraged 'not to.' I was a school principal before and you were sort of encouraged 'not to.' But I found that it really breaks trust if you don't. . . .

Larry: Two situations are immediately jumping to mind. In one, a client had shared, but wouldn't give details or names, and the next day the *suspected* abuser showed up and was in my waiting room and assumed I was reporting and wanted to talk to me. It was at that point that *he* talked to me and I shared with him, "You're coming here has now mandated that I report. When you're name was withheld, to keep me from that, and now you thinking that I'm sharing that" And so I shared with him that I was required to report it, in that situation. I called, are you familiar with [name of a therapist]. . . .

Larry: Anyway, again benign from the standpoint that he's an authority in that field, child protection team, and just wanted to be certain of my responsibilities there. He said report. I reported it. Other situation. My other situation that immediately comes to mind was . . . again withholding of names by the party. It was something that had taken place in the past. And they didn't know if they wanted to face the hassle that . . . and worked to influence them to report. And they indeed reported that situation.

I then asked if he would have reported the allegations if there had not been the legislated mandate.

Larry: (Pause) The first I gave you, back then, my tendency because of how it came about was to attempt to influence the situation for good, was probably not the wi-, apart from the law, apart from reporting, was probably overreaching at that point in my life. And yet I was wise or self-protective enough (laugh) to ask someone in authority what I should do and did indeed do that. And was able to have the best of both worlds in that I was able to influence the situation directly by telling the man "I'm reporting you, here's why. I'm not against you." He had a different explanation for what happened; but (I) was able to have some positive influence in that situation. . . .

Larry: Going back to specifics of your question, I'm glad the law is what it is. My tendency back then was not. . . . Don't go through the

hassle, but, can I save the world and find some way that's for good. And I'm glad the law saves me from my earlier inclinations of being a rescuer and mandates that I do that and so that becomes more matter-of-fact now. It just I'm not . . . I'm not encountering it as much because I don't deal with that popu-, I don't deal with the younger children much, so I would have to. . . . I guess we're talking specifically of abuse? I had a situation where a client informed me that she had purchased a hand gun and was on the three day waiting period and I discovered it's not against the law to kill yourself . . . to buy a gun and kill yourself in Florida. . . .

Most of Betty's social work career had been in gerontology. "Oh, I've reported financial abuse, financial exploitation, emotional abuse, physical abuse. I've reported that for the geriatric population." When asked about reporting child abuse, she said that she had not had occasion to do so in her professional capacity, but:

Betty: I've been tempted some, sometimes just to report on somebody I knew doing something wrong—a personal friend—um but I didn't under one or two circumstances. One was a minor who um who was living with somebody whose over 18 and the parents were encouraging that.

Mike: Hmm

Betty: They weren't at all saying this is wrong, this is not right. What happened, someone who is 14 moving in with a 20 year old um and that's statutory rape and that's against the law and uh that was one time in all of those couple of years where I did not report that.

When I asked her why she did not report it, she said that the parents felt that it was okay and the child "wanted to do it, was out the door, it . . . , was grateful to be out the door, I didn't actually blame her for wanting to be out the door of that person's house [the parent's]," and lastly:

Betty: I wasn't in the social work world. I was in an acupuncture student role and it was an odd situation. . . . Because I, you know . . . it was an odd situation. Um so that's a . . . that could be a very tricky situation to know.

Betty appeared to be very conflicted about her role in this non-report. She also had not reported a colleague whom she felt had been impaired.

Betty: I mean what are you supposed to do? You know, uh anytime you're anywhere, 24 hours a day? Be a social worker and report, you know—at seven in the morning and 12 at night, wherever you see. It's a little bit tricky. So I think I brought some boundaries to um when I report? It's like, none of my business. . . .

Betty: And I haven't read the legal directory recently but, you know, but I . . . But it's something that I feel very strongly about, I mean I *have*, when somebody is doing something wrong. The same with a colleague if they're impaired, you know, I comfort them and then if I . . . I've never reported an impaired colleague but I comforted them and they've changed or they've moved out of my way?

She went on to talk about colleagues whom she thought were doing things that should not be done in their lives and practices. She was concerned that she really did not know those persons in those instances and felt that there was also a cultural reason that people [and she by extension] do not report.

Betty: I just don't think that many people do report because they live in America I mean I've lived a lot of different countries and I've been to a lot of places where people aren't free and um so know what that feels like and so I can see where people in America would feel like they were over stepping there boundaries as far as where people are free cuz this country is very free.

Betty: People are free to do and be and so on. Most people think that's their procreative right.

Betty had talked with colleagues about the problems mentioned above. She apparently came to the conclusion that the mandate to report abuse was too broad and did not cover some situations in which factors other than law were of importance.

Ph.D. Karen was more comfortable with the concept of mandatory reporting of abuse than she had been on the other legal topics. She said that she could not recite the law nor a particular case, but she did know how it effects her.

Karen: Well it *is* a hard question. Cause I want to be careful about it. Because what I try to do is, rather than take away the power from a person and say I have to report this, is to work with that person and empower that person to become the reporter. Works a lot better than just blowing the whistle on somebody. There's a lot of, now there's off>, there's, you know, there's lots of resentment because of the fact that it's just a lot of, you know, disempowering of someone. So, I . . . There's a lot of . . . I mean when that stuff comes up in therapy, that's often when I seek consulting the most, with other professionals, and often with my husband, who is a psychologist and, who, uhm does court testimony and, really knows uhm a lot about mental health and the law. So, I absolutely seek consultation, when Ifff I am in a position to do, that kind of reporting. I do not do it in a vacuum. I mean, first of all, you know, I consult with colleagues . . . and always let my supervisor know . . . and it gets just important, to document very well.

Though she said she had not wanted to report, she had reported both anonymously and after letting clients know that she was going to report. Throughout her interview, Karen referred to "law." It was the central theme of her interview. She said she could not cite the law on mandatory reporting but she certainly was aware of its ramifications for her as a mandatory reporter. When she feels that a legal issue might come up she would consult with her husband who is a forensic psychologist, her colleagues and her supervisor, and the university attorney when a question of law comes up.

Karen: That's right, and I don't become an attorney, I, mean if the university. . . . I would consult with colleagues, and then supervisors and then university attorney. So I'm not going to interpret the law. I mean that's not my . . . my role is to initially interpret the law and then it's my duty to talk with people whose job that is, to fully interpret the law for me. I don't mean to be vague, but I came to . . . you know. . . . Like. . . . You know, I can't even tell you *where* the statute is [laugh].

Although she had a support system for these matters, she tried to remember the laws themselves. When questioned about law and confidentiality she had said that she tried to give people from the beginning a view about what confidentiality entails and that she is legally subject to having to report abuse.

Karen: Oh yeah, yeah yeah. I let people know that things that we talk about in the therapy session are confidential between the two of us unless something. . . . I can't even remember the words, cause I've been on leave for almost two years. Within the, within the limits of the law. And when some people ask more about that, they say "whatta you mean within the limits of the law?" I say, "by law, in the state of Florida I'm a mandatory reporter of child abuse and elder abuse.

Gail had also reported suspected child abuse. She said that it was "extremely stressful and upsetting." She told the parents that she had to report and did so with them in the room. "I did it with them." I ask her if she would have reported it if there had not been a legal mandate to report.

Gail: Probably not, in this situation. Because I didn't really believe her. So I probably wouldn't have reported it.

Gail: I've, I mean, if you had no doubt that she was lying, then I guess you wouldn't need to report it. But I think when you're not certain, you're suppose to report it, and I know when I reported it I said over the phone in my report "This girl has a history of lying about different kinds of things." I don't know if she's ever lied about *this* particular thing before, which was being slapped by her dad, but, she certainly had a history of lying about other kinds of things. And they were very much like, "Well, thank you for reporting it, we're the ones that need to investigate the reality of that." They wanted to have that say. Still

Mike: And you reported to a social worker?

Gail: To the department of Children and Family.

After listening to my explanation on the *Ramona* case, third-party lawsuits, the legal rulings on some treatment practices, mandatory reporting, and the decline in the use of psychological expert witnesses as I understood them from my literature review, Gail explained in depth how her treatment practices are designed to help clients see themselves as something other than a victim, how her treatment would emphasize forgiveness and empowerment, and how she emphasizes healing and communication rather than searching for resolution of relationships. Each of these were elements which she felt protected her from legal actions.

Gail: Well. I think. . . . It's funny that coming from the law perspective, none of the things you've shared feel stressful, or upsetting or like they are taking power away. And maybe part of it is because I don't really feel like I have a certain orientation toward therapy, but I do think that I would almost always work with the people I worked with towards moving away from perceiving themselves as victim. And I would always be working towards forgiveness and for trying to repair relationships as is possible, and so, I think the way I would empower someone would hopefully be a way that's not going to be harmful to other people or. . . . I would never, for instance, encourage someone to pursue some drastic course of action in their lives, without finding some ways—even when someone is hysterically making decisions for themselves, it's going to impact someone else, and maybe in a possibly harmful way—to still communicate as lovingly as possible. Why, for instance, they're leaving a marriage or why they've decided to stop interacting. I think law gets involved in these kinds of situations when communication is broken down and relationships feel very wounded. I mean, I think that maybe in a row between a father and his daughter, part of why things got to the level they got was because there wasn't a strong enough influence there that was helping for some kind of healing, or some kind of resolution or maybe supporting a lot of the sense of being a victim. That's just not something I would do in the therapy situation.

Gail: So the law doesn't upset me. It doesn't. I don't feel worried about it. I don't feel like it impacts my practice. What's funny is to me, where I feel more constrained is by things like insurance. I feel

much more constrained by it. I think therapy has changed in an enormous amount because of. . . .

Mike: Tell me about this.

Gail: Well, I think insurance companies want to, really, dictate the way treatment happens and how long it should be and how long society. . . .

Gail had earlier equated accountability and ethics with law (above). This was the only time that “law” was a topic of conversation during Gail’s interview.

Rick had not had an occasion in which he felt that the mandate to report applied. He felt that such matters were “individual.” He had talked more about how he would work with the client directly rather than others outside the therapy sessions.

Under the heading of mandate to report, Zoe included warrant to report the possibility that a client may do harm to self or others. She was comfortable with the mandate to report abuse and had done so somewhere between five and ten times with her own clients and more when supervising interns’ cases. Nevertheless, she regretted having to report because she found that reporting often had negative consequences for the therapeutic relationship. She noted from her experience that different states had slightly different statutes and reporting requirements. In addition, she had to breach confidentiality fifteen to twenty times because of risk of suicide. I asked her if she would have reported without a legal mandate. While she cited the ethical mandate to report she noted that different therapists define “reasonable suspicion” differently.

Zoe: Humm. That’s an interesting question. I think, well, our ethics would suggest that we should report. So I think I would have . . . reported. Uhm. . . . I think every mental health care provider probably has their own definition of what is a *reasonable* suspicion—that abuse or neglect is occurring—and, how little you need, to make it reasonable suspicion, and how much you have to

make it reasonable suspicion. I think everyone has their own threshold on that.

I next asked her if she thought that there might be a tendency to over-report. She said that she thought that, “Yes. I think there’s a tendency to err on the side of false positives . . . because the way the laws are written, they *say*, reasonable, suspicion.” She was concerned that the children might be physically abused because of the report, but that this possibility was something that must be borne since sometimes many reports are necessary before protective services do something to rectify it.

Zoe: But, I look at,> I know sometimes it’s like, the critical number of reports it’s necessary for the child to be removed, and if I can add to that *weight*, like if I’m reporting it and someone else is reporting it. I look to it as ultimately someone is going to do something that’s an effective, way of relieving that child from that situation, whether it’s removal from the home or getting the parents to, have parent-training, or *something*. Something.

Zoe also said that the statutes she has seen typically call for more than a reasonable suspicion. That they often call for “something closer to a, defined plan or a definite, a definitive intent or an intended victim.” She concluded, “So, we have to be. We have to be given more definitive, I think, information. Reasonable suspicion is not enough.”

Psychiatrist Ben had a more stringent standard for reporting suspected abuse than the other therapists. He feels that part of a report would be a statement that the therapist has some evidence that the abuse is going on. He had not personally reported child or elder abuse. I asked him if he knew someone who had and he said, “I have, and they’ve done that, and it’s always a case by case situation, you know. You know what’s going on uh but if I felt there was abuse going on, I would feel obligated to report it.”

Jack had reported child abuse “10-12 times “ and elder abuse two or three. “With the children it was mostly. I’m trying to think. Most of the encounters, not all of them, but most of the encounters are through the emergency room. When we were, when I was in training.” He was aware of the mandate to report and knew exactly where to report the child abuse, but had forgotten which state agency he had used for the elders.

LCSWs on Mandatory Reporting

LCSW Amy had reported elder abuse and neglect through the abuse registry. The hospital where she worked did not have a pediatrics wing. She had not been exposed to children in her capacity as a LCSW and had never had occasion to report child abuse. Larry had reported abuse several times as a LCSW. He told of being encouraged to report while functioning in the therapy setting as opposed to encouragement “not to report” in an educational setting. He told of an instance in which he had not decided whether to report until the suspected abuser came to talk to him. He felt that coming to talk with him mandated that he report. He did so after consulting with someone knowledgeable about child protection services. In a second instance, he had influenced family members to report suspected abuse. Larry said he was glad that reporting is mandated. He feels that early in his career he would have tried to take care of the situation with the client as a rescuer rather than putting the responsibility for the case in the more experienced hands of the state child protection agency. Betty had not reported and had felt conflicted about her decision in a particular case; nevertheless she stood by her decision. Will had not had occasion to report abuse.

Psychologists and a Counselor on Mandatory Reporting

Of those psychologists who reported suspected abuse, all had expressed some misgivings. Karen's statement appears to indicate that she feels that reporting is indicative of some sort of failure. She works to empower her clients. By reporting she takes away the power of the client and places it in the hands of others. She pre-warns the client in the intake interview that she is legally required to report abuse and likelihood of harm despite her adherence otherwise to the ethic of confidentiality. She also consults her support system—her husband who is a forensic psychologist, her supervisor at the university where she works, and the lawyers provided by the university for that and other treatment related purposes.

When psychologist Gail had reported the one instance of possible child abuse, she informed the alleged perpetrator(s) (in this case a parent accused of slapping the child) that she was legally bound to do so. She also had consulted with the other professionals in her clinic for advice. When asked if she would have reported if there had not been a legal mandate, she said, "Probably not." She went on to explain that the child had a history of lying and that she had relayed that fact to the Protective Services. Gail also went into some detail about how her treatment practices help to keep the client from seeing her/himself as a victim. Her treatment emphasizes forgiveness, empowerment, healing, and communication rather than a reacting as a victim. Unsaid but implied was that a client who thinks she/he has been abused would report the abuse her/himself.

Psychologist Zoe also regretted the necessity of reporting abuse although she had reported more often than the other clinical psychologists. She based her regret on the negative consequences for the therapeutic relationship that usually ensued and on the

likelihood that the client would be punished or abused because of the report. Her decision to report nevertheless, was based on the necessity for several reports from different sources, in many cases, before Protective Services would do something that would end the abuse. She also was concerned about the ambiguity of the definition “reasonable suspicion.” She noted that this term can be and has been interpreted in a number of different ways by reporters or non-reporters of abuse. This has sometimes led to erring on the side of false positives (reporting suspected abuse when there is none). She said that even without the legal mandate to report, she would have reported the cases she did, because of her professional ethics.

Psychiatrists on Mandatory Reporting

A psychiatrist, Jack, had reported elder abuse many times, and child abuse more often than any of the other therapists. Part of his reporting may have to do with his work in emergency rooms, where physical abuse is more likely to be first reported. He was not conflicted about the necessity of reporting. Ben on the other hand had not had occasion to report. He had a more stringent standard for reporting, but felt that if confronted with a case, he had a clear idea of when he would report, and would do so without hesitation.

CHAPTER 10 CONCLUSIONS AND DISCUSSION

This dissertation analyzed interviews with licensed or certified therapists to investigate how deviance in therapy is constructed and managed. It used narrative analysis, supplemented by content analysis and conversation analysis, to study four common narratives addressed by the therapists in their interviews. Open interviews were conducted so that the therapists could define the concepts, set priorities for the interviews, and minimize the interviewer's role.

One of the limitations of the research regards the sample of therapists who were interviewed. How many therapists should have been interviewed? Which ones should have been interviewed? There is no way to determine how typical the interviewees were. The purpose, however, was to explore the construction of deviance and not to establish parameters about deviance in therapy. To accomplish this, therapists from different training backgrounds were interviewed. Sampling was suspended after the tenth interview because salient themes were emerging that provided insight into the construction of deviance.

The loosely structured interviews yielded narrations about: 1) orientations to therapy; 2) memory, suppression, and repression; 3) accountability and ethics; and 4) legal issues and therapy. Each bore a relationship to how deviance is constructed and managed. These narratives became repetitive in content and saturation was reached on many points, albeit not necessarily on those that were anticipated at the outset.

Orientations to Therapy

The first saturation point emerged as I sought to find out what therapy really was for these therapists. Somewhat surprisingly, no over-arching theoretical or disciplinary orientation dominated their orientations to therapy. No patterns emerged that distinguished one group from another. Rather, the nuanced narratives regarding orientations to therapy left little doubt about how individualistic therapists have become. No "party line" emerged that reflected disciplinary training. Although some identified schools of thought that had influenced them, they did not express special allegiance to a particular orthodoxy. In fact, most of the interviewees hesitated and had to work hard to articulate an orientation to therapy. They did not have pat definitions. One admitted that it had been a long time since he had even thought about the topic.

What emerged instead was consistency in how the therapists defined their roles. They knew, immediately, how to talk about their role in relationship to their clients. One of the common emphases was on interactions designed to assist the client. All displayed a service orientation. The choice of role bridged the knowledge base obtained during training and the structure of their occupation with the particular demands of practice, which were client-based and individualistic. The guiding ethos of their practices was to do no harm. This included a) keeping clients in therapy long enough to help; b) releasing them from therapy if it is not helping; and c) not substituting their own agenda for the client's.

These therapists also adopted a problem-solving orientation. They had an eclectic approach to techniques and strategies so they could tailor therapy to the particular needs of the client, concentrating on what would work for each client. These therapists

attended to individual differences in clients. The pragmatic bent meant that the interviewees used a different mix or combination of techniques to try to produce results for each particular client. Future research should examine whether therapy has become more eclectic and pragmatic and if so, what has contributed to this development.

The problem-solving focus had several other implications for the construction of deviance. Focusing on the problem separated the problem behavior from the person, making the therapists reluctant to label people as deviant. The problem-solving orientation also focused on the here-and-now, not the past, so the place of memories in therapy was minimized. These therapists focused on current problems and behaviors with an eye toward improving the quality of life of their clients. They did not seek out memories or dwell on past conditions. There was also an emphasis on getting clients to self-actualize as a part of this problem solving. That emphasis minimized reasons for confronting third-parties who may have wronged them.

Saturation was also reached on some behaviors which were defined as clearly deviant. The interviewees all agreed that some actions were deviant. It was wrong to have sex with a client while under therapy (or later). It was wrong to breach client confidentiality unless legally mandated to report. It was wrong to dominate the interactive process in therapy and overpower the client. It was wrong to harm or contribute to the harm of third-parties, including therapy interns/students or other third parties who are confronted by patients for real or perceived affronts that emerge during therapy. It was wrong to engage in practices that exploit the suggestibility of clients.

Some anticipated themes did not emerge from the interviews. Therapists were selected from different training backgrounds in anticipation that different training would

lead to different outlooks on therapy and professional deviance. Training did not seem to affect orientations to therapy. For example, the respective orientations of the therapists were quite individualistic, which meant that the social workers were as different from each other as they were from the psychologist or psychiatrists. One of the social workers keyed on the guiding nature of a personal relationship to the client with his model being suggested by his relationship to his God. To another, therapy was a process by which old hurts are healed so they would not interfere with contemporary living. A third LCSW saw coping with past problems more as overcoming obstacles than as healing process. To a fourth, therapy was an opportunity for the therapist and client to grow and gain insight.

The psychologists each put his/her own special spin on therapy as well. One thought it was a special position of trust from which the therapist could help clients believe that they could have a better life—one of greater harmony and peace. Another saw therapy as solving problems of stress—exploring options for making changes. A third agreed about the centrality of making wanted and healthy changes but did not link the problems to stress. A fourth psychologist saw therapy in very broad terms as helping to enhance living. That could range from addressing low-level functioning generally to isolated and specific aspects like assertiveness.

The psychiatrists did stress that therapy is used to overcome the disorder of mental illness rather than primarily a problem to be solved with the client. One psychiatrist used a psychodynamic approach and felt that drugs were a useful and helpful tools for accessing memories. The other downplayed the psychoanalytic approach and stressed supportive therapy which was cautionary about the use of memories.

Importance of Memory, Suppression, and Repression

Memory, suppression, and repression were not important to the interviewees, including those who had used psychoanalytic therapy and those who dealt with clients who had suffered CSA. I expected more variation across therapists on these matters if for no other reason than the media and academic attention given them. The research approach was premised in part on an initial working assumption that suppression and repression of memory in child sexual abuse cases would provide fertile ground, at least among recently trained therapists, to prompt thinking about how deviance in therapy is constructed. That assumption proved to be inaccurate.

These therapists structured their practices and pursued techniques that de-emphasized memory. They adopted 1) a here-and-now orientation; 2) a problem-solving orientation; 3) a client self-actualizing orientation; and 4) sensitivity about inducing suggestibility in clients. Their practices steered them away from techniques that would exploit suggestibility. The interviewees perceived that techniques designed to elicit memories posed problems for good therapy.

The therapists were all leery of the problems associated with notions of repression, but disagreed about the validity of the construct. Some accepted the concept and agreed that memories could be repressed; others were more skeptical. Because they stressed the "here-and-now," none of the therapists dwelt on old memories or actively sought to draw them out. If the clients presented them, the therapists would deal with the memories but primarily in terms of the memory being an obstacle to solving current problems. They recognized that memories are imperfect under the best of circumstances and need to be dealt with carefully and put into context. No one thought, for example,

that a discovered memory should be the basis for making accusations. Some recognized the difficulties in verifying the information. Most thought that the therapist's primary concern should be with helping the person develop skills for coping in the "here-and-now" and did not think that required returning to the past.

Few of the therapists ever used techniques that are central to regression therapy (e.g., hypnosis, imaging) and none of them did routinely. The pragmatic and eclectic orientations meant that they did not have a visceral disdain for regression therapy or its associated technique. In some instances some might actually use one of the techniques. More often, they considered that 1) they were not sufficiently trained in the technique or 2) thought that they could pursue more promising approaches or combinations to help the client. For these reasons they could and did avoid the techniques and situations that have given rise to controversy over deviant therapy practices. They structured their work in ways that minimized the chances that repressed memories and regression techniques would come into play. They limited their exposure to the most controversial situations. Future research should examine whether a kind of "defensive" practice predominates therapists so that they can limit their exposure by avoiding risky or controversial techniques.

Part of the way in which therapy was structured resulted from work contexts. Several therapists, for example, operated in larger medical organizations and worked for doctors who enjoyed professional dominance (see Freidson 1970a). They provided information and insight that became part of a more comprehensive intervention but did not make lone decisions about client needs or problems or treatment. This research was

not designed to examine systematically the way in which work contexts affect practices (including deviant ones). It may be a fruitful site for future research.

The interviews raised several other issues about how therapy is conducted that warrant more careful consideration. The repression debate was revealed to be academic rather than played out in practice. The research did not provide the strategic site for explaining how deviance is defined and labels applied as had been expected. Future research may need to look at more pragmatic, practical therapy-oriented issues to get more complete information about the construction of deviance.

One of the features of these therapists' practices was that they used brief therapy rather than extended numbers of sessions (as would often be required in memory retrieval). The interviews suggested that brief therapy was influenced by such things as payment schedules of HMOs, insurance companies, and government aid programs. Future research should examine more systematically how these external demands and conditions are constraining and influencing therapy (and potentially reducing the likelihood of using risky or controversial techniques).

Accountability and Ethics

The topics of ethics and accountability also elicited universal responses. The therapists endorsed the injunction to do no harm, a professional standard that ties into their service ethic. Therapy was to help the client. This service ethic played out in how they defined deviance. The line between good and bad therapy was often deemed to be crossed when therapists were hurting instead of helping. Everyone concurred that having sexual relations with a client crossed that line. Most referred to harm caused by violating confidences, by substituting the therapist's agenda for that of the client, or by continuing

therapy when it was not helping. Some even extended the injunction beyond the bare minimum required by their professional organizations, for example by limiting all social relations (going well beyond the proscription of no sex with clients). The therapists were also wary of techniques which might prey on the client's suggestibility, and they warned against substituting their own agenda for the client's needs or client's agenda. That would cross the line into "bad" practice.

The therapists also accepted the professional organizations' guidelines without question. They thought these were sufficient for controlling deviant therapists. Their position on breach of confidentiality was consistent with the professional organizations' standards. They also accepted the proscription against having sex with clients.

Although the interviewed therapists had similar ideas about what "bad" practice, they were universally reluctant to label a therapist as deviant. They separated behavior from the person. The behavior may present a problem to be solved, but the solution did not seem to involve labeling the person. Whether this reluctance to label deviants is a matter of professional courtesy/deference or derivative from other training and occupational factors needs to be studied in more detail in the future.

We might expect that many practices and situations in therapy will remain secret and private—because neither the therapist nor the client will raise the issue. If other therapists are also reluctant to label someone as deviant, the problem of control is raised. In other areas of professional practice (e.g., surgery), norms absent some form of sanction fail to control deviance (Lanza-Kaduce 1980). Indeed, for professions, there may be a paradox.

One of the major consequences of professional autonomy is the diminished probability that compliance will be secured by the coercion of superior authority (see Freidson 1970a; 1970b). The two primary informal means of control exercised by fellow practitioners—talking to (Freidson and Rhea 1963) and personally boycotting (Freidson 1970b)—apparently have little impact on professional misconduct. . . . [T]he most effective mechanisms are those in which an errant doctor is more likely to be detected. (Lanza-Kaduce 1980, 350-51)

Lanza-Kaduce goes on to argue that in the case of unnecessary surgery the effectiveness of fellow professionals to control deviance is augmented by instances of detection and negative reaction. He notes that informal means (boycotting others or talking to others about their practices) are less effective because "such informal methods are open to interpretations other than professional censure. Why some procedures are effective and others are not may be best explained by differences in the certainty of establishing poor practice" (Lanza-Kaduce 1980, 351). These therapists allowed wide berth to other therapists for the approaches they used to try to solve the problems of their clients. The interviewees recognized the uncertainty that is inherent in modern therapy

It seems these therapists shifted the responsibility to their professional organizations to help define and regulate deviant practices. Some explicitly put faith in the ability of professional ethical standards and certification procedures to check deviant therapists. They saw their own practices as being consistent with professional norms that put clients' needs front and foremost in doing therapy. They saw their role as assisting, guiding, and facilitating client-centered efforts to change for the better. The goal was for the client to achieve self-efficacy with their help. In this sense, social control seemed to stem from an occupational or professional cultural consensus rather than disciplinary actions or censure from one's peers.

Legal Factors

The interviews obtained information about three legal issues to see how formal social control affected the construction of professional deviance by these therapists. Therapists agreed on several matters. In terms of certification and licensing, the therapists basically liked the current legal arrangements and thought they were effective for the most part. They recognized that some areas could be improved, but were unclear about what the respective roles of the local, state, and federal regulators should be.

The interviews produced unexpected results in terms of court rulings. The therapists were universally unaware of particulars of watershed legal cases which directly affected therapy practices (notably the *Tarasoff* and the *Ramona* cases). They understood, however, the directive to report possibility of harm by the client (although some did not know the *Tarasoff* case by name) and approved of it. They did not identify the *Ramona* case, but thought that third-party suits were unlikely to affect their practices.

The therapists were aware of the statutory provisions on mandated reporting of child or elder abuse, and all but one had reported abuse. For all, the definitions on when to report and what triggered the need to report were nebulous. They were all conflicted about whether a report would help the client in all instances. In problem cases, they would consult others both in and out of therapy to get feedback about what is deviant and how to control their practices. For example, therapists sought the advice of peers and other professionals (e.g., administrators and/or lawyers) when confronted by ambiguous situations that may trigger decisions about mandatory reporting.

Statutes and court cases invoke fairly certain interpretations of standards and dramatize detection and negative reactions. But the legal developments did not

necessarily contribute to the construction or control of deviance among these therapists. All the therapists were aware of the mandatory reporting statutes. Only some of them were familiar with the court cases that warranted reporting of dangerous clients and the prospect of damages if they failed to make such reports and a third party was injured (*Tarasov v. Regents of the University of California*). They were mostly unaware of the *Ramona v. Isabella* decision that established that therapists were liable for injuries caused by a client's accusations based on unreliable memories recovered during therapy.

Regardless of the level of knowledge about the law, its impact on the practices of these therapists was limited. For example, some therapists who knew they had to report abuse were conflicted about doing so. Some pursued words that offered pseudo-legalistic reasons to excuse them from the obligation. If the perpetrator was not named, they may not have to report. If the reference was too vague, they may not have an obligation. In other words, even the mandatory statutes left wiggle room for interpretation. Perhaps for some the confidentiality of therapy sessions and their autonomy reduced the chance of detection so that, consistent with their individualistic orientations, they were willing to construct their own ideographic standards about reporting. The legal standards could be pursued with little chance that they would be second guessed or held accountable. These data provide little evidence that legal social control agents constitute a salient audience for defining deviance or adjusting professional behaviors. Future research should explore the factors that contribute to this insulation from legal controls.

APPENDIX A
CONTACT LETTER

Dear Dr. (Mr. or Ms.) (insert name),

For my doctorate in sociology at UF, I am interviewing therapists on practices, opinions and outlook in the present legal and social atmosphere. You uniquely fit the research design as a local (insert licensure or certification) originally certified since 1996. I sincerely hope to interest you in being an interviewee for my research.

Should you agree to be interviewed, I believe that beyond satisfying the APA ethical directive for psychologists to contribute to public understanding of mental health issues, this interview can be interesting for you—For example: this interview can provide a sociological template for understanding your own place within the discipline of therapy. Your expertise is in doing therapy, mine is in understanding the breadth and range of the field of therapy.

My research at this point indicates that a new ethical and legal climate exists for all therapists regardless of discipline or theoretical perspective, due primarily to the controversy over repression, regression, and recovery of memories. I explore the revised directives for professional ethics and some relevant legal rulings. Additionally, the sometimes sensational media coverage on the regression debate has been instrumental in advancing an unprecedented public awareness of the existence of polar positions within mental health. I focus on your insights, feelings, and knowledge about these within the practice of therapy.

As a sociologist I have studied both the history and the recent changes now transforming the field of therapy without being directed to specialize in only one therapy theoretical perspective. From this paradigm I am likely to have information which you may wish to explore further, especially on legal rulings and the intrusion of the media. I intend to discover where the line is drawn between good practice and unacceptable practice. How good therapy practices (offices) are now being set up with the moral standards prescribed by these legal rulings and the revised APA opinions on ethics. How do the good purveyors of mental health purvey it? What do the therapy disciplines of counselor, clinical psychologist, and psychiatrist have in common and what is the range of differences between them?

Please agree to be interviewed, you are one of the few who meet the qualifications required for the study. I will call you on (date to be supplied) to see when you may be interviewed. I enclose a copy of the Institutional Review Board consent form, required by the National Institute of Health when doing research concerning human subjects and an optional demographic data form.

Thank you for your consideration,

Mike Ryan

Doctoral Candidate; Department of Sociology

Phone: 374-2294 Email: mryan@soc.ufl.edu

APPENDIX B
INFORMED CONSENT FOR INDIVIDUAL INTERVIEW

My name is Mike Ryan. I am a doctoral candidate in sociology at the University of Florida. I am currently doing research for my dissertation on effects, similarities, and differences in insights, socialization methods, knowledge, and feelings within and between therapy disciplines while focusing on the debate on repressed and/or false memories of childhood sexual abuse.

If you choose to participate, we shall engage in an interactive interview which will last approximately one hour. You do not have to answer any question you do not wish to answer. I will audio tape record the interview. After transcription the tapes will be erased and destroyed. Your identity will be protected. The interview will be confidential to the extent provided by law. Any data that identify you by name or phone number will be destroyed upon completion of this project. There are no anticipated risks or direct benefits in participating. You will receive NO compensation for participating. After my research is completed, I will be happy to discuss my general conclusions with you.

If you should agree to participate, you are free to withdraw your consent at any time and discontinue participation at any time without prejudice or repercussion. If, at any time, there are questions about this procedure, contact me or my dissertation chair, Dr. Lon Lanza-Kaduce, at the numbers listed below. If you would like to participate, please read the following statement and sign and date the appropriate line below.

I have read the procedure described above. I agree to participate in the procedure and I have received a copy of this description.

Participant's Signature _____ Date _____

Mike Ryan, Ph.D. Candidate/Interviewer _____ Date _____
<mryan@soc.ufl.edu>; or 352 374-2294

Dr. Lonn Lanza-Kaduce, Committee Chair _____ Date _____
<lkkll@crim.ufl.edu> or 352 392-7648

If you have any questions or concerns about your rights as a research participant, please contact the UFIRB office, Box 12250, University of Florida, Gainesville, Florida 32611-2250 (phone: 352 392-0433).

APPENDIX C
DEMOGRAPHIC DATA

If for any reason you feel uncomfortable in answering any or all of the following, omit that category.

Circle relevant category

1. Age: I am 21 or older. Yes No
2. Gender: M F
3. Race: Black, Hispanic, Native American, Oriental, White,
Other _____
4. Education: Last year of course work:

5. Completed course work (MA, ABD, PsyD, Ph.D., M.D.
Other _____
6. Number of years you have actively counseled (worked as a therapist) whether during formal education or after finishing: 0, >0 to 1, 1 to 2, 2 to 3, 3 to 4, 4 to 5, More than 5
7. Discipline: Mental Health Therapy, Clinical Social Work, Clinical Psychology, PsyD, Other Psychology, Psychiatrist
Other _____
8. Theoretical perspective:

APPENDIX D
CONTACT PHONE CALL

(Note: since a phone call is an interaction and actual conversation varies with the circumstances and the participants, this appendix relates an ideal type for asking if they received the material, understood it, have any questions regarding it, and if they agree to set up an appointment)

Hello, Dr. (Mr. or Ms.) _____. I am Mike Ryan, the sociologist who sent you a letter requesting to interview you for my dissertation. Did you get that material? Is there anything you would like me to clarify about any of it or would you like me to refresh your memory on it? I certainly hope that you will agree to be interviewed. Can we set up an appointment?
Thank you.

APPENDIX E
TYPES OF PROBES USED

Topics (With Possible Questions)

1. The Therapy Situation
 - a. What branch of therapy do you identify yourself with (i.e., Yung, Adler, Freud, behaviorist, etc.)?
 - b. What therapy sites have you experienced or been involved with?
 - i. Sites: Private practice? Hospital? Etc.?
 - ii. What is your office like? Set up where therapy is done?
 - c. How do you do therapy?
 - i. Authority--how important is it, how maintained? What does it involve?
 - ii. What discovery techniques do you use or might you use in foreseeable circumstances?
2. Memories
 - a. Importance in therapy
 - b. How retrieved? Dreams? Deconstruction? Pursuing lines of inquiry from correlations with present symptoms?
3. Diagnosis and Treatment of Persons Regarding Repressed Memories
 - a. Do you differentiate in discovery and treatment of repressed as opposed to suppressed memories? What does this involve?
 - b. Have you ever treated anyone with Repressed memories?
 - i. How determined? Methods used? Inquiry based on symptoms?
 - ii. How did/could you use repression in treatment?
 - c. Should counselors attempt to verify alleged abuse? Question the repression?
4. The Individual Client
 - a. How do you feel about victimhood of client--How determined, How approached to client
 - i. At lived border of reality of client
 - (1) How is this approached?
 - (2) What symptoms are looked for and why those?
 - ii. In past--How discovered (e.g., memories, records; who: client, others, therapeutic techniques)?
 - b. Construction of a viable self
 - i. What is the role of the therapist? Impartiality? Involvement as a co-interested party?
 - ii. What adaptive ideologies, attitudes and behaviors are used? Generally and for treatment of a particular client?

- iii. Is confrontation of others by the client necessary?
 - iv. Other requirements (i.e., support groups, relevant assigned readings, living groups, etc.)?
- 5. Aspects Bearing on the Therapist Other than the Individual Client: False memories? How determined? Importance to therapy?
- 6. Effects of legal rulings on practice of therapy
 - a. Which?
 - b. Importance of *Ramona* and *Tarasoff*?
 - c. Expert witnesses in tort cases involving memories recovered?
- 7. Retractors (how deal with, what to do about?)
- 8. In what ways do you see differences between disciplines?
 - a. Techniques?
 - b. What are the self-interests of disciplines? Monetary and status effects?
- 9. Do you think the practice of therapy is changing from ways it was practiced before you became certified? How?
- 10. How is the concept of repression constructed in your discipline?
 - a. How important are memories in diagnosis and treatment?
 - b. How are you trained about repressed memories? How are they used? Questions validity of repressed memories? Disregards the possibility of false memories? Does not mention the possibility of false memories?
 - c. What discovery methods should be used to search for salient childhood events when repressed memories are suspected?
 - d. Should the validity of memories recalled during therapy be verified by means other than the client's memory? Attributes the likelihood of past sexual abuse to client solely on the basis of present symptoms?
 - e. What treatment methods are used when repressed memories are found. Does treatment involve "survival groups" and removal from influence of family of origin?
 - f. Can repressed memories be determined from symptoms such as:
 - i. Indirect associations: dissociation, PTSD, anorexia or bulimia, sleeping disorders, or depression.
 - ii. Direct associations--sexual disorders.
 - g. What kind of training, education are necessary for treating persons who are suspected to have been abused and their life course affected by the abuse?
 - h. Are training, education, or professional association same as previously (pre-1970s) associated with counseling, or do you think there is a change? Why?
 - i. Have you heard of the term survivors. Some people use it to designate those who profess memories of childhood sexual abuse. What do you think about this usage?
 - j. There is discussion of backlash in the literature, how is it used within your therapy discipline? For example for therapists who now:
 - i. Question the validity of repressed memories?
 - ii. or Advocate defensive methods to block tort suits
 - iii. or Refer to some retractors

- iv. or Talk about "shoddy practices?"
11. What should (or should something) be done about therapists who elicit false memories?
 12. What methods (if any) of training or what association memberships should be required for all therapists?
 - a. Is there a decline of hegemony of psychiatrists in mental health and treatment--Do you feel that untrained therapists and others with personal agendas are taking over many of the analytic positions in this area?
 - b. Is there need for more certification for psychiatrists, psychologists, psychological degree recipients, clinical social workers?, etc.? By whom (associations?, government?, Is there a need for a unified certification)?

Issues

How are memories, especially false memories, constructed in society? (More broadly, I am interested in how you perceive differences in construction by the legal profession, media, and public and private interest groups as well as the other counseling professions.)

Should memories be used as a basis for therapy? If so, what are the ramifications of differences of methods for construction of memories?

What are the foundations of producing false memories of childhood sexual abuse?

What are analytic practices leading to false repressed memories of childhood sexual abuse?

Question of who is making the accusations--the child of years ago or the adult of now--validity question--differences in belief of testimony?

The research sites vs. the counseling sites (differences in sites by discipline).

What do you have to say about the role of law in expert testimony by these analysts?

Have you come across statistics or articles on remembered childhood sexual abuse which you consider of questionable validity? Which?

What do you think about the newly involved practices (family practitioners, uncertified psychotherapists, educational counseling psychologists, and others) when compared with medically trained therapists (psychoanalysts and other psychiatrists) and the older more traditional therapy practices (psychologists).

Who will advocate methods conforming to the repression paradigm rather than focus on the discovery of possibilities of a false or manufactured memory?

Will students who are researchers/academicians offer more caveats to conform more closely to scientific methodology than those written by clinicians. (Vantage Point Differences).

Are discovery methods, verification attempts, and treatment designs conducive to finding repressed memories and exclusive of possibilities for discovery of false memories? (Methodological Differences).

Saliency of the repressed memory concept for the research participant and attitude toward the struggle for control in mental health and "professional dominance" by the

medical and traditional professions can be studied through examination of the usage of value laden terms and issues as applied by respondents.

APPENDIX F
UNDERSTANDING THE SUBJECTS' PERSPECTIVES

If we are analyzing how a text works, we should not forget how our own text has its own narrative structure, designed to persuade the reader that, confronted with any given textual fragment, 'we can see that' a favoured reading applies. (Silverman 1993, 75-6)

Below are data and findings from the conversational analysis for the first two interviewees. Different perspectives were discerned:

Language of Moral Exactitude

Karen, a doctor of educational counseling, was a licensed mental health counselor. Through the interview she became a person—a living representation of a particular point of view in the history of therapy. Her interview, a freely-offered story of her place in therapy, provided me with my first data for understanding therapists and their view of the line between good and bad therapy at this point in theory and practice of therapy. What her role has been, what she thinks about other therapists, and what she feels about her role and the line between good and unacceptable practices of the other therapists came out during the interview from a moral-legalistic perspective.

This interview of Karen was marked with hesitations and requests for clarifications. Since Karen's responses indicated that intelligence was not an issue and since the interview probes were so general, I suspected that she was trying to ascertain my position as interviewer before giving her own answers on some of the concepts. I would have to rephrase the probe in several different ways before she would come forward with

her feelings or thoughts. The very first and undemanding task—putting the content cards in order—required my input several times. (The content cards were discussed in Chapter 4.) Second-guessing of my motives became evident at this point and continued to a greater or lesser degree throughout the interview.

Since she was the first subject I interviewed, I bore in mind that some of my questions might not have the polish that subsequent interviews would provide. Since it was necessary to elicit her story on the concepts and her place in therapy I attempted to eliminate, as much as possible, interactions as an interviewer that would influence her answers. I did this by limiting my probes to providing concepts and asking what she thought about them and thereafter using her answers as springboards for detail and exploring links between the concepts. The particular concepts on the cards had been chosen as the terms that were most often applied in articles which discussed repression and the line between acceptable and unacceptable therapy practices and techniques. Due to my grounding in the vocabulary of these topics from my literature review, I was able to take care to rephrase questions in ways that eventually allowed her to unveil her own trajectory rather than from any vantage that I might provide.

Although Karen appeared extremely eager to do the interview and proved to have a sense of humor, I had difficulty in getting her to respond to probes. Many times within the interview I had the impression that she was awaiting a cue from me as to how I felt about a particular issue. She complained, though laughingly, of the generality of the “questions.” I explained to her that the questions were to give her all the leeway possible to direct the tenor of the responses.

This search for cues became apparent from the very onset of the interview, as I gave her the concept cards and asked her to put them in order. It took nearly five full minutes for her to select five of them.

Mike: First, I have some cards, and I would like you to just go through them and put them in order

Karen: Oh, my goodness. Put them in order in terms of. . . .

Mike: Of whatever.

Karen: Okay, put them in an order.

Mike: Any order.

Karen: OK. All of them, huh?

Mike: Yeah . . . there are some of them that are repeats.

Karen: This is projective? Good thing this is not a video looking at me. (Both laugh). . . .

Mike: At least the five that you think are most important.

Karen: Most important . . . hmh te hmm hum (humming).

As time continued to pass I reminded her of the topic of the interview.

Mike: What we are looking at is the line between good practice and questionable practice.

Karen: That's how you want me to think about this as I sort?

Mike: Yeah that's one of the ideas, and where therapy is now, at this point.

About four minutes after I had first asked her to select the five topics from the cards, she said:

Karen: I know what I am going to do—just decided what I am going to do with these. (Indecipherable) . . . process it and one of the things that get sorted are people with tests like these are quick to make

judgments or they think about the possibilities forever. [laughs] I know. I know, but I'm just thinking. . . . You've got someone who's gonna try to think like, "Well if I put these, then what will that mean." Rather than "Oh this, this, this, this."

A minute of uninterrupted silence ensued, with no sound except the sound of her, flipping through the cards. Then she said, "Ok, then these are all not done," indicating all but five of the cards. It was only after I had suggested that she could use the topic of the interview as a guide that she made had progress in her selection. While it is possible that this one cue influenced her to use a legal perspective in her responses throughout the interview instead of other responses (some of which are covered below), repetition of this theme showed that it was not the deciding factor.

As the interview reached it's final stage, she returned to a consideration of the concept cards. Rather than focusing on the line between acceptable and unacceptable practice she related that she ordered the concepts according to her "professional interests."

Karen: Do you want to know why I. . . . How I ordered them?

Mike: I know how you ordered them.

Karen: No, no. But, why. I mean have you fig-, in terms of. . . .

Mike: Why did you order them.

Karen: What did I put? 'Do no harm . . . for I do believe *that*, above all. Uhm. I put these. . . . (Fumbling with cards on her lap) Oops! I won't lose them. In order of my sort of professional interests. (Laugh.) Yeah, yeah. Meaning what do I choose to go to trainings about. What do I like talking about the most, what do I, what am I most curious about these days. And, I am interested in forensic work, so I. . . . Yeah. That's why I put law and mental health up there. I'm very, I find criminals endlessly fascinating.

I was unable to determine definitively whether she was just nervous at being interviewed or careful due to her often expressed interest in legal matters when confronted with matters as controversial as the concepts of accountability, ethics, repression, and regression therapy. As the interview proceeded, she was able to answer probes on these, seemingly without undue nervousness, leading me to conclude that her objection to the generality of the probes was more likely due to her interest in legal exactitude and equating morality with legality.

Two other excerpts also indicate her “mock” objection to the generality of questions, again laughingly:

1. Mike: Okay. Now what do you think, perceive of >

Karen: (Laughs) nohohoh.

Mike: > the law in terms of abuse, child abuse?

2. Mike: What do you think about anorexia and bulimia?

Karen: [exhaling and laughing] Your questions are so open-ended I think their awful.

Mike: Do you think that that's a [laughs]. . . .

Karen: I think they're awful and I don't (laughing) wish it on anyone.
[laughs]

Mike: Well, I want to see where you go with it, in terms of >

Karen: Yeah. Like if you're. . . .

After raising the objection in both instances, she immediately responded to the initial probes. Although her interview was my first and my delivery may not have been as polished as it later became, she spoke in a language of moral correctness. Karen, who in addition to her Ph.D. in educational counseling was a licensed mental health counselor,

evinced her interest in, and commitment to, legal correctness far more often and emphatically than the other interviewees.

This was demonstrated in three ways during the interview. First, she directly stated that she was interested in legal matters. Second, in adaptation to this, she spent much more time in discussing legal aspects of therapy and certification than any of the other interviewees. Third, three of the five concept cards she selected for discussion (*primum non nocere*—“do no harm,” ethics and therapy, and accountability and law) all contain elements of morality and legal substance. Her protracted attention to choice of cards evinces the significance of these particular selections. Her insistence on seeing the concept cards as a test, rather than merely an ordering designed to provide areas of discussion, was not duplicated by subsequent interviewees.

Language of Precision

Gail, a Ph.D. in clinical psychologist, evinced assurance, competence, comprehensiveness, and precision. She did this in several ways. Throughout the interview her demeanor was relaxed. Her tone of voice was well modulated and even. She almost always used complete, compound, and coherent sentences. Her expositions were so coherent that I would have thought that she saw the concept cards before the interview if I had not known that she could have little idea of what the probes would or could be.

She would cover a topic to her satisfaction without seeking approval (e.g., asked for clarification of probes before delivering her response; presented her feelings on controversial issues—regression therapy, use of ritalin, etc.—matter-of-factly). She very seldom used superfluous phrases or words: “you know,” “I mean,” “uh,” “er,” or even

silences, which are often used in speech to indicate discomfort, that the speaker is putting her/his thoughts together and will have more to add, or that there is a break so that the other person can take a discussion turn. When she had finished on a topic to her satisfaction, she would definitively stop and wait for the next prompt.

When she felt that she had covered a topic and had nothing more of relevance to add, she would listen to what I was saying and indicate her attention by saying “um hmm,” but would not add to the conversation unless she had something meaningful to say. For example, late in the interview, I brought up the topic of ethics for a second time. Early in the interview she had talked about her selection of the “accountability and ethics” concept card. As a renewed probe on ethics, I noted that published standards of ethics were very similar among the therapy disciplines.

Mike: Yeah. In my review of the ethics, the statements on ethics in each of these disciplines that I’ve mentioned—they’re . . . very similar.

Gail: Um hmm

Mike: Uh, and it’s a. So it’s. It seems like that uh, there’s a certain element of uh commonality >

Gail: Um hmm

Mike: > already.

Gail: Um hmm

Mike: And they’re

Gail: Also you got

Mike: I mean, I’m I’m not advocating a position here.

Gail: Um hm

Mike: I’m, you know, >

Gail: Umhm

Mike: > stating what I, what I know >

Gail: (indecipherable)

Mike: > to get your >

Gail: Um hmm

Mike: > feedback across from it. . . . Ahm, I I've, I don't know, but I, but I wonder, you know, shou-should there . should uh there be a national, some kind of national input? and if so, what?

From her use of “um hmm” to show that she understood what was being said but not chose not to pick up her turn in the conversation at obvious break points, revealed that she had said what she wanted to say on ethics earlier (very concisely and thoroughly) and did not respond to my cues to add comments about similarities or differences between the disciplines, which she might have noted. She started to say something once but stopped and I did not pick up on it enough to ask more directly. In the end I asked directly for her feedback. Getting a period of silence to that probe and no further answer, I then reluctantly moved to another related concept feeling that something had been left unsaid and that I had been unable to elicit it.

When I asked if she paid much attention to court cases and particularly about the *Ramona* case she said, “I’m not sure, but just let me know.” I explained the ruling on the case and the following interchange transpired:

Mike: Did any of that become familiar to you as you read that particular case, or about it?

Gail: I haven't heard about that case before.

Mike: Do you know about third-party law suits?

Gail: Uhm.

Mike: Or did you know before I talked about it?

Gail: No.

Since the only information she had on this came from me as interviewer, without apology Gail would not and could not provide an answer that was assured, competent, comprehensive, or precise. She did not speculate during any segment of the interview.

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BIOGRAPHICAL SKETCH

I was born at home in Lubbock, Texas, November 2, 1940. The doctor was late but I was not. My childhood was happy and active with three brothers and three sisters. Though poverty-stricken, both of my parents devoted their lives to making our lives happy and fruitful.

I graduated from Monterey High School in Lubbock, Texas, in 1959. The next year I started my college education with a psychology course from the University of California Extension in San Francisco. I studied at City College, San Francisco, from Spring 1961 through Spring 1963; San Francisco State from Fall, 1963 to Spring 1965 and Summer of 1967; San Fernando Valley State College, Northridge, California, from Spring 1966 to Spring, 1967; Wayland Baptist College, Plainview, Texas, in the Summer and Fall of 1981; and Texas Tech University from Fall of 1992 to Spring 1997. I received a Bachelor of Arts degree in sociology with a psychology minor December 18, 1993, and then a Master of Arts degree in sociology from Texas Technology University May 10, 1997. I also attended the University of Florida from Fall, 1996 to Spring, 2002, and Summer and Fall, 2004.

During my adulthood, I held many jobs—from in the trades, throughout the clerical realm, owning a business, and teaching in a proprietary school and in a high school. I moved from Lubbock to Ft. Ord, California, in 1959 and then to San Francisco in 1960. I lived in many cities in California including about five years each in San Francisco and Berkeley. I moved to Boston in 1975 and to Madison, Wisconsin, the next

year. I moved back to Lubbock in 1976. I lived in Gainesville, Florida, from 1996–2002, when I moved to Lafayette, Louisiana, to teach at the University of Louisiana at Lafayette, where I am currently.

I was married in 1963 and divorced in 1965. I remarried in 1976 and divorced in 1989. Each marriage blessed me with a son, Eric Lee Ryan and Wesley Gilbert Ryan, and cursed me with the legal pain of being separated from their socialization during much of their childhoods. My plan after receiving the Ph.D. is to teach and do research at a to-be-determined university and be as accessible as possible for my sons, who reside in California and Texas.