POTENTIAL ABUSES OF POWER IN PSYCHOTHERAPY

A thesis submitted in partial satisfaction of the requirements for the degree of Master of Arts in

Education, Educational Psychology, Counseling & Guidance

by

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May, 1984
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ABSTRACT

POTENTIAL ABUSES OF POWER IN PSYCHOTHERAPY

by

Paulette Rubick Freedenberg

Master of Arts in Counseling and Guidance

The purpose of the study is to develop a list of therapist behaviors which could be considered abuses of power. A survey of the opinions of therapists, counselor-educators, clients and prominent authors in the field provides the data for the development of the list.

The study examines the following hypotheses:

1. It is possible to develop a list of therapist behaviors considered to be abuses of power.

2. It is possible to achieve some consensus among therapists, clients and counselor-educators as to what those abusive behaviors are.

3. It is possible to express those behaviors in clear, behavioral terms.

In order to complete the survey, two instruments were developed: 1) an interview guide for therapists and counselor-educators and 2) a client self-report questionnaire. Listings of abuses gathered from
these instruments were compared with information available in the current literature to determine areas of consensus.

It was found that the three major subject groups agreed on eight of 10 major categories of abuse but there was no agreement amongst them at the level of behavioral specifics. Of the 71 behaviors delineated by respondents in the study, 50 were clearly stated in behavioral terms. There was agreement between two subject groups on 13 of the 71 behaviors indicated.

The results of the study confirm that it is possible to develop a list of behaviors considered to be abuses of power in therapy (Hypothesis (1)) and to express those behaviors in clear, behavioral terms (Hypothesis (3)). However, the data presented here indicates that it is not possible to achieve consensus among the subject groups considered in the study (Hypothesis (2)).
CHAPTER ONE

Background of the Study

Introduction

For many, therapists have become the new philosophers and wisdom figures in our society. As the use of psychotherapy increases and becomes more generally accepted and as psychotherapeutic thought and philosophy continues to permeate our thinking and infiltrates the media, people give more and more credence to the position of "therapist." No longer is he seen in the remote Freudian model: detached, intellectual, unresponsive, likely to subject you to years of analysis and limited one-way interaction. Instead, he is more likely to be viewed as a resource person, someone to help guide you through the critical experiences in your life: marriage, divorce, loss, self-exploration. As his role has shifted from authority figure to partner-aide-guide-expert in human relations, his ability to influence has undergone an interesting metamorphosis.

At one time, when therapy was primarily under the influence of the medical model, the therapist possessed most of the power in the therapeutic relationship. Although his stance was supposed to be neutral - a blank sheet against which the client could project his neurosis - he actually assumed a position of great power. Able to make interpretations and guide the client's perceptions of what he was saying, he became the essential factor in the client's being able to understand himself and what his inner feelings and thoughts really meant. As therapy and therapists became more humanistic and
responsibility for the direction and outcomes in therapy shifted to the client, the therapist became less the parental figure dispensing cogent analysis of observed phenomena and more a partner in the process of self-exploration and self-understanding. Even proponents of active-directive therapies concerned themselves with the partnership aspects of the process, encouraging clients to set their own goals and make continual self-evaluation of the processes they were experiencing. Logically, it would seem that once the role of "therapist" became less authoritarian and parental in nature that the ability of the therapist to influence clients so directly would diminish. Surprisingly, this has not been the case. As therapists have become accepted as partners-helpers-guides they have become less threatening and more approachable. Consequently, clients are more able to trust themselves and their life struggles to them.

The conclusion that experience with a therapist may be beneficial is inescapable in today's world. "Dear Abby" commonly recommends marriage counseling in her advice columns; major television networks have regular spots on their newscasts for human relations issues (sexuality, handling divorce-singleness-loss-stress); Toni Grant and other radio personalities daily provide advice and psychological theory to millions of listeners (a practice which is controversial in the field); magazines regularly carry articles which transmit psychotherapeutic philosophy into our lives (how to raise your children, handle being a working mother, keep your husband/wife satisfied, find happiness and self-fulfillment). It is the pervasiveness and resulting acceptance of psychological thought that gives the therapist a
position to influence he may not have had in the past. At the very least, it gives him a broader and more receptive audience.

The therapist's ability to influence, then, has not diminished. Rather, it has changed quality and character; it has become less the power of uncontested authority and more the power of vested authority.

We have given therapists our sanctions and trust. We expect them to have a degree of expertise and anticipate that their interventions will be beneficial to us. However, this is not always the case. As Bernie Zilbergeld (1983) states in *The Shrinking of America*:

> Given the reckless abandon with which therapy is recommended to everyone, people clearly believe it can only be for the good. The idea has long been held by therapists that at worst, counseling can only fail to help you change. A moment's thought should be sufficient to indicate that a method powerful enough to produce positive change is also capable of producing harm, a conclusion supported by many studies.

The issue of abuse and harm in psychotherapy has increasingly come to the public attention, especially with the revelation in the early 1970's that some therapists were engaging in sexual activities with their clients. Since that time, the list of potential abuses of psychotherapy has grown as more public attention has been given to the harmful aspects of the therapeutic experience. Ironically, therapists are finding themselves in the position of having been empowered with a great deal of influence, status and prestige at the same time that psychotherapy has undergone a major cycle of critical scrutiny. Therapists handle this confusing predicament in one of the following ways:

1. Focus on the potential harms of therapy to the extent that
they abandon practice or become radically outspoken. ("We all do it. I quit!")

2. Acknowledge the problem areas but deny the possibility that they exist in their own practice. ("They do it, but I don't.")

3. Acknowledge the problem areas but deny the power of their position. ("I don't have the power to do it.")

4. Seek to remain sensitized to power and harm issues while practicing therapy to the best of their ability. ("I could be doing it. I must be conscious and aware so that I avoid doing it as much as possible.")

Ideally, all practicing psychotherapists would embrace the fourth position. In a spirit of good faith and conscientiousness they would gladly improve their skills or attitude in order to reduce the potentials for harm to their clients. Unfortunately, there are several mitigating factors which prevent this from occurring, such as:

1. Client-related factors
   a. Variability in individual client response to treatment techniques
      Some clients find confrontation, for example, to be extremely helpful, while others find it almost abusive. Therapists can have difficulty in pinpointing exactly what behaviors are likely to be harmful to any one client.
   b. Inability of clients to assess the harm/benefit of treatment practices
      Some clients are too vulnerable, psychologically unsophisticated or confused by conflicting needs to judge
the effectiveness of their therapeutic experience. Therapists who expect a client's evaluations to be inaccurate may minimize or ignore legitimate feedback about their abusive behaviors.

c. Influence of client behaviors which affect negative outcomes

Since reactions such as resistance and transference do exist, therapists are sometimes tempted to deny the possibility of their own role in creating negative experiences for the client.

2. General factors

a. Differences in counseling theory or technique

Some therapist behaviors considered beneficial in one system are considered harmful or even destructive in others. This, like client response variability, makes the clear determination of abusive behavior difficult.

b. Denial of the power role of the therapist

Increasingly, current therapies have shifted responsibility for the outcomes in therapy to the client. This had led some therapists to underplay the degree to which they believe they are influential in the client's life or capable of "inflicting" harm.

c. Difficulty in assessing harm or abuse

Due to the variation in techniques, difficulty in determining concrete measures of outcome, and lack of significant outcome and evaluation research in the field
it has been hard to make reasonable judgments about harm or benefit in psychotherapy.

3. Therapist-related factors

   a. Addiction to the power position
   b. Clouded self-perceptions
   c. Interference of theory

   Rigid adherence to any one particular therapeutic style can lessen a therapist's sensitivity to the presentational needs of the client. In an effort to honor the precepts of a therapy style, the therapist could utilize methods which are harmful for the particular individual he is treating.

   d. Denial of the possibility of abuse

   There are some therapists who maintain that everything a client experiences in therapy is ultimately beneficial. Even those incidents which appear to be harmful provide the client with opportunities to develop skills and gain self-awareness he might otherwise never have had.

Considering the number of mitigating factors, it is not surprising that therapists could avoid dealing with the issues of abuse and power in a meaningful and personally relevant manner. However, it is believed that if psychotherapy is to survive this particular cycle of public examination, therapists will have to become sensitive participants in the process of self-examination. This project is intended to be a first step in making that task a little easier.
Statement of the Problem

There is growing recognition in the field that therapists do have influential power over their clients, that it is possible to abuse that power, and that more attention should be given to the issues of harm in therapy. The problem addressed in this study is to determine whether those abuses can be identified, whether a general consensus can be reached among therapists, counselor-educators and clients as to what those abuses are, and whether those abuses can be expressed in clear behavioral terms that will be useful in the field and in future projects.

Purpose of the Study

The purpose of this study is to develop a list of therapist behaviors which could be considered abuses of power. In order to determine whether a listing can be developed which represents the attitudes of all segments of the therapeutic community the following procedures will be employed:

1. Personal interview of therapists and counselor-educators
2. Client self-assessment questionnaire
3. Review and analysis of findings in the current literature

The information gained from these sources will be compared and analyzed to determine areas of agreement.

The gathering of this material is the first step in a larger project aimed at the development of an assessment tool designed to sensitise counselor-trainees to those behaviors which may contribute to negative outcomes for their clients.
Importance of the Problem

With the advent of consumerism and the growing possibility of national health insurance, therapists are beginning to be called upon to demonstrate in clearer terms what they do, how effective they are at doing it, and what the outcomes of their interventions have been. Increased public awareness of the potential for harm in therapy has made this careful scrutiny of therapeutic behaviors even more critical.

While abuses have probably always existed, there may never before have been such a general awareness and recognition of the problem. A 1976 Vanderbilt University survey of 150 experienced therapists and researchers revealed that "...there was virtual unanimity that there is a real problem of negative effects" (Strupp and Hadley, 1977). However, there appears to be some hesitation in the field to engage in meaningful self-examination. As Jonas Robitscher (1980) states in The Powers of Psychiatry:

...There has been too much emphasis on the good that psychiatrists do. Few practitioners are concerned with psychiatric abuses...

Statistics, of course, are not available, but we can assume on the basis of reported cases that similar examples of the misuse of psychiatric authority exist, are not reported, and outnumber the reported cases by an overwhelming ratio. We get the same impression from reading the newspaper stories, the studies of sociologists, and the personal accounts of patients and former patients that document some part of the abuses mental patients receive. It is only by going to these sources that we learn how psychiatric power is used, for there is nothing in the standard psychiatric texts to indicate psychiatric power is ever misused.

According to prominent authors in the field, the time has come for therapists and theoreticians to openly address the issue of abuse and take the steps necessary to minimize harmful and negative outcomes
for the clients.

"Our profession has too long operated on the belief that it was doing a good job for the public," says Dr. Shapiro. "It is time that we forget about our exaggerated claims, about the theories of Sigmund Freud and our mystical shibboleths of the Unconscious and start doing the solid research necessary for a profession with integrity" (Robitscher, 1980).

There are several reasons why leaders in the field consider an examination of abuses in therapy to be vital at this time:

1. Therapists change our values

   As will be discussed at length in Chapter Two, therapists are in a position to affect our concepts, values, and beliefs about how we should live our lives. A simple examination of the media output will reveal the intensity of the infusion of current psychotherapeutic belief into our culture. Because of the pervasiveness of this indoctrination, it is essential that practitioners in the field be clear about what practices are harmful or beneficial to clients.

2. Even "good" therapy can have bad consequences

   Despite the sincere efforts of therapists to prevent negative effects, they will and do occur. Recognizing this reality, therapists are obliged to remain as aware as possible of the effects of their interventions.

3. Psychotherapy is too powerful to not be scrutinized

   Psychiatrists have been happy to exert their authority without giving an opportunity for it to be challenged. They insist on making their decisions in obscurity where the process of decision making can go on free from questioning. They continue to want to define limits for their patients and clients without defining their own.
The force of psychiatrist-patient interaction is too powerful; the controls that psychiatrists sometimes are required to impose on patients are too encompassing for this power to be exercised without scrutiny and with only a few safeguards. Every exercise of psychiatric authority demands scrutiny. If the patient's dreams or slips of the tongue or associations are worth attention, so too are the psychiatrist's methods and values (Robitscher, 1980).

4. Clients are sometimes unable to recognize improper practice

In order for a therapeutic relationship to develop, a great deal of faith in the good will of the therapist must exist. It is just this sense of trust that makes it difficult for some clients to view their therapy objectively, to consider the possibility that the experiences they have had in therapy may have been harmful or abusive. Further, many clients do not know what to expect from therapy and therefore are unable to make an assessment of outcome.

5. Abuses are often subtle and hard to pinpoint

Beyond the grossly obvious abuses in therapy such as sex with clients, there are numerous harmful practices which are, though subtle, equally injurious to the client. Since most therapists work alone, outside the reach of peer review, and since there are few commonly accepted standards of practice in the field, it is difficult to monitor and determine when these subtly damaging practices are occurring. As has been stated before, there is hardly a general agreement as to what these abuses are. For this reason alone it is important that an analysis and listing of abusive behaviors be conducted.

6. Society is increasingly holding therapists accountable
Consumers are clearly more aware than they ever have been that therapy has negative outcome dimensions. This consciousness is increasingly being translated into practical terms that affect the income and security of therapists. As national health insurance becomes more prevalent and third-party payment becomes the norm, therapists will no longer be able to practice free from the influence of governmental health agencies. In order to be paid, they will be required to demonstrate effectiveness and adherence to whatever standards of practice become the norms of the agencies controlling the funds.

7. There is a moral imperative to protect the best interests of the clients

Therapists are ethically responsible to insure that clients are protected from harm. A recognition that abuses do exist necessitates that efforts be made to minimize their occurrence.

Need for the Study

In order to make any intelligent assessments of the existence of abuse or harm in psychotherapy, it is necessary to determine what behaviors are likely to be beneficial or harmful to clients. As far as the author's research has revealed to date, there have been no previous projects which seek to compile a list of abusive behaviors which are clearly stated in behavioral terms and which are representative of the opinions of therapists, counselor-educators and clients. Usually, research focuses on the opinions of one segment of the therapeutic
community and does not represent a comparison or analysis of the beliefs of the other significantly influential or impacted parties. It is the contention of the author that a listing of abuses should reflect the points of view of those affected as well as those who perpetrate the particular behavior in question. To this end, the opinions of clients, therapists, counselor-educators, and prominent authors in the field will be examined, analyzed and compared.

It is hoped that the results of this study will fulfill a need for a listing of abuses that is 1) representative of the opinions of clients as well as practitioners, and 2) useful in further projects designed to analyze the existence of abusive practices. It is believed that the usefulness of the results will be directly related to the clarity with which the abusive behaviors are described and the degree to which there is agreement among the various segments of the therapeutic community as to what those behaviors are.

Hypotheses

1. It is possible to develop a list of therapist behaviors considered to be abuses of power.
2. It is possible to achieve some consensus among therapists, clients and counselor-educators as to what those abusive behaviors are.
3. It is possible to express those behaviors in clear behavioral terms.

Limitations of the Study

This study is limited to the opinions expressed by the clients,
therapists and counselor-educators surveyed. Participants are all residents of California, and it is assumed that their responses to the personal interviews or questionnaires are honest representations of their beliefs and attitudes at this moment in time.

Client Population

There are 23 client respondents, all of whom live in or near Ventura County. Seventeen are female, three male; they range in age from 22 to 54, with a mean age of 33.7 (M 33.7).

Therapist/Counselor-Educator Population

The 12 therapists and counselor-educators interviewed reside in California communities from San Diego to San Francisco, with the majority (6) living in Los Angeles. Ten are male, two female; they range in age from 39 to 67, with a mean age of 47. Eight are currently practicing therapists, six are counselor-educators also, and three are counselor-educators only. They represent a cross-section of therapeutic schools including client-centered, behavioral, humanist-extential, gestalt and family systems. There are no participants who represent the psychodynamic school or who possess a medical degree or license as a psychoanalyst. Respondents possess the following licenses or credentials: MFCC, Psychologist License, PhD or EdD, Pupil Personnel Credential and School Psychologist Credential. Their reported years of experience as therapists range from five to 30, with a mean of 12.4.

Definition of Terms

1. Therapist
A licensed professional, other than an MD, engaged in the service of providing psychotherapy. (Although psychiatrists are obviously therapists, this study strives to focus on those abusive behaviors which are primarily non-medical and within the range of normal daily activity of the LCSW, MFCC, PhD in Counseling Psychology and Licensed Psychologist.)

2. **Power**

   The ability to exert influence over the ideas, behaviors, values or emotions of another person.

3. **Abuse**

   Any therapist behavior which harms the client emotionally, physically or adversely affects his life or personal functioning.

4. **Abuse of Power**

   Any abuse which results from the therapist's use of his position of influence and power in the therapeutic encounter.

Outline of the Remainder of the Study

Chapter Two reviews the literature and discusses the research related to the issue of abuse. It presents a categorization and listing of behaviors considered potentially abusive by authors in the literature reviewed and compares these findings to the ethical standards of four major professional organizations.

Chapter Three discusses the methodology and procedures utilized to conduct the study. It includes a description of the design of the study, the population and sample, the instruments utilized and the and the treatment of data.
Chapter Four presents an analysis and interpretation of the data gathered in the study. It includes a comparison and item analysis of the data and a discussion of the results.

Chapter Five summarizes the results of the study, delineates conclusions which follow from the results and presents recommendations for improving the study and continued related research.
CHAPTER TWO

Review of the Literature

Introduction

Since the early 1970's when Thomas Szasz (Heresies, The Myth of Mental Illness, The Myth of Psychotherapy) spearheaded the trend toward critical scrutiny of the profession, concern over the issue of abuse in therapy has grown. It is not difficult to find a number of books and journal articles that address themselves to the potentially harmful practices in therapy. Research for this study includes over 50 sources whose major focus is to sensitize the reader to problem areas in the practices of the profession. Generally, authors tend to focus in the following areas:

1. Abuses in a particular field or system of therapy

Many of the early works focus on harmful practices occurring in mental hospitals and as a result of medical intervention (The Powers of Psychiatry, The Myth of Mental Illness, Going Crazy). Others focus on harmful techniques associated with one system of therapy or another (Complete Guide to Therapy).

2. Abuses related to larger issues

Many authors, especially those whose apparent frame of reference is political or sociological as well as psychological, tend to view abuse in terms of influence, power and control. Rather than concerning themselves with particular therapist techniques, they address questions of attitude,
dominance and the need to control, as well as the larger social context of the therapist's interventions (The Psychological Society, R.D. Laing; The Philosophy and Politics of Psychotherapy, The Shrinking of America).

3. Abuses related to breaches in ethical conduct

Some authors approach the question of harm in therapy from the ethical standpoint. They address questions such as: "What should a therapist do or not do?" and "What are the behaviors that breach standards of moral conduct?" They attempt to establish some criteria for what is harmful/beneficial then seek to measure practices of therapists against those standards (Values, Ethics, Legalities and the Family Therapist, Psychiatry and Ethics, APGA-APA-AAMFC Codes of Ethics).

While a fair degree of attention has been given to the question of potential abuse in therapy, a research of the literature has not revealed any major research projects which have sought to address the particular problem presented in this paper, which is to develop a comprehensive listing of potential abuses which reflects a consensus of the opinions of both clients and therapists in the field.

Individual authors tend to present a listing of abuses within the context of their own viewpoint or experience (i.e., within the medical system) or focus on a particular kind of abuse (i.e., sexual). However, they do not generally attempt to formulate a listing that reflects the views of all significantly involved groups.

It has been established through research that therapists have
influence over their clients (Greenspoon, 1955; Krasner, 1958; Quay, 1959; Salzinger, 1959; Staats, Staats, Heard & Finley, 1962; Truax, 1966, Verplanck, 1955). This evidence does provide us with the fundamental baseline for the hypotheses of this project. If it has been shown that therapists do have the ability to influence their clients, then we are able to consider whether the influence is harmful or beneficial.

To some extent, this research has been done. Carkhuff and Truax, working in the 1960's, were able to delineate certain therapist behaviors likely to produce beneficial results for the client. In addition, authors and researchers such as Rogers, Combs, Patterson, Kelly and Maslow have given considerable attention to the positive interventions of therapists: "What attitudes, beliefs, techniques can the therapist utilize to truly help the client?" (Shertzer and Stone, 1980). Interestingly, it has been shown that therapists who possess certain qualities are equally effective, despite differences in technique or theoretical approach to psychotherapy.

There has been some outcome research aimed at evaluating the impact of therapy on the client. These studies attempt to document client reaction to therapy by measuring observed behaviors and by utilizing standard assessment instruments given before and after treatment. The information gained in these studies is essential in the field, and again provides a theoretical framework for the study. If we are able to document that some harm has occurred, we are free to examine the causes of that harm. However, precisely because it is outcome-based, it does not provide insight into the specific causes of
harm; it does not enable us to come to conclusions about specific behaviors.

Although the materials available to the author at this time did not provide a comparison base for research methodology, they did aid the development of this study in the following manner:

1. Provide a general frame of reference

The wealth of sources which address the general issue of abuse in therapy were extremely helpful in providing a basis of understanding of the problem of abuse: how to define it, recognize it, express it in behavioral terms, minimize it in the future.

This background made the creation of interview forms and questionnaires much easier and the organization of the findings more systematic.

2. Provide an indication of what leaders in the field consider to be abusive practices in therapy

The author was able to develop an initial listing of potentially abusive behaviors to be compared with the findings in this study. This listing, which will be presented in alphabetical order, is a compilation of the opinions and attitudes of the authors listed in the bibliography.

**Research Findings**

There is general agreement in the literature that therapists have prestige and stature in our society and derive a degree of authority and power as a result of their position (Haley, 1969; Robitscher, 1980; Ruitenbeek, 1972; Szasz, 1978; Zilbeigeld, 1983). They are able to
exercise this power in a variety of ways, some more subtle than others:

1. Set up broad categories defining normal and abnormal behavior

   For example, therapists today have decided that homosexuality is no longer deviant behavior but a variation of sexual preference that may or may not cause psychological difficulty. This change in attitude has drastically affected treatment approach as well as societal attitudes towards homosexuality.

2. Permeate the culture with psychological thought

   Even people who cannot tell the difference between a psychologist and a psychiatrist, and who would scrupulously avoid seeing either one, have had their attitudes shaped on abortion, sexuality, child rearing, treatment of criminals, drug use, and most other aspects of modern life by psychological opinions and psychiatric opinions that filter to them through newspapers, popular psychology books, films, television commentary, and increasingly through television dramas, soap operas, and situation comedies (Robitscher, 1980).

3. Present themselves as authorities

   Although much of modern psychotherapy has no basis in science, some therapists nevertheless present themselves as if they have knowledge or skills that are grounded in scientific fact. Clients who accept them as experts and their analyses as truth empower therapists with an undue amount of influence.

4. Perform legal functions

   Therapists can be called upon to act as expert witnesses in court proceedings. They can make determinations which
significantly affect people's lives (i.e., child custody, parole, military service and employment determinations).

5. Influence medical decisions

Therapists have been consulted to help determine whether a client can undergo medical procedures: abortion, sterilization, sex-change, life-maintenance procedures, elective cosmetic surgery.

In addition to these more observable functions therapists have been empowered to assume, there are many subtle ways in which they can influence the client: suggestion, reinforcement of particular values or client choices, analysis, interpretation, use of body language to signal approval or disapproval. Just how they are able to exert this influence will become apparent as we examine the list of abusive behaviors compiled from an analysis of the current literature.

Abuses of Psychotherapy

1. Coercion

Unfortunately, people do not always freely choose to participate in therapy or psychological experiments. According to Israel Goldiamond (1976), "In all events, consent to participate in some activity where the consequence contingent on participation was made critical by the consequence-delivery system should be considered as having been obtained under coercion." Prisoners whose parole rests on their cooperation or students whose grades depend on compliance are examples of individuals who may be acting under the influence of coercion.

2. Confidentiality
One of the most commonly cited abuses in therapy is a breach of confidentiality. Therapists have been known to gossip amongst themselves, give confidential information to interested parties without the client's consent, and make psychological recommendations based on confidential material without consulting or informing the client of the criteria for judgment. These behaviors can be harmful because they are a betrayal of trust. The client, who may have difficulty trusting anyone, is once again victimized by his willingness to be vulnerable.

3. Labeling

Although the use of diagnostic labels is controversial in the field, most of the authors maintained a negative view of their general use. Thomas Szasz (1974) commented that "psychiatric diagnoses are stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others."

Some concerns related to the use of diagnostic labels include:

a. Once labelled, the client gets stuck with that label.

b. Labels color other's perceptions of the person and how they treat him.

c. Diagnoses are not scientific or often even accurate, and thus labels are not a true statement about the client.

If the labels were shown to have high
reliability and validity, exposure to this "secondary deviance" (deviance imposed by social institutions and of which the individual is essentially innocent) might be warranted. But dispositional diagnostic labels do not have this scientific character. Rotter (1960, p. 407) has referred to their propaganda value as opposed to their informational value, while Sarbin (1967) has argued that the labels are "vacuous, save as an epithet of pejoration (because they are of little scientific value because of their) reliance on an outworn mentalistic concept - the ghost in the machine... (p. 453)." Menninger (1963) went even further, referring to dispositional labeling as "pejorative name calling (p. 47)..." (Stuart, 1970).

d. Labels carry personal, legal and social stigmas.

e. Clients who are labelled may start to categorize themselves as patients and attempt to live up to their label. They acquire the lifelong identity of being a patient (Stuart, 1970).

f. The label introduces a new fear. The client may think the label represents the whole person: "Who I am is a 'paranoid'."

g. Therapist behavior toward client is affected by the label.

h. The label negatively biases the client's opportunities in work, school and the social environment.

Several of the above concerns were validated by Rosenhan (1973). In his study, several volunteer pseudo-patients were admitted to different mental hospitals. Their negative experiences in terms of diagnosis and treatment led the author to
conclude that "...any diagnostic process that lends itself so readily to massive errors of this sort cannot be a very reliable one."

4. Money Issues

The therapist who needs a certain patient load to maintain his lifestyle is vulnerable to abuses related to charging:

a. Keeping client in treatment longer than necessary in order to secure the therapist's income.

b. Terminating clients too early who are unable to pay.

5. Omnipotence - The Therapist as God

Whether he desires or recognizes it or not, a therapist is given a certain degree of power by the client. There is a strong historical basis for this occurrence. From the days of witchdoctors and shamans, to the era of spell-binders like Mesmer and up to modern times, people have chosen to endow a selected elite with special powers to heal their psychic wounds. There is nothing inherently pathologic about the need for a wisdom figure, although one might prefer that individuals develop the ability to look within for personal strength. The difficulty arises when the object of their faith buys into their distorted image of him, when he too sees himself as omnipotent and able to give the client more than he can in reality provide.

It is not surprising that some therapists choose to view themselves in this manner, even on an unconscious level,
considering the following factors:

a. Therapists are a power elite
   
   As Ruitenbeek (1972) states in a biting critique of therapy:
   
   They belong to one of the high-status professions in this society. This means that no matter how stupid their utterances or how badly they treat people, they are respected. We accord the same privilege to doctors and lawyers. This protection by attainment of status makes the therapist immune from serious criticism. It is this immunity, combined with the general powerlessness of the people undergoing therapy, that allows therapists to do the enormous amounts of harm they do.

b. Therapists operate from a one-up position
   
   Although many therapists would probably wish that it weren't the case, they are automatically in a superior power position due to the mere fact that someone is coming to them for help. It would be possible to exploit this position or allow it to continue throughout the therapy if the therapist has unresolved issues himself about control, dominance and power.

c. Society needs experts
   
   People in need of help need to believe that someone has the expertise to alleviate their suffering. This degree of faith is necessary in order to facilitate the development of mutual trust in therapy (Levine, 1972). A therapist can easily be caught
between his desire to present a reassuring level of expertise to the client and his desire to accurately assess what he can, in reality, do. Efforts to maintain the balance can tip in the direction of exaggerated claims and inaccurate self-assessment.

The danger of assuming the omnipotent position, beyond the strain it puts on the therapist himself to perform and be all-knowing (Robitscher, 1980), is that the client becomes vulnerable to the following abuses:

a. Manipulation by the therapist

The therapist who mistakenly believes that he knows all and can do all may be tempted to tell the client what to do, think, believe or feel.

b. Mismanagement of transference

At some point in therapy, many clients transfer anger or hostility from their own lives onto the therapist. Those therapists who like to be treated like gurus might misinterpret this reaction as being directed toward them and react punitively (Kovel, 1976; Robitscher, 1980).

c. Encouragement of dependence

Therapists who exploit their position of superiority in therapy rob the client of the opportunity to develop the autonomy he will need to function in the world. Clients don't need gurus as much as teachers and guides who will help them learn to
manage their own lives (Levine, 1972).

d. Subjection to behavior control

Therapists who act like gods may be tempted to mold and direct the behavior of the client. Although this is based on the belief that they know what is best for them, it violates their right to self-determination and informed choice (London, 1969).

6. Sex with Clients

The therapeutic experience is intimate and personal and it is not surprising that sexual feelings and attractions could arise in that setting. However, the decision of the therapist to engage in sexual activity with a client during therapy is considered a blatant abuse of power. Probably sexual interactions have been occurring between client and therapist long before the public became aware of it in the late 1960’s. Freud wrote to Sandor Ferenczi, a Hungarian psychoanalyst, in 1931:

You have not made a secret of the fact that you kiss your patients and let them kiss you; I have also heard that from a patient of my own...

Now I am assuredly not one of those who from prudishness or from consideration of bourgeois convention would condemn little erotic gratifications of this kind. And I am also aware that in the time of the Nibelungs a kiss was a harmless greeting granted to every guest. I am further of the opinion that analysis is possible even in Soviet Russia where so far as the State in concerned there is full sexual freedom. But that does not alter the facts that we are not living in Russia and that with us a kiss signifies a certain erotic intimacy. We have hitherto in our technique held to the conclusion that patients are to be refused erotic gratifications...
Now picture what will be the result of publishing your technique. There is no revolutionary who is not driven out of the field by a still more radical one. A number of independent thinkers in matters of technique will say to themselves: why stop at a kiss? Certainly one gets further when one adopts "pawing" as well, which after all doesn't make a baby. And then bolder ones will come along who will go further..." (Robitscher, 1980).

Unfortunately, Freud's predictions have been fulfilled.

Popular awareness of the fact that a certain minority of therapists had sexual relations with clients and advocated it as treatment began in 1969 when James McCartney published "Overt Transference" in The Journal of Sex Research. From that point until the late 1970's increasing evidence emerged indicating that sexual activity was much more prevalent than had been believed (Robitscher, 1980).

The sense of alarm in the public and professional community is based on the belief that sexual activity with the therapist can harm the client in several important ways:

a. Takes advantage of the client's trust in the therapist

The client, vulnerable and unable to make the most sound judgments about her needs and desires, is in no position to consent to a physical relationship with someone as powerful as her therapist. She needs to know that he will protect her best interests, rather than seek to gratify his own needs.

b. Increases her powerlessness

Clients who report or object to physical
advances are often not believed. Even in court proceedings, women have been treated as "mentally ill" and their testimonies have been discredited on that basis. Already in a one-down position with some therapists, her powerlessness and victimization is reinforced by the person she believed would help her.

c. Arouses fears of sexual exploitation
d. Exploits the inequality of the relationship

Robitscher (1980) quotes William Masters as saying that "...the sexually dysfunctional person is a pushover for seduction by an authority figure such as the psychotherapist...The innumerable examples of patient seduction, both heterosexual and homosexual, are a disgrace to our profession."

Proponents of the use of sex as therapy justify their behaviors on the basis of the following beliefs:

a. The patient was the seducer.

b. The client wanted notoriety or money.

c. The incidence of sexual misconduct is so rare that it shouldn't be dignified by calling attention to it.

d. The enemies of psychotherapy are publicizing the rare negative outcomes in order to discredit the technique.

e. This is not a case of overstepping previously drawn
boundaries, but redefining standards of acceptable treatment.

However valid these beliefs may prove to be in some cases, the overwhelming majority of leaders in the field maintain that sexual activity with clients is a dangerous and destructive practice. It is the abuse that initiated this period of critical scrutiny of therapy and is the one abuse most commonly cited by clients, therapists and counselor-educators.

7. Social Control

Some of the more outspoken and dramatic critics of psychotherapy are particularly vehement about the issue of social control (Robitscher, 1980; Ruitenbeek, 1972; Szasz, 1974, 1976, 1978). They contend that psychotherapists are in the unique position to influence the thinking, values, and life-circumstances of individuals without being scrutinized themselves.

In essence, therapists represent the current thinking of society at the time concerning illness/health, acceptable behavior, and effective means for personal change. As a result, Szasz (1976) believes, therapists become "...dealers in adjustment to the dominant ethic." An excellent example of this is the treatment women have experienced historically. For example, at different moments in history they have been helped to adjust to their inferior position in society, rather than encouraged to assert their equality as they would
be today.

8. **Therapist inadequacies in skill or judgment**

Harmful behaviors in therapists may result from inexperience, lack of skill or weakness in judgment. Several authors (Haley, 1969; Kovel, 1976; Levine, 1972; Robitscher, 1980) cited specific technique-related abuses which are listed below. It should be noted that abuses related to the utilization of a particular style or technique (i.e., behavioral interventions, body work) were not included:

a. Too-rapid dissolution of client's defenses against anxieties.

b. Failure to recognize real environmental factors affecting client's condition (health, major life trauma).

c. Failure to inform client of procedures, expectations, methods and techniques, formulation of goals.

d. Mismanagement of counter-transference; reacting to client hostility punitively or judgmentally.


9. **Values Indoctrination**

Therapists are not value-free, although they may wish to be able to present themselves as if they were. As early as 1957, Carl Rogers noted:

One cannot engage in psychotherapy without giving operational evidence of an underlying value orientation and view of human nature.
It is definitely preferable, in my opinion, that such underlying views be open and explicit, rather than covert and implicit" (Ard, 1966).

Unfortunately, the process of values communication can exist without the therapist being aware of it. His gestures, body language, how and when he responds, which client responses he reinforces, all communicate his value system. It is not surprising that research has demonstrated that clients tend to adopt the dominant beliefs of their therapists (Shertzer and Stone, 1980).

The therapist who transmits his values to clients can harm them in the following manners:

a. **Undermine the development of autonomy**

   If the purpose of therapy is to help individuals gain control over their own lives, repeated experience with a therapist who tells them how to live or what to believe can be counterproductive (Kovel, 1976; Levine, 1972; Robitscher, 1980).

b. **Takes advantage of client's vulnerability**

   Clients are often not in the position to judge the merits of any particular belief the therapist may present. Having placed a certain degree of faith in him, they are especially vulnerable to his suggestions and may not have the personal resources or intellectual clarity at that time to assess the merits of his values.

c. **Places clients in a "no-win" situation**
Therapists who maintain that there is a particular way to think, act or behave in therapy place their clients in a difficult position. If they agree with the therapist's beliefs or techniques, they are able to remain in the process with him and hopefully get the help they seek. If they defy him when they believe it is appropriate, they run the risk of being terminated from therapy or being labelled "resistant" or "unwilling to work." This creates a double-bind that could be more devastating than their original presenting problems (Haley, 1969).

Authors of the CPGA monograph "Ethics and the Counselor" maintain that therapists must maintain a high awareness of their own values and personal needs in order to avoid the undue influence of personality traits on the therapeutic process. Obviously, therapists with important unresolved personal issues outside their awareness will not be able to accurately monitor what values they project, nor will they be able to guarantee that their perceptions and responses to the client are accurate and unbiased by unconscious personal dilemmas. (See CPGA monograph for listing of basic needs for therapist self-assessment).

The above listing of nine major areas of potential abuse in therapy clearly indicates that authors in the field are aware of and concerned about the abuses that can occur in therapy. However, when
the author examined the ethical standards and guidelines of four major professional organizations in the field, it became clear that there is not a great deal of agreement as to what is considered acceptable and unacceptable behavior.

The comparison chart included here was made by listing the standards indicated in each organization's guidelines. Agreement with the standard is indicated by a check in the appropriate column. For comparison, a column was created to indicate agreement with the listing of abuses developed from research.

Table 1
Comparison of Ethical Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>APA</th>
<th>JHP</th>
<th>AAMFC</th>
<th>APGA</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be objective</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show integrity</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uphold community moral and legal standards</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not misrepresent qualifications</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Do not exaggerate skill</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Uphold confidentiality</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Be loyal to client in conflict of interest</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Refer responsibly</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inform client about use of confidential material</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Do not do therapy with family, friends, etc.</td>
<td>x</td>
<td></td>
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<tr>
<td>Make a contract about relationship</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
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<tr>
<td>Do therapy in person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't solicit clients</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>APA</td>
<td>JHP</td>
<td>AAMFC</td>
<td>APGA</td>
<td>Research</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
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<td>-------</td>
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<td>----------</td>
</tr>
<tr>
<td>Do not see someone else's client</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
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<tr>
<td>Do not disparage colleague</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Consider client's finances when charging</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Take no commission on referral</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Volunteer some service</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Don't promote commercial enterprises</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
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<tr>
<td>Work out fees at the outset</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Maintain high standards in testing and research</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Encourage self-determination</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Strive to know self</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help client take risks</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Let client choose own values</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid persuasion</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Do not sexually seduce</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Point out client's exploitive conduct</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not be sarcastic</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support growth-promoting conduct</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited touching OK</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Show no discrimination in offering services</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Keep records</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Support client during adjustment to change as result of therapy</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Uphold professional ethics</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inform community about services provided by MFCC's</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
</tbody>
</table>
In combination, the four organizations address only three of the nine major areas of abuse indicated in the research of the literature. Further, there is very little agreement among them as to what constitutes helpful for harmful therapist behavior. In part, this may result from the vague nature of many ethical standards materials. For example, monograph authors speak in terms of "the client's best interest" or "what is growth-producing for the client" without specifying exactly what that means in behavioral terms. Also, ethical guidelines tend to consider practical realities and needs of the therapist or the organization not usually addressed in the literature (i.e., advertising). While it can be concluded that there is little agreement between the opinions of authors in the literature reviewed and standards presented in professional ethical guidelines, further research would have to be conducted to determine the significance and pervasiveness of that lack of consensus.

Summary

A review of the literature reveals that authors in the field of psychotherapy believe that therapists have power and that they have the ability to abuse that power. A categorization of their opinions reveals that there are nine major areas in which abuses can occur: coercion, confidentiality, labeling, money issues, omnipotence, sex with clients, social control, therapist inadequacies in skill or judgment and values indoctrination. Although there appears to be a degree of consensus within the literature as to what is abusive, a comparison of this listing with the combined ethical guidelines of four major professional organizations shows very little agreement.
While it can be concluded that it is possible to develop a listing of abusive behaviors from a study of the literature, these findings suggest that consensus with other populations in the field may not be assumed.
CHAPTER THREE

Methodology and Procedure

This chapter is a description of the methods and procedures that were employed in the conduct of this study. The intention of this study is to develop a listing of behaviors considered to be abuses of power in therapy.

Design of the Study

This study is a cross-sectional survey of therapists, counselor-educators and clients. The research design used for evaluating hypotheses (1), (2), and (3) includes a therapist and counselor-educator interview process and the administration of a client questionnaire. The general procedural plan of this study was as follows:

1. Review of the literature

The current research literature related to abuses of therapy was studied in order to:

a. Develop a general frame of reference.

b. Help determine appropriate content of interview forms and questionnaires.

c. Determine what leaders in the field consider to be abusive practices in therapy in order to provide material for comparison with other subject groups.

2. Develop therapist and counselor-educator interview procedure

An interview guide was designed to enable the interviewer to gain information about the individual's background,
personal statistics, experience, credentials, theoretical orientation and attitudes about abuse in therapy.

Twelve therapists and counselor-educators were interviewed over a period of three months. Results of the interviews were compiled and responses categorized in order to develop an initial listing of abusive behaviors.

3. Develop client questionnaire procedure

A self-report questionnaire was developed to determine client personal statistics, experience in therapy and opinions about the positive and negative aspects of their therapy. Twenty-four questionnaires were returned to the author directly or by mail. The responses were compiled and comments about helpful and harmful therapist behaviors categorized.

4. Compare findings

Listings of abusive behaviors developed from research with clients, therapists, counselor-educators and by study of the current literature were compared to isolate areas of consensus.

The semi-structured interview format was chosen for the therapist and counselor-educator portion of this study in order to provide the subjects with the optimal opportunity to express their attitudes about abuse in psychotherapy. Pilot interviews with several therapists and educators not included in this study revealed that:

1. Subjects who responded to questions in writing tended to give briefer, less comprehensive responses than those who were
interviewed in person.

2. Subjects were universally enthusiastic about the topic and expressed a great willingness to devote the time necessary to conduct a lengthy personal interview. These two findings supported the choice of the personal interview design.

The questionnaire format was chosen for the client survey in order to give the author access to a large, randomly chosen sample of subjects and to provide the atmosphere of anonymity and confidentiality that clients seemed to require. Pilot interviews with students and associates who had been in therapy revealed that:

1. Subjects universally expressed that they had experienced harmful or abusive practices in their therapy.

2. Subjects were unwilling in personal interview to discuss the specifics or speak in detail about the negative experiences they had encountered.

3. Subjects indicated that they would be more willing to communicate their experiences in writing, especially if anonymity could be guaranteed.

These findings supported the choice of the questionnaire design.

Population

The twelve subjects for the interview portion of the study are therapists and graduate level counselor-educators. All but one subject have practiced or are currently practicing psychotherapy. All but one subject possess or have possessed the licenses and credentials necessary to practice psychotherapy in the State of California. No other
restrictions were imposed (i.e., number of years of experience, theoretical orientation, sex, age or education background).

Table 2
Description of Therapist and Counselor-Educator Population

<table>
<thead>
<tr>
<th>Total number of subjects</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>41 to 67</td>
</tr>
<tr>
<td></td>
<td>M 47.0</td>
</tr>
<tr>
<td>Sex</td>
<td>Male 10</td>
</tr>
<tr>
<td></td>
<td>Female 2</td>
</tr>
<tr>
<td>Degrees, licenses or credentials</td>
<td>MFCC 6</td>
</tr>
<tr>
<td></td>
<td>Licensed</td>
</tr>
<tr>
<td></td>
<td>Psychologist 4</td>
</tr>
<tr>
<td></td>
<td>PhD or EdD 8</td>
</tr>
<tr>
<td></td>
<td>Pupil Personnel Credential 2</td>
</tr>
<tr>
<td></td>
<td>School Psych. Credential 1</td>
</tr>
<tr>
<td>Number of years as a therapist</td>
<td>5 to 30</td>
</tr>
<tr>
<td></td>
<td>M 12.4</td>
</tr>
<tr>
<td>Subjects currently seeing clients</td>
<td>8</td>
</tr>
<tr>
<td>Average hours per week seeing clients:</td>
<td></td>
</tr>
<tr>
<td>Individually</td>
<td>3 to 30</td>
</tr>
<tr>
<td></td>
<td>M 13.3</td>
</tr>
<tr>
<td>In groups</td>
<td>0 to 10</td>
</tr>
<tr>
<td></td>
<td>M 3.5</td>
</tr>
<tr>
<td>Setting where subject has done most of work as a therapist</td>
<td>Private Practice 7</td>
</tr>
<tr>
<td></td>
<td>Social Service Agency 0</td>
</tr>
</tbody>
</table>
Subjects for the client portion of the survey are persons who have had experience as clients in therapy. No other restrictions were imposed (i.e., number of years in therapy, kind of experience, age, sex, etc.).

Table 3
Description of Client Population

<table>
<thead>
<tr>
<th>Total number of subjects</th>
<th>24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>22 to 54</td>
</tr>
<tr>
<td></td>
<td>M 33.9</td>
</tr>
<tr>
<td>Sex</td>
<td>Male 5</td>
</tr>
<tr>
<td>Hours in individual therapy</td>
<td>2 to 200</td>
</tr>
<tr>
<td></td>
<td>M 55.2</td>
</tr>
<tr>
<td>Distribution of hours:</td>
<td></td>
</tr>
<tr>
<td>Number of hours</td>
<td>Number of subjects</td>
</tr>
<tr>
<td>1-10</td>
<td>6</td>
</tr>
<tr>
<td>11-20</td>
<td>3</td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
</tr>
<tr>
<td>31-50</td>
<td>5</td>
</tr>
<tr>
<td>51-100</td>
<td>4</td>
</tr>
<tr>
<td>100+</td>
<td>4</td>
</tr>
</tbody>
</table>
| Hours in group therapy | 0 to 390  
<table>
<thead>
<tr>
<th></th>
<th>M 93.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distribution of hours:</td>
<td></td>
</tr>
<tr>
<td>Number of hours</td>
<td>Number of subjects</td>
</tr>
<tr>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>1-50</td>
<td>9</td>
</tr>
<tr>
<td>51-100</td>
<td>2</td>
</tr>
<tr>
<td>101-200</td>
<td>3</td>
</tr>
<tr>
<td>200+</td>
<td>4</td>
</tr>
</tbody>
</table>

| Number of different therapists client has seen | 1 to 10  
|                                              | M 3.2 |
| Distribution of numbers:                      |        |
| Number of therapists                          | Number of subjects |
| 1                                               | 4       |
| 2                                               | 7       |
| 3                                               | 4       |
| 4                                               | 4       |
| 5                                               | 1       |
| 7                                               | 2       |
| 10                                              | 1       |
| ?                                               | 1       |

| Setting:                                      |        |
| Private Practice                              | 19     |
| Social Service Agency                         | 4      |
| College/University                            | 6      |
| Public School                                 | 1      |
| Church                                        | 3      |
| Other: Peer Counseling                        | 1      |

| Therapist's primary style or orientation to therapy: |        |
| Client-Centered                                   | 12     |
| Behavioral                                       | 7      |
| Existential                                      | 3      |
| Family Systems                                   | 3      |
| Gestalt                                          | 7      |
| Psychodynamic                                    | 3      |
| Other:                                           |        |
| Eclectic                                        | 4      |
| Emotional Expression                            | 1      |
A review of the client population data reveals that the majority of the clients have had a great deal of both individual and group therapy, primarily in the private practice setting. All subjects were aware of their therapist's credentials and all but three were aware of their therapist's style or orientation to therapy. The vast majority of subjects rated their overall experience in therapy as basically positive ("Somewhat helpful" or better), although only six indicated in part two of the questionnaire that there was nothing harmful about their therapy experience.

Sample

The twelve therapists and counselor-educators interviewed are all
residents of the State of California. They reside in communities from San Diego to San Francisco, with the majority living in Los Angeles (6). Six of the subjects were interviewed in person at the CACES Conference on Generic Core Curriculum held at Asilomar, California in September, 1983. Participants in this conference are representatives of the graduate level counseling and guidance departments of the California State University and University of California system schools. Subjects were chosen at random from among the conference attendants. The remaining six interview subjects were chosen at random from among the author's professional and educational acquaintances in Ventura, Los Angeles, and Santa Barbara. These interviews were conducted in person (1), by telephone (3) or through correspondence (2).

The 24 client respondents were chosen at random from among the friends, family, acquaintances and clients of students attending a graduate level Child Counseling class at the CSUN extension campus in Ventura. Data collected verifies that all subjects meet the sole criteria for participation in this portion of the study; having had experience in psychotherapy. No verifiable conclusions can be made about other characteristics of the population (such as education, socio-economic status, etc.). However, the method of administration and collection of data may support the assumption that most subjects are residents of California, and probably Ventura and Santa Barbara Counties.

Description of the Instruments

Preliminary Interview Form. In order to complete the therapist and counselor-educator survey, an interview guide was developed. A
copy of the guide (Preliminary Interview Form) is included as Appendix A.

This nine-item instrument was developed and designed for therapists and graduate level counselor-educators. It is based on the premise that therapists and counselor-educators will have a basic awareness of the issue of potential abuses in therapy and will have a theory or experience-based opinion about the topic which they are willing to share in interview.

The instrument was developed to gain general background data on subjects and to provide information and material for the development of a listing of potential abuses in psychotherapy as viewed by therapists and counselor-educators (Hypothesis (1)). The interview form is divided into two parts:

1. Responses to general background questions: sex, age, years and kind of experience in therapy, licenses and degrees.
2. Responses to statement concerning abuses in therapy. Subjects were asked to express agreement or disagreement with the following statement:

   Therapists are in the position to exert a great deal of influence over the values, goals, and self-perceptions of their clients. Usually, this ability to affect the client is carefully monitored by the therapist, in an effort to allow the individual to remain autonomous and self-responsible. However, there is a potential for abuse of power by the therapist.

   Subjects who agreed with the statement were asked to describe the behaviors that would indicate to them that a therapist was abusing his power.

Client Questionnaire. The client self-report questionnaire was
developed in order to test hypotheses (1), (2), and (3). A copy of the
questionnaire is included as Appendix B.

This eleven-item instrument includes nine closed-form and two
open-form questions. It was developed and designed for persons who
have experienced psychotherapy. It is based on the premise that
clients will have formed an opinion about the negative and positive as-
pects of their therapy experience and will be willing to share their
conclusions in writing.

The instrument was developed to gain general background data on
the subjects and to provide information and material for the develop-
ment of a listing of potential abuses in psychotherapy as viewed by
clients (Hypothesis (1)). The questionnaire is divided into two parts:

1. Nine closed-form questions designed to provide general back-
ground data: age, sex, number of hours in group and indi-
vidual therapy, setting of therapy, licenses and orientation
of therapist and general impression of therapy.

2. Two open-form questions designed to give the client the op-
portunity to express opinions about the negative and positive
aspects of his therapy experience.

Validation of the Instruments

The questionnaire and interview guide were given to a panel of
judges (therapists and educators who would not be included in the
study) to determine if the questions were clear, easily understood,
and likely to produce the information needed in this study. The indi-
viduals contacted validated the clarity and appropriateness of the
instruments' designs and contents.
Procedure of Administration

The interviews were conducted solely by the author in person (7), by telephone (3) or through correspondence (2). All subject responses were recorded on the Preliminary Interview Form. Any additional comments subsequently sent to the author were attached to the original interview form.

To complete the client survey, 100 questionnaires were distributed among approximately 40 students at the Ventura Learning Center with the instruction to distribute them at random among friends, clients and acquaintances who had been in therapy. Twenty-four questionnaires were returned to the author directly or by mail within one month (December to January, 1984).

Treatment of Data

The information gathered as a result of the interview and questionnaire processes was compiled and categorized by the author. No statistical methods were utilized to analyze the data. Subject responses to part one of both instruments are included in the "Description of Population" section of this chapter. Responses to part two, which deals directly with subject beliefs and attitudes about the issue of abuse in therapy, will be discussed in Chapter Four.
CHAPTER FOUR

Analysis and Interpretation of the Data

The purpose of this study was to determine whether a listing of potential abuses in therapy could be created which represents a consensus of the opinions of clients, therapists and counselor-educators. This chapter is an analysis and comparison of information gathered from the interview procedure, questionnaire and review of the literature.

Presentation of the Data

Therapist and Counselor-Educator Interview. The interview guide was divided into two parts: the first focused on relevant background data (reported in Chapter Three) and the second gave subjects the opportunity to comment directly about the issue of abuse of power in psychotherapy. An analysis of the data gathered reveals that the persons interviewed believe there are several ways in which a therapist can abuse his power. Their responses have been categorized as follows:

1. Coercion
   Participation in psychological experiments when the reward is necessary to one's well-being.

2. Confidentiality
   Flaunting, threatening or holding power over the client due to knowledge of privileged information.

3. Encouragement of Dependency
   Abuses related to the encouragement of dependency were cited by the majority of subjects interviewed. Next to
sexual abuse, which is often mentioned first, abuses related to client dependency were discussed by more subjects and at greater length than any others. Subjects indicated the following specific behaviors which encourage dependency:

a. Keeping client in therapy too long, beyond his point of need.
b. Doing research or "homework" for the client.
c. Leaving material unresolved week to week to "hook" the client into continued therapy.
d. Setting self up as expert - the only one who knows, listens or cares.
e. Giving advice.
f. Making the client rehearse everything - making the therapist essential to the client's psychological health.

All of the behaviors create an atmosphere in which the therapist becomes indispensable to the client's progress. Instead of learning skills which will enhance autonomy, he becomes enmeshed with the therapist as problem-solver and guide.

4. Labeling and Diagnosis

Subjects did not universally question the use of labels as was common in the current literature. In fact, several respondents indicated that labels and diagnoses, when properly utilized, were a helpful and necessary part of responsible treatment. Those who were opposed to the use of labels maintained that they were harmful to clients in the following
ways:

a. Colors how the person is seen by outsiders (3rd party effect).

b. Colors the therapist's perceptions of the client.

c. Affects the client's self-perception (he internalizes the label and can be hurt by it).

d. Fits a person into a category and the therapist's power makes him buy into it.

e. Fixes people at one point in time - doesn't recognize the "process."

f. Elevates the therapist to expert status and underscores the inequity of the relationship.

g. Breeds insensitivity to the person - focuses attention on "analytic detective work."

h. Subjects client to high risk of incorrect diagnosis.

5. Money

a. Overcharging.

b. Keeping a client too long for financial reasons.

6. Omnipotence

Therapists can perpetuate the inequality inherent in the therapeutic relationship in several ways. Fundamental to the decision to do so, conscious or not, is a desire to be omnipotent or omniscient - a guru in someone's life. Interview subjects indicated that this elevated status is maintained by means such as:

a. Requesting that the client discuss his problem only with
the therapist.
b. Maintaining an aura of secrecy about therapy (i.e., not allowing client to take notes or withholding test results).
c. Taking advantage of positive transference and avoiding resolution of it.
d. Refusing to let go of the client (not terminating when client's goals are reached, prolonging the mentor/mentee relationship).
e. Overstepping role boundaries (i.e., encouraging friendship, socializing).

Some subjects stated that the harm to the client inherent in this behavior is the encouragement and prolongation of dependency.

7. **Sex with Clients**
   a. Seduction.
   b. Romantic involvement before or shortly after therapy ends.

   Some subjects questioned the practice of becoming sexually involved with clients even after therapy has terminated. It was maintained that the relationship in therapy is unique and somewhat unrealistic and not a wise backdrop for the development of a romantic relationship.

8. **Social Control**
   a. Socializing the client to a poor system.

   The problem man not be the client, but the system he is in.
   b. Sexism (i.e., socializing women to an oppressive system).
c. Behavior control.

Behavioral techniques which are used to change the client without client choice or awareness are considered particularly dangerous, especially if utilized by a person or group of persons who place their own goals above the best interest of the individual.

9. Therapist inadequacies in skill or judgment

a. Not confronting client in order to be liked.

b. Being afraid to risk the client's anger.

c. Using hypnosis without the client's consent.

d. Failing to be "present" with the client; being distracted, not providing a service but appearing to do so.

e. Becoming fixed in a theoretical mode.

Theoretical rigidity can lead to clouded perceptions of the client, attempts to fit the client to the theory rather than finding the appropriate treatment modality for that individual, or hostility towards the client for failing to adhere to the theoretical model. Fritz Perls is well known for chastising clients for "being unwilling to work" in his particular style.

f. Inept - not well-trained, careful or knowledgeable (i.e., may miss physical causes of psychological difficulty).

g. Imposing structure too quickly.

h. Focusing on the past and thus diverting client from pressing existing issues.

i. Lacking self-awareness.
j. Being unable to set appropriate limits; unable to say no, being too available.

k. Failing to acknowledge the power he holds; refusing to take responsibility for his affect on the client.

10. **Values Indoctrination**

   a. Imposing own value system on the client.

   b. Taking a stand for/against client's behavior or choices based on own values.

   c. Utilizing selective reinforcement of client behaviors

Subjects commented that issues related to values are a problem not only for the client, but for the therapist as well. When he is unaware of his personal issues, needs or projections, he is likely to have clouded perceptions of his client. Further, his value and needs system can influence his, and ultimately the client's, perspective on what the presenting problem really is.

The therapists and counselor-educators interviewed were universally enthusiastic and eager to discuss the issue of abuse in therapy. This is not to imply, however, that there was not some controversy over whether therapists do have the power to abuse clients or whether abuse is a serious issue in therapy today. Objections to the basic hypotheses of this study were raised in an aura of philosophical discussion, centering on the following points:

1. The damage in therapy is over-estimated. The client will protect himself.

   It was proposed by one subject that it is impossible to truly "damage" a client. Because all persons have a basic
tendency towards health, they will be able to protect themselves successfully and eventually grow from even the most negative experiences.

2. What the client sees as abusive may only be the pain of being in a tight spot.

Clients who are facing their inadequacies and deep personal issues will often experience emotional pain and resistance to the process. Should they discontinue therapy at this point, they might mistakenly view their therapy experience as having been causative of the suffering.

3. Outsiders can't judge what will be harmful in therapy.

One subject cited his personal experience observing a Synanon encounter group. He reported that to him it appeared extremely abusive and damaging. However, he later learned that the client considered the experience growth-producing and helpful.

4. Crying about ethics reflects a rigidity in a person.

This subject maintained that choosing to judge the harm/benefit of another person's experience in therapy reflects a degree of rigidity in someone. It is not possible to make determinations for others as to what is likely to be harmful to them.

5. The client has a role in abuse.

One subject commented that the occurrence of abuse probably relates to something in the client's personality; a need to be dominated, an extension of a desire for human contact.
This subject believes that both parties are consenting adults and one is not more responsible than the other for any negative outcomes of their experience together. Other subjects, however, held that all of therapy is manipulation and power and that handling that power is an ethical issue, a sacred trust.

Although there was a degree of philosophical questioning about the existence and possibility of abuse, all subjects were aware of and willing to suggest several potential areas of abuse in psychotherapy. The abuses most frequently discussed, and often first mentioned, were those related to the issue of dependency. Although almost all subjects mentioned sexual abuse, they expressed more open concern about the less visible abuses than can occur when a therapist chooses to keep a client dependent upon him.

Issues which may merit further exploration in research include:
1. Why are most of the therapists male? Does gender affect perception of what is abusive in therapy?
2. Does theoretical orientation affect perception of abuse in therapy?
3. Does the absence of medically and psychodynamically oriented therapists affect the data outcome?
4. Are therapists able to perceive in themselves the presence of the abusive behaviors they perceive in others?
5. How do therapist and counselor-educators responses compare and differ?
6. To what extent can these findings be extrapolated to the
general population of therapists and counselor-educators? A much broader sample would have to be considered to make this determination.

**Client Questionnaire.** The first portion of the client questionnaire focuses on background material and gives the client's overall impression of therapy. These results are reported in Chapter Three ("Population"). In the second portion of the client questionnaire subjects are given the opportunity to respond freely to the following questions:

1. What therapist behaviors were most helpful to you? (Left you feeling positive about yourself, understood, more self-aware, etc.)

2. What therapist behaviors were most harmful to you? (Left you feeling judged, less able to deal with issues, dependent on the therapist, emotionally damaged or sexually abused, etc.)

Although the intent of the study is to focus on the abuses in psychotherapy, it was believed that the inclusion of a question about positive experiences would remove bias from the study and avoid prejudicing the client's responses towards the negative. Responses to this question fell into three major categories: therapist personal qualities, therapist behaviors and therapist techniques. This data is presented as Appendix C.

Client responses concerning the positive aspects of their therapy experience validate much of the research that was done in the 1960's by Carkhuff and Truax. Study subjects prefer therapists who are consistent, supportive, open, warm, sincere and accepting. They like
their therapists to be self-disclosing and actively engaged with them: helping them clarify, giving feedback, offering alternatives, confronting within an atmosphere of support and free choice.

However, of the 24 respondents to the questionnaire, only six indicated that there was nothing harmful about their therapy. The remaining 18 spoke in relatively specific terms about the behaviors and techniques which they believed were negative for them. These opinions have been organized into major categories in order to facilitate comparison:

1. Confidentiality
   a. Breached confidentiality.

2. Manipulation and Control
   a. Seemed to be trying to read my mind and then structured the sessions accordingly: "I felt manipulated."
   b. Imposed her interpretations on me.
   c. Put her answers on my problem.
   d. Didn't help me determine what my goals were and made me feel dumb for not knowing.
   e. Berated me for "withholding" when I was simply not ready to share.

3. Money
   a. Charged too much money.

4. Relationship Problems
   a. Overreacted to my friendly gesture and called on "professional distance."
   b. Didn't respond to me personally at all after therapy -
made me question if we had really had a relationship at all.

c. Didn't respond to my feelings.
d. Gave no feedback; not a two-way street.
e. Wouldn't get involved.
f. Too many silences. ("He sat way across the room. He seldom smiled. I felt judged, found wanting.")
g. Never stopped talking.
h. Didn't support me (sided with my wife).
i. Terminated me suddenly, without notice. ("I felt abandoned, disregarded, betrayed.")
j. Changed the subject abruptly. ("I felt ignored.")

5. Self-centered
   a. Too self-centered and not interested in me.
b. Explained own family problems instead of listening.
c. Let own issues get in the way, not objective.
d. Talked theory and ignored my pain.
e. Lectured instead of showing empathy and listening.

6. Sexist
   a. Jumped to traditional assumptions.

7. Sexual Issues
   a. Encouraged sexual acts in his presence.

8. Technique Problems
   a. Pushed me to deal with issues too soon.
b. Had too high expectations. ("I felt judged.")
c. Confronted me too harshly, not enough support.
d. Didn't confront enough, not enough challenge.

e. Forgot an appointment.

f. Looked for a quick cure.

g. Didn't protect me or focus problems in the group; joined group members in judging me.

h. Asked questions excessively.

9. Values Indoctrination

a. Imposed her values on me.

b. Interjected too much therapist opinion.

The 18 subjects who expressed opinions about the harmful aspects of their therapy were in general agreement on two major issues: 1) that therapists should respect their autonomy (not manipulate or impose values), and 2) that therapists should be actively involved with them in a personal, sincere and caring way (focus on them, give feedback, listen). This is consistent with opinions reported in chapters two and three.

The client questionnaire validated hypotheses (1) and (3) in that it provided a listing of behaviors considered harmful by clients and those opinions were expressed in relatively clear, behavioral terms. Clients, more so than therapists or counselor-educators, were more likely to speak in specific terms which ultimately makes their responses more useful in future projects. Clearly stated behavioral abuses (i.e., "he encouraged sexual acts in his presence") are much easier to incorporate into assessment data and give a clearer sense of exactly what practices are to be considered harmful than broader statements (i.e., "he manipulated me").
It was interesting to note that although 18 (roughly 75%) of the respondents found something harmful in their therapy experience, the majority rated their overall experience in therapy as positive ("Somewhat Helpful" or better). Even those respondents who were most vehement in their discussion of abusive practices indicated that there were positive aspects of their therapy. Further research on a much larger sample population would have to be conducted to determine whether these findings are representative of the general client population.

Other issues which may merit further exploration in research include:

1. Why are most of the clients female?
2. Why do most clients responding have more than one therapist?
   Do most people who see therapists eventually see more than one?
3. Is there a relationship between factors such as number of hours in therapy, number of therapists, experience in individual vs. group therapy, therapist orientation, and the client's overall impression of the therapy?
4. Why do most clients rate their experience as positive, even when they are able to cite harmful or abusive experiences?
   Is there a need to see it as positive?
5. Do most clients (at least 75%) find something harmful about their therapy?

Comparison of Findings

The listings of abusive behaviors developed from this research
data and by study of the current literature have been compared to isolate areas of consensus (Hypothesis (2)). This data is presented as Appendix D.

An analysis of this data reveals that there is agreement (80%) among clients, therapists and counselor-educators and authors in the literature reviewed that abuses occur in eight of the ten major categories presented: confidentiality, dependency, money, omnipotence, sex with clients, social control, therapist inadequacies in skill or judgment and values indoctrination. However, when specific behaviors indicated within the categories are compared, there is no agreement among the three populations. Of the 71 specific behaviors indicated, there is agreement on only 13 (approximately 18%) and then only between two of the three subject groups. Table 4 lists the behaviors on which there is some consensus (two of three subject groups) and indicates which population groups are in agreement.

Table 4
Degree of Consensus
Among Subject Groups

<table>
<thead>
<tr>
<th>Therapist Behavior</th>
<th>Subject Groups in Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting self up as an expert</td>
<td>Therapists &amp; Counselor-Educators</td>
</tr>
<tr>
<td>Giving advice</td>
<td>&quot;</td>
</tr>
<tr>
<td>Overcharging</td>
<td>&quot;</td>
</tr>
<tr>
<td>Not confronting enough</td>
<td>&quot;</td>
</tr>
<tr>
<td>Imposing values on client</td>
<td>&quot;</td>
</tr>
<tr>
<td>Giving advice or too much opinion</td>
<td>&quot;</td>
</tr>
<tr>
<td>Therapist Behavior</td>
<td>Subject Groups in Agreement</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Labeling</td>
<td>Therapists &amp; Counselor-Educators and Authors in the Literature Reviewed</td>
</tr>
<tr>
<td>Keeping client in therapy too long for the money</td>
<td>&quot;</td>
</tr>
<tr>
<td>Having sex with clients</td>
<td>&quot;</td>
</tr>
<tr>
<td>Socializing client to a poor system</td>
<td>&quot;</td>
</tr>
<tr>
<td>Encouraging sexist role</td>
<td>&quot;</td>
</tr>
<tr>
<td>Being fixed in a single mode of treatment</td>
<td>&quot;</td>
</tr>
<tr>
<td>Pushing client to deal with issues too quickly</td>
<td>Authors in the Literature Reviewed and Clients</td>
</tr>
</tbody>
</table>

The results of the interview process, client questionnaire and research of the literature reveal that it is possible to develop a list of therapist behaviors considered to be abuses of power (Hypothesis (1)). However, a comparison of this data (Appendix D) failed to demonstrate any agreement among subject groups at the level of behavioral specifics, thus disproving Hypothesis (2). At first glance, this lack of consensus is not surprising. Clients approach the issue of abuse from a single-experience perspective. Therapists, educators and authors in the field may have a broader outlook, having been exposed to several individual clients and having observed other therapists. However, an analysis of the data does not reveal the kind of consensus among these remaining subject groups (all but the clients) that one might expect. Of the 13 behaviors on which two subject groups agreed, there was no pattern of sub-group agreement. It should
be concluded that consensus was not achieved within this study.

The research data was further analyzed to determine to what extent the behaviors were presented in clear, behavioral terms (Hypothesis (3)). The criterion basis for this judgment was:

1. Is a specific behavior being described?
2. Would a non-professional understand the behavior that is being described?
3. Is there an absence of value or judgment-based terms in the description of the behavior?

For example, the statement "keeping the client in therapy too long" does not meet any of the criteria and thus would not qualify as a clear, behavioral statement. (First, a non-professional might question what "keeping in therapy" means. How does one do that? Further, he might wonder what is meant by "too long." Who makes the determination as to what the appropriate length of time should be?) Statements such as "forgetting an appointment" or "using hypnosis without the client's consent" are much more behavior-specific and would qualify.

An analysis of the 71 statements concerning abusive behaviors presented in Appendix D reveals that 50 meet the criteria for consideration as clear, behavioral terms and 21 do not. It can be concluded that study subjects express some behaviors in clear terms (approximately 70%) but not all. Whether Hypothesis (3) is validated or not is a difficult assessment. In a strict sense it is not, especially if the statement "it is possible to express those behaviors in clear, behavioral terms" is considered to be absolute and all-inclusive. Strictly speaking, it is clear that it was not done in all cases.
However, the question remains as to whether it is "possible." If it is "possible" in 50 of the 71 cases, then it could be argued that the possibility exists. One cannot make the determination from the materials presented whether the subjects merely did not express their opinions behaviorally or were unable to do so. Further research with the subject population would have to be conducted to make this determination. However, for the purposes of this study it is concluded that the existence of a 70% possibility validates the hypothesis.

Summary of the Data Analysis

The data presented represents a categorization of the opinions of therapists, counselor-educators, clients and authors reviewed in the literature concerning potential abuses of power by the therapist. An analysis of the data reveals that there is agreement on eight of the ten major categories of abuse, but no consensus on specifically defined behaviors within those categories. Data analysis further indicates that behaviors are clearly expressed in behavioral terms 50 out of 71 times. These findings support hypotheses (1) and (3), but do not validate Hypothesis (2).
CHAPTER V

Summary, Conclusions and Recommendations

The purpose of the study was to develop a list of therapist behaviors which could be considered abuses of power. Research conducted was based on the following hypotheses:

1. It is possible to develop a list of therapist behaviors considered to be abuses of power.
2. It is possible to achieve some consensus among therapists, clients and counselor-educators as to what those abusive behaviors are.
3. It is possible to express those behaviors in clear, behavioral terms.

In order to test these hypotheses, a cross-sectional survey of therapists, clients and counselor-educators was conducted. Procedures employed included a semi-structured interview of therapists and counselor-educators and the administration of a self-report questionnaire to clients. The results of these procedures were compiled and responses categorized and compared with material developed from a review of the literature. It was found that all but six respondents were able to indicate several areas of potential abuse in therapy. Subjects agreed that abuses occur in eight of ten major categories: confidentiality, dependency, money, omnipotence, sex with clients, social control, therapist inadequacies in skill or judgment and values indoctrination. However, when specific behaviors indicated within the categories are compared, there is no consensus among subject
populations. Of the 71 specific behaviors indicated, there is agreement on only 13 and then only between two of the three subject groups.

A further analysis of the research data revealed that of the 71 statements concerning abuse in therapy, 50 meet the criteria for consideration as clear, behavioral terms and 21 do not. It was concluded that subjects are able to express some behaviors clearly, but not all.

The results of the study confirm that it is possible to develop a list of behaviors considered to be abuses of power in therapy (Hypothesis (1)) and to express those behaviors in clear, behavioral terms (Hypothesis (3)). However, the data indicates that it is not possible to achieve consensus among the subject groups considered in the study (Hypothesis (3)).

Conclusions

It is clear that there is considerable awareness and concern about the issue of abuse in psychotherapy in the professional community. Therapists, counselor-educators and authors in the field speak easily and with conviction about the importance of acknowledging and working to diminish the potentially harmful practices that occur. It was therefore not difficult to develop a list of abusive behaviors, as long as one was satisfied to merely amalgamate the diverse opinions of over 70 persons surveyed or reviewed in the literature.

As might have been anticipated at the outset, subjects are interested and readily offer their opinions about abuse, but their conclusions do not necessarily coincide with other subjects. There is acknowledgment of the problem but not agreement at the level of
behavioral specifics. This is the fundamental factor which makes the study of abuse so difficult, at times frustrating, and which renders efforts to delineate abuses so important.

The difficulty in achieving consensus is acknowledged in the literature and often discussed among practitioners. Reasons for this lack of agreement fall into the following categories:

1. **Theoretical**

   We can't agree because there is so much variation in style in therapy. A technique utilized by a behaviorist may seem abusive to a Rogerian, for example. Since different therapists utilize different methods, and they all work for some clients sometimes, we cannot make broad statements about what is harmful and what is not.

2. **Philosophical**

   a. We can't agree on what is abusive because we do not agree that therapists have the power to harm clients. Clients have a self-protective mechanism against abuse at best and may be instigators and participants in the harm at worst. Ultimately, the responsibility for the outcomes and experiences in therapy are the clients'.

   b. We cannot determine from the outside what is harmful for a client. Reactions to experiences in therapy are highly personal and often colored by the particular pathology of that individual. Even clients who report abuse may actually be responding to the difficulty and stress of the growth process rather than the behaviors and
and interventions of the therapist.

c. Interventions in therapy are so unique and spontaneous that they cannot be categorized or even anticipated. A behavior which would seem inappropriate in one context may be just right in another. Efforts to delineate behaviors and attach a value judgment to them, therefore, ignore the realities of the therapeutic exchange.

3. Practical

We may be able to agree in broad terms about what is abusive, but any efforts to operate on a more specific level will meet strong opposition in the professional community. Therapy is a personal skill usually conducted in private. It requires the practitioner to draw upon his individuality and utilize inner resources—in­sights—intuitions—perceptions in the service of the best interest of the client. Most therapists, therefore, would strongly resist any efforts to restrict or rigidify the boundaries of appropriate behavior.

Considering these strong objections, the categorization of abusive behaviors appears to be a futile endeavor, which is probably why so little research has been done in this area. However, the difficulty of the task does not negate the necessity. On an ethical level, it seems clear that clients have a right to protection from as much abuse as possible. If 70 people can agree in broad terms about what is potentially harmful, perhaps the consensus can be extended to the level of behavioral specifics. To achieve this, however, several limitations and compromises may have to be accepted, such as:
1. There will not be complete agreement among concerned parties about what is abusive. Because of individual differences in style and philosophy, it is probably impossible to expect complete agreement. However, a survey of a large enough sample will probably reveal a degree of consensus (75% or better) necessary to develop a useful listing of specific behaviors.

2. Decisions about what is abusive will be representative of the best of current thinking and will thus be subject to periodic revision.

   Judgments about therapeutic intervention reflects the state of the art beliefs about how people change, what is effective technique, what is harmful/beneficial. For example, family systems practitioners of today bear little resemblance to the 19th century Freudian analysts, and it can be expected that future practitioners will be utilizing techniques beyond current imagination. Given the variability and likelihood of change within the profession, it cannot be expected that a listing of abuses can be developed which will represent the field for any significant period of time. Persons endeavoring to create a listing at this time must accept that they are making judgments relevant only to the present and immediate future.

3. There will be resistance to the development and utilization of a list of abuses, and that listing will be subject to a great deal of critical analysis.
As discussed earlier, there are strong philosophical, theoretical and practical objections to the creation of a definitive listing of abuses in psychotherapy. As a result, there may be resistance to the creation of a set of boundaries or restrictions. In a discipline which relies so heavily on intuition and spontaneous human reaction the likelihood of an easy acceptance of categorizations and judgments of therapist behaviors is slim. Even under the best of circumstances, to make value judgments about the professional behaviors of others is to invite a personal reaction and a great deal of critical scrutiny.

To seek to develop a listing of abusive behaviors, then, may require an acceptance that agreement will not be universal, findings will not be permanent, and criticism will probably be continuous. These limitations might be intolerable if the goal is to make the definitive statement about abuse in psychotherapy. However, if one is seeking to create awareness and a state of continued sensitivity to the issue, the limitations become assets. The lack of universality, permanence, and likelihood of disagreement could mean that there would be active debate among professionals and a degree of personal involvement in an issue that often only receives consideration in ethics classes or rare philosophical discussions. Creating a listing, even within the limitations presented, provides the practicing therapist with something concrete to consider and evaluate. It gives form to an ill-defined but serious issue within the practice of psychotherapy. In the long run, it gives the client a greater degree of assurance
that the issue of abuse is being given serious and continuous attention within the field.

Although the original intent of this study was to develop such a listing, one which represented a consensus of opinion within the community, the resulting data did not lead to that result. It is possible that the failure to achieve consensus was related to the following flaws in the research design and procedures:

1. Sample size and selection procedure

   Although the sample for survey procedures was chosen at random, it was too small to provide a data base for a study of this nature. A larger sample may reveal greater agreement at the level of behavioral specifics than can be gained by comparing the opinions of 36 subjects and approximately 40 authors in the field.

   Further, subjects representing different parts of the country and a wider range of theoretical schools of thought (especially psychiatry and psychoanalysis) may provide a more balanced picture of the opinions of persons in the field as a whole.

   Finally, the method chosen for administration of the client questionnaire did not result in an adequate response rate. This factor alone may have skewed the results. At the least, it limited the sample size.

2. Procedures and choice of instruments

   It is possible that the use of three different procedures in conducting the survey (personal interview, self-report
questionnaire, and study-analysis of the literature) may have affected the likelihood of achieving consensus. For example, therapists and counselor-educators were asked directly to comment about the potential areas of abuse in psychotherapy. Through a process of personal interview, they were able to refine and clarify their beliefs, expand upon their ideas in much more detail than they might have on a written form. Clients, on the other hand, were approached in a much more indirect manner (the word "abuse" was not even mentioned in the questionnaire) and they tended to give briefer, more specific and more individualized responses. Although some clients in pilot studies expressed reluctance to talk openly about the issue of abuse in therapy, it might have enhanced the study to utilize the interview procedure with all subject groups in order to optimize comparison of resulting survey data.

3. Focus of the study

The results of the survey lead to the conclusion that the focus of the study may have been too ambitious and wide in scope. Instead of attempting to achieve consensus, it may have been sufficient to aim at developing an initial listing for use in future research projects. This categorization of abuses could become the basis for comparison and evaluation in a more comprehensive and in-depth study of a much larger and more representative sample.

Although consensus was not achieved, important preliminary
material for use in further research was delineated by subject groups. The 71 behaviors indicated could provide a springboard for discussion and evaluation in future projects.

Recommendations

It is recommended that future research observe the following procedures and guidelines:

1. Sample

   In order to adequately survey the opinions of various sub-groups in the therapeutic community, it is recommended that research focus on one major group at a time (i.e., clients) and greatly increase the sample size. Responses to the question of abuse can be so individualized, especially with clients, that a much greater sample should be utilized if any patterns of agreement are expected to emerge.

2. Procedures

   In order to insure that subject opinions are given full opportunity for expression, the personal interview format is suggested for future in-depth research. Although the danger of interviewer bias is always present, the opportunities for more comprehensive expression of beliefs easily offset this limitation. Although the use of interview may somewhat limit the sample size, it appears to provide more useful information in the initial stages of a project of this kind. It is further suggested that subjects be asked directly to respond to the question of abuse in therapy, as was done in the interview process, and that they be given clear instructions
to express their opinions in behavioral terms.

The overall procedural plan of a project designed to develop a comprehensive listing of abusive behaviors as defined in this chapter could include the following:

1. Refine the major categories of potential abuse

   The categories utilized in this study were developed by the author as a convenient and logical means to organize the responses given in interview and found in the study of the literature. It would be helpful to submit this categorization system to a panel of judges to determine their applicability in further research.

2. Conduct further in-depth interviews of subject groups

   Large, representative samples of therapists, clients, counselor-educators and authors in the field could be surveyed to obtain more data and to increase the likelihood of achieving consensus. Each subject group should be surveyed separately to determine what their particular sub-group considers abusive.

3. Combine data obtained from subject groups to develop a master list of abuses. Present this listing to a cross-section of all subject groups for response, revision, and evaluation of items.

   It is possible that subjects would agree more if their ideas were stimulated by the beliefs and attitudes of others. For example, a particular therapist may not have thought of sexual abuse as an issue at the time of interview, but could
certainly concur if the issue were raised by someone else. A comprehensive listing of the beliefs of a large sample could provide an effective baseline for more thorough evaluation of the issue of abuse.

4. Analyze reactions to the master list to determine areas of consensus.

5. Refine the master list to include only those items on which there was 75% or greater agreement among subject groups.

6. Resubmit the master list to a new sample for response and evaluation.

At this point, the participation of a professional organization or group of organizations might be especially useful. Ethics or standards committees or members at large could be asked to participate in final revisions of the list.

7. Present the listing to the community for consideration and critical assessment.

8. Encourage discussion of the findings and the utilization of the list in counselor-training programs, workshops, and continuing-education programs for practicing therapists.

The issue of abuse is a thorny subject in psychotherapy, one which is usually avoided due to the difficulties in pinpointing exactly what is meant by an "abuse." However, the difficulty of the task should not deter professionals in the field from continued efforts to tackle and define the problem. If we have been able to determine what is helpful to clients, we should be able to delineate behaviors that could be harmful. It is hoped that this study will be an initial step
in that direction.
BIBLIOGRAPHY


APPENDIX A

PRELIMINARY INTERVIEW FORM
TO: THERAPISTS, COUNSELOR-EDUCATORS
RE: MASTER'S THESIS PROJECT

I am currently a Master's Degree Candidate at CSUN. As part of my thesis project I am interviewing therapists, clients, and counselor-educators. I would greatly appreciate your comments, responses and ideas to the enclosed survey form. Of course, all material will be confidential. However, I would appreciate your including your name and address if you wish to participate in further refinements of my thesis research. Also, if you are aware of sources or materials relevant to my topic, please indicate on the form given. Feel free to use both sides of the enclosed sheet and any additional pages you need.

If you are not currently a practicing therapist, please indicate your current occupation and how it relates to the field of therapy or counselor training.

Thank you very much,

Paulette Freedenberg

(author's address and phone number)
Preliminary Interview Form

Age ________________________ Sex ________________________

Degrees, Licenses, Credentials ______________________________________

How many years have you been working as a therapist? _________________

Are you currently seeing clients? ________________________

During your most active years as a therapist, how many hours per week, on the average, were spent seeing clients:
  Individually _________________
  In Groups _________________

In what setting have you done most of your work as a therapist?
  Private Practice __________
  Social Service Agency ______
  College/University _________
  Public Schools ____________
  Other ______________________

What is your primary style or orientation to therapy? Please choose the category that comes closest to your philosophical orientation:
  Client-Centered ____________ Psychodynamic _________________
  Behavioral __________________ Family Systems _______________
  Existential _________________ Other ________________________
  Gestalt _____________________

Thank you for supplying this background data. Please respond to the following statement:

"Therapists are in the position to exert a great deal of influence over the values, goals, and self-perceptions of their clients. Usually, this ability to affect the client is carefully monitored by the therapist, in an effort to allow the individual to remain autonomous and self-responsible. However, there is a potential for abuse of power by the therapist."

Do you agree with this statement? If so, please describe the behaviors which would indicate to you that a therapist is abusing his power:
APPENDIX B

CLIENT QUESTIONNAIRE
TO: THERAPISTS, CLIENTS, and COUNSELOR-EDUCATORS

RE: MASTER'S THESIS PROJECT

I am currently a Master's Degree candidate at CSUN. As part of my thesis project I am interviewing therapists, clients and counselor educators. I would greatly appreciate your comments and response to the enclosed survey form. Of course, all material will be confidential.

Upon completion of the enclosed form, please return it to the person who gave it to you or send it to me at the address listed below.

Thank you so much for your help and cooperation!

Paulette Freedenberg

(author's address)
Client Questionnaire

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
</tr>
</thead>
</table>

Approximately how many hours of individual therapy have you had? _____

How many hours of group therapy? ______________________________

Number of different therapists you have seen? __________________

In what setting(s) have you seen a therapist?
- Private Practice       - Public Schools
- Social Service Agency - Church
- College/University    - Other

What was your therapist's primary style or orientation to therapy?
(If you have seen more than one therapist, please answer for each.)
- Client-Centered
- Behavioral
- Existential
- Family Systems
- I don't know
- Gestalt
- Psychodynamic/Analysis
- Other

What licenses/credentials did your therapist hold: (answer for each)
- MFCC (Marriage, Family and Child Counselor)
- LCSW (Licensed Clinical Social Worker)
- Licensed Psychologist
- Ph D
- Minister
- I don't know
- MD/Psychiatrist
- Other

Please indicate on the following scale your general impression of your experience in therapy: (Circle one number)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Helpful</td>
<td>Somewhat Helpful</td>
<td>Neutral</td>
<td>Somewhat Helpful</td>
<td>Harmful</td>
<td>Very Harmful</td>
<td></td>
</tr>
</tbody>
</table>
Client Questionnaire: Page Two

Note: Please feel free to use as much space as you need to answer the following questions, including the back of this sheet.

What therapist behaviors were most helpful to you? (Left you feeling positive about yourself, understood, more self-aware, etc.) Please list below and describe any specific incidents:

What therapist behaviors were most harmful to you? (Left you feeling judged, less able to deal with issues, dependent on the therapist, emotionally damaged or sexually abused, etc.) Please list below and describe any specific incidents:
APPENDIX C

THERAPIST BEHAVIORS
CONSIDERED HELPFUL BY CLIENTS
THERAPIST BEHAVIORS
CONSIDERED HELPFUL BY CLIENTS

Therapist Personal Qualities

1. Consistent

"His behavior is consistent, so I can depend on him to listen and be supportive (that doesn't mean he always agrees with me!) but I am secure in knowing that he is always there."

2. Supportive, non-judgmental

3. Open

4. Warm and concerned

"Went beyond the call of duty...called my home when my sister was having major brain surgery."

5. Sincere and doesn't take advantage of client

6. Accepting

"Made me feel comfortable, listened to and not pressured to self-disclose."

7. Intuitive and insightful

8. A good role model

9. Knowledgable

Therapist Behaviors

1. Listened

"They did a lot of listening and reacting honestly as people, not as 'therapists' so much. I didn't feel like a 'patient' which was very important to me."

2. Supported my independence

"His goal is to teach the individual effective coping skills, so one is independent of him. (He works himself right out of a job!)."

3. Accepted, supported and encourage me
"Allowed ventilation of past hurts."
"Emphasized my own personal power to explore issues and make decisions that would benefit me the most."
"Encouraged me to 'stretch' myself to do things that were hard or scary."

4. Self-disclosed
5. Was honest with me
6. Answered my questions directly
7. Referred me to another therapist responsibly
8. Made time for me (extra appointments, correspondence)
9. Suggested alternatives and new solutions
10. Confronted me
11. Encouraged self-responsibility
   "Required introspection."
   "Directed me to determine own needs vs. wants."
12. Was very direct
13. Gave me feedback
14. Gave me perspective and sense of reality
   "Showing conditional aspects of relationships."
   "Helping me to have realistic expectations."
   "Pointing the reality of interactions."
   "Helps me put the past and future in perspective so I can function in the now."
15. Clarified
   "Clarifying my thoughts for me."
   "Setting up a priority of issues."

Therapist Techniques

1. Rehearsal
   "Practicing out loud what and how I would tell my partner things I need for him to know."
2. Homework
   "Used outside of therapy exercises that reinforce the sessions."

3. Gestalt "empty chair" technique

4. Self-awareness exercises

5. Sharing books and articles

6. Interviewing me "as a child"

7. Utilizing "I deserve" statements

8. Working through transference

Note: One client felt that the absence of "any particular counselor technique or approach" was a positive aspect of her therapy.
APPENDIX D

COMPARISON OF SUBJECT GROUP LISTINGS OF ABUSES IN PSYCHOTHERAPY
## COMPARISON OF SUBJECT GROUP

### LISTINGS OF ABUSES IN PSYCHOTHERAPY

<table>
<thead>
<tr>
<th>Major Category</th>
<th>Therapists and Counselor-Educators</th>
<th>Authors Reviewed in the Literature</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coercion</td>
<td>Participation in psych. experiments</td>
<td>Coerced participation in therapy</td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Flaunting, threatening or holding power over client due to knowledge of privileged information</td>
<td>Gossip</td>
<td>Lack of content</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Making psychological decisions without informing client</td>
<td>Encouraging dependency for the client</td>
</tr>
<tr>
<td>Major Category</td>
<td>Therapists and Counselor-Educators</td>
<td>Authors Reviewed in the Literature</td>
<td>Clients</td>
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</tr>
<tr>
<td>Dependency (continued)</td>
<td>Leaving material unresolved week to week</td>
<td></td>
<td>Imposed her interpretations on me</td>
</tr>
<tr>
<td></td>
<td>Setting self up as expert</td>
<td></td>
<td>Put her answers on my problems</td>
</tr>
<tr>
<td></td>
<td>Giving advice</td>
<td></td>
<td>Did'nt help me define my goals</td>
</tr>
<tr>
<td></td>
<td>Making client rehearse everything</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labeling and Diagnosis</td>
<td>Labeling client</td>
<td>Labeling client</td>
<td></td>
</tr>
<tr>
<td>Money</td>
<td>Overcharging</td>
<td>Charged too much money</td>
<td></td>
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<tr>
<td></td>
<td>Keeping client too long for economic reasons</td>
<td>Keeping too long for the money</td>
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<td></td>
<td></td>
<td>Terminate too soon due to lack of money</td>
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<tr>
<td>Major Category</td>
<td>Therapists and Counselor-Educators</td>
<td>Authors Reviewed in the Literature</td>
<td>Clients</td>
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<tr>
<td><strong>Omnipotence</strong></td>
<td>Requesting client discuss problems only with therapist</td>
<td>Encouraging dependency</td>
<td>Trying to read my mind - I felt manipulated</td>
</tr>
<tr>
<td></td>
<td>Maintaining aura of secrecy</td>
<td>Subjecting client to behavior control</td>
<td>Too self-centered</td>
</tr>
<tr>
<td></td>
<td>Taking advantage of positive transference</td>
<td>Mismanaging transference</td>
<td>Explained own family instead of listening</td>
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<tr>
<td></td>
<td>Refusing to let go of the client</td>
<td>Manipulating</td>
<td>Let own issues get in the way</td>
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<td></td>
<td>Overstepping role boundaries</td>
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<td></td>
<td>Encouraging dependency</td>
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<tr>
<td>Major Category</td>
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<td>Authors Reviewed in the Literature</td>
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<tr>
<td>Omnipotence (continued)</td>
<td></td>
<td></td>
<td>Talked theory and ignored my pain</td>
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<td></td>
<td>Lectured instead of listening</td>
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<tr>
<td>Sex with Clients</td>
<td>Having sex with clients</td>
<td>Having sex with clients</td>
<td>Encouraged sexual acts in his presence</td>
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<td></td>
<td>Seduction</td>
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<td></td>
<td>Romantic involvement</td>
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<td></td>
<td>before or after therapy ends</td>
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<tr>
<td>Therapist Inadequacies in Skill or Judgment</td>
<td>Not confronting client in order to be liked</td>
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<td>Not enough confrontation</td>
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<tr>
<td></td>
<td>Being afraid to risk the client's anger</td>
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<td></td>
<td>Using hypnosis without client's consent</td>
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<td></td>
<td>Failing to be &quot;present&quot;</td>
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<td>Major Category</td>
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<tr>
<td>Therapist Inadequacies in Skill or Judgment (continued)</td>
<td>Becoming fixed in a theoretical mode</td>
<td>Insistence on using single method of treatment</td>
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<td>Imposing structure too quickly</td>
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<td>Focusing on the past</td>
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<td></td>
<td>Lacking self-awareness</td>
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<td>Being unable to set limits</td>
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<td>Failing to acknowledge own power</td>
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<td>Too-rapid dissolution of client's defenses</td>
<td>Pushed me to deal with issues too soon</td>
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<td></td>
<td>Failure to recognize real environmental factors</td>
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<td>Failure to inform client of goals, procedures, etc.</td>
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<td>Mismanage counter-transference</td>
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<td>Major Category</td>
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<td>Authors Reviewed in the Literature</td>
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<tr>
<td>Therapist Inadequacies</td>
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<td>Group leader</td>
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<td>in Skill or Judgment</td>
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<td>Looking for quick cure</td>
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<td>Too high expectations</td>
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<td>Excessive question-asking</td>
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<td>Berate me for withholding when just not ready</td>
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<td>Not responding to my feelings</td>
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<td>Therapist Inadequacies in Skill or Judgment (continued)</td>
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<td></td>
<td>Didn't support me</td>
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<td></td>
<td></td>
<td>Sudden termination</td>
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<td></td>
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<td>Abrupt change of subject</td>
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<td></td>
<td></td>
<td></td>
<td>Overreacted to friendly gesture</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>No response to me after therapy was over</td>
</tr>
<tr>
<td>Values Indoctrination</td>
<td>Imposing own values on the client</td>
<td></td>
<td>Imposed her values on me</td>
</tr>
<tr>
<td></td>
<td>Taking stand for/against client's actions based on own values</td>
<td></td>
<td>Too much therapist opinion</td>
</tr>
<tr>
<td></td>
<td>Utilizing selective reinforcement of client behaviors</td>
<td></td>
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</tr>
</tbody>
</table>