VOCATIONAL REHABILITATION COUNSELORS IN THE STATE OF WISCONSIN: THEIR THEORETICAL ORIENTATION, THE TYPES OF THERAPEUTIC INTERVENTION THEY PURCHASE, AND THE USAGE AND VALUE OF THESE TECHNIQUES

by

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ABSTRACT

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Vocational Rehabilitation Counselors in the State of Wisconsin: Their Theoretical Orientation, the Types of Therapeutic Intervention They Purchase, and the Usage and Value of These Techniques.
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The purpose of this descriptive study was to determine what types of therapeutic intervention rehabilitation counselors in the State of Wisconsin purchase, how frequently they do, and the value counselors place in the certain types of therapeutic intervention. This study also looks at the issue of repressed memories and how frequently rehabilitation counselor's clients are recovering memories in therapy, and how many have resulted in legal actions. A survey was developed by the researcher and mailed to 215 rehabilitation counselors working for the state agency in 1999. 112 counselors responded for a return rate of 52%. Descriptive statistics were used to analyze the responses from the survey.

Results from this survey indicated that the fifty-seven percent of the counselor's caseload was general, and the theoretical orientation that counselors refer their clients to most frequently is eclectic or general, with behavioral and client-centered also being strong. The most frequently purchased therapeutic technique purchased was biofeedback, with relaxation therapy being second. In looking at how many clients have been involved in legal actions related to material discovered or developed in therapy, it was reported that there were sixty-eight client's claims against parents, siblings, clergy, teachers, day-care workers, etc. Thirty-seven clients filed claims against there own therapist, and twenty-nine parents had counter claims against their sons/daughters therapist. In looking at how many clients in the past ten years had uncovered material dealing with sexual abuse, alien abductions, and satanic rituals; there were eight hundred and thirty-three cases of sexual abuse, fifty-six cases of satanic rituals and twelve cases of alien abductions. When counselors were asked if they knew if any of their client where it seemed likely that a memory of trauma was somehow suggested by a therapist rather than by a genuine experience, fifty-four responded no, thirty two responded undecided, and thirteen responded yes.

This survey uncovered interesting results as reported by rehabilitation counselors in the State of Wisconsin and raises serious questions about the type of psychotherapy that is being conducted with clients today.

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CHAPTER I
Introduction

The purpose for this study is to determine what types of psychotherapy rehabilitation counselors in the State of Wisconsin refer their clients to, and how valuable they consider those various types of therapy to be. Due to the recent controversy that has developed over repressed memories versus false memories this survey will also look at the frequency with which rehabilitation clients are recovering memories in therapy, and how many have resulted in legal action.

For many years the question of what a rehabilitation counselor's role is has been highly debated. In 1954, Public Law 565 made efforts to clarify the role of the rehabilitation counselor. Since 1954, studies on the role of the rehabilitation counselor have focused on delineating a unique professional identity as well as an appropriate educational curriculum for preparing individuals for the role of rehabilitation counselor. In looking at this issue, C.H. Patterson (1957) focused his efforts on whether the rehabilitation counselor should be trained as a counselor or a coordinator. Although both roles were seen as necessary for serving the disabled person during the rehabilitation process, Patterson (1957) advocated a division of labor with state rehabilitation agencies employing both rehabilitation counselors and rehabilitation coordinators. Viewing the training of counselors as the purpose of graduate education in rehabilitation, Patterson (1966, 1967, 1968, 1970) encouraged state rehabilitation agencies to employ graduate school-trained rehabilitation counselors to function as psychological counselors. Psychological counselors would work with only those clients needing to resolve personal adjustment problems (Rubin & Roessler, 1995). Patterson stressed that state rehabilitation agencies should employ rehabilitation coordinators to find cases, do intake

interviews, assemble reports, determine eligibility, manage cases, arrange for services from other professions, do public relations work, and place clients on jobs. (Rubin & Roessler, 1995).

Another professional's views on this issue was that of Whitehouse (1975) who referred to the rehabilitation counselor as a rehabilitation clinician--a professional who works with the whole person. The rehabilitation clinician must have multiple behavioral competencies coupled with a comprehensive knowledge base. Overall, Whitehouse (1975) viewed the rehabilitation clinician as a professional whose skills include those of a therapist, guidance counselor, case manager, case coordinator, psychometrician, clinical life reviewer, vocational evaluator, educator, team member, social and family relations, placement counselor, community advocate and client advocate, life engagement counselor, long-term conservator, and clinician (Rubin & Roessler, 1995).

Attempts have also been made empirically to define the role and function of the rehabilitation counselor. Such efforts have focused on reports of what counselors say they do or on observations of what they actually do. In a study conducted by Muthard and Salomone (1969), they discovered that many state rehabilitation agency counselors estimated that they divide their time roughly into thirds: one-third solely to counseling and guidance; one- third divided among clerical work, planning, recording, and placement; and one-third divided among professional growth, public relations, reporting, resource development, travel, and supervisory administrative duties (Rubin & Roessler, 1995).

Other pre-Rehabilitation Act of 1973 studies support the Muthard and Salomone (1969) study above finding that counseling and guidance is the single greatest activity to

which rehabilitation counselors report devoting their greatest amount of time. In another study, this time involving Iowa, Illinois, and Minnesota state rehabilitation agency counselors, Miller and Roberts (1971) found that counselors reported face to face contacts with clients as the job activity on which they spent the greatest amount of their time. Rubin, Richardson & Bolton (1973), also found in a study of 87 counselors from 11 different state rehabilitation agencies, that rehabilitation counselors spent the greatest amount of their time in direct contact with clients. These more recent studies suggest that rehabilitation counselors spend approximately one-fourth of their work time in counseling and guidance activities (Rubin & Roessler, 1995).

According to the Neely (1974) study, rehabilitation counselors are unable to function primarily as counselors, because their caseloads were too large and their agencies applied too much pressure for closures (rehabilitation/gainful occupation) (Rubin & Roessler, 1995).

So the debate still continues as to what the rehabilitation's counselors role is. In looking at the counseling aspect for rehabilitation counselors many agree that in addition to not being trained to conduct long-term psychotherapy, rehabilitation counselors have very limited time to devote to that activity due to large caseloads and extensive case-management responsibilities (Rubin & Roessler, 1995).

Even though counselors often find that they are too pressed for time to conduct effective therapeutic counseling, it has been pointed out by Munro and Bach (1975) in a study they conducted that having time limits in counseling does not preclude the possibility of achieving therapeutic goals (Rubin & Roessler, 1995). What Munro and Bach's study found, was that skillful time-limited counseling, when compared to

counseling for a longer undetermined time period, led to increases in client independence and self-acceptance. There was also less need for additional counseling for those clients who were involved in time-limited counseling (Rubin & Roessler, 1995). The reason this is so, according to Reid and Shyne (1969), is that time-limited counseling requires the counselor to narrow down and focus on the objective or immediate goals that the client wishes to achieve. This type of counseling is very appropriate for the role that the rehabilitation counselor plays in helping clients identify vocational placement goals and necessary sub-objectives in the counseling, physical restoration, and vocational training areas (Rubin & Roessler, 1995).

So what type of therapy should counselors rely on? Today there are over 400 psychotherapies all claiming to help individuals (Karasu, 1986). Each type of therapy has it's own theoretical orientation with a different focus and approach to helping individuals. Since every individual is different, one certain type of therapy may work better for one individual than another. The same case applies for choosing a therapist. An individual may interact better and more efficiently with one counselor than another. The ideal situation is for the individual to find the therapist that they feel most comfortable with, and whose theoretical orientation is one that fits the needs of the client.

How a counselor sets up goals that they think are important in therapy, the techniques and methods they employ to reach these goals, the way in which one sees the division of responsibility in the client/therapist relationship, their view of their role and function as a counselor, and also their views on the place of diagnosing and testing in the therapeutic process are all determined by ones theoretical orientation (Corey, Corey, &

Callanan, 1993). A therapist's theoretical orientation is usually determined by the education they received, and what they feel they are most comfortable and effective with.

Practicing counseling without having an explicit theoretical rationale is like flying an airplane without training, experience, or maps to help you, or skydiving without a parachute. Theoretical orientation should not be seen as a rigid structure that sets out the specific steps of what to do in a counseling situation, but rather be looked at as a general guideline that counselors can use to make sense of what they are doing (Corey, Corey, & Callanan, 1993). A theoretical orientation should give counselors a basis to refer to and base their counseling techniques around, and still allow them to develop their own unique, yet effective counseling style.

A counselor's main goal is to help the client learn and practice new ways of thinking and living. Counseling helps clients make choices and act on them. Effective counseling results in improved relationships, better coping skills, and personal growth (Cavaliere, 1995). Vocational Rehabilitation Counselors hold these same goals and expect to see the same outcomes as do other counselors in other professions, but their emphasis is more on returning to work or better education to obtain better employment. Along with having the same goals of bettering individual's lives, all counselors have an obligation to their clients and to their profession to be accountable for the quality of the professional services they offer. Legally, the therapist must possess the level of learning, skill and ability that others similarly situated possess; must exercise reasonable care and diligence in the application of knowledge and skill to the patients needs, and they must use their best judgment in the treatment and care of all patients (Stone v. Procter, 1963;

cited in Furrow, 1980). Effective counselors are also expected to be fully honest with themselves and others about the limits of their own expertise (Pope & Vasques, 1991).

The American Psychological Association (1992) requires professionals to only provide services and techniques for which they are qualified by training and experience. Being competent as a therapist does not mean being able to treat every person that needs counseling. A reasonable therapist will accept only clients that can benefit from the training and skill the therapist has acquired. Competency includes knowing what client conditions you cannot treat because you are not qualified by training and experience (Parrot III, 1997). Failure to practice at a reasonable level of competence may result in accusations of malpractice.

When a counselor recognizes that a client's needs are beyond his or her expertise, the counselor is responsible for making referrals to other qualified counselors. In making referrals of clients, counselors need to help clients understand the reasons for the referral and the specific qualifications of the professional to whom the referral is made (Parrot III, 1997). This case also applies for vocational rehabilitation counselors.

When rehabilitation counselors find they can no longer counsel their clients effectively, or feel they need other professional help, they often refer them on to the psychotherapist. When this referral is made, the client should always be informed of the conditions under which they may receive therapeutic assistance at or before the time when the therapeutic relationship is entered. In individual and group situations, particularly those oriented to self-understanding or growth, the therapist is obligated to make clear the purposes, goals, techniques, rules of procedures, and limitations of the relationship. This standard was set forth in the American Personnel and Guidance

Association: Ethical Standards Section (Van Hoose & Paradise, 1979). As one can see, there are many rules and guidelines that counselors must follow to be effective and ethical to the clients they serve.

The purpose of this study is to investigate the nature of psychotherapy provided to clients of the State of Wisconsin Division of Rehabilitation. What type of therapy so rehabilitation counselors refer their clients to, and how effective do they feel different therapeutic modalities are. It will also look at how many individuals are recovering memories of abuse through therapy sessions, and how many of those have resulted in legal actions.

Statement of the Problem

The purpose of this investigation is to determine what Wisconsin Division of Vocational Rehabilitation counselors are purchasing when they refer clients to psychotherapy, what therapy techniques are being utilized, and what percentage of their caseload receives psychotherapy. Due to the recent controversy that has surrounded the recovering of false memories during therapy, this survey will also look at the frequency with which clients are recovering memories in therapy, and how many of these clients have been involved in legal actions related to material discovered or developed in therapy.

Subjects in this study were all of the Vocational Rehabilitation Counselors employed by the Wisconsin Division of Vocational Rehabilitation.

A two page questionnaire containing 16 questions was distributed to the 215 vocational rehabilitation counselors working for the state agency in 1999. The specific goals of this research were:

1. To determine what type of psychotherapy vocational rehabilitation counselors are purchasing.

2. To determine what percentage of their clients receive psychotherapy.

3. To determine what specific therapy techniques are being utilized with their clients.

4. To determine the frequency and nature of repressed memory therapy.

5. To assess the amount of clients who have been involved in legal actions related to material discovered or developed in therapy.

CHAPTER II
Literature Review

Introduction

This chapter will briefly review the major counseling theories, then examine the nature of the repressed memory debated, and then conclude with observations on the protections for clients in therapy.

Major Counseling Theories

Due to the serious consequences psychotherapy can have on an individual's life, it is extremely important to know what type of therapy is being provided along with the specific techniques the therapist is using. As stated earlier, there are over 400 different types of psychotherapy. For the purpose of this study, the major most frequently used types of therapy were looked at.

Freudian Therapy. The Freudian theoretical orientation developed by Sigmund Freud is a therapy that is deterministic. Freud believes that our behavior is determined by irrational forces, unconscious motivations, biological and instinctual drives, and these develop through essential psychological stages in the first six years of life (Corey, 1996). Freud believed that an individual retains unconsciously primitive biological and sexual impulses which if expressed, would cause retribution from the individual's own superego and society. To prevent this from happening, the individual relies primarily on the defense mechanism of repression; that is, the individual represses these unacceptable impulses from conscious awareness. When repressed material in the unconscious threatens to escape into consciousness, the individual experiences signal anxiety. To alleviate this anxiety, the individual uses a variety of defense mechanism, including compensation, sublimation, reaction formation, rationalization, displacement, and projection. Although both adjusted and distressed individuals use these defense mechanisms, their excessive use is considered indicative of a neurosis (Parker, Szymanski, Mora, 1992).

The goals of Freudian therapy are to make the unconscious conscious, and to reconstruct the basic personality. It assists clients in reliving earlier experiences and works through repressed conflicts. It's emphasis is on achieving intellectual awareness (Corey, 1996).

Person-Centered Therapy. Person-centered or client centered therapy was developed by Carl Rogers. This therapy focuses on the client gaining a greater sense of independence. Person-centered therapy focuses on the individual, not on the individual's problem or issue. The goal of person-centered therapy is not only to solve problems, but to assist clients in their growth process, so that they can better cope with problems that they are now facing, and problems they could avoid in the future (Corey, 1996). This approach uses few techniques but stresses the attitudes of the therapist. The basis techniques of this therapy require the therapist to actively listen, reflect feelings, provide clarification, and "be there" for the client. The relationship between the therapist and the client is the focal point for this therapy. In order for the relationship to be productive, the therapist

needs to display genuineness, warmth, empathy, and respect for the client (Corey, 1996). By having these characteristics, a productive therapeutic relationship will be achieved.

Rational Emotive Therapy. Rational-Emotive Therapy was developed by Albert Ellis. The main goal of RET is to eliminate any emotional disturbances by substituting rational beliefs and thinking for those irrational thoughts. Ellis states that one way to understand the structure RET is to consider the A-B-C paradigm: "When a highly charged emotional consequence (C) follows a significant Activating Event (A), A may be seen to, but does not actually, cause C. Instead, emotional consequences are largely created by B, the individual's belief system (Ellis, 1984, p. 196). Major assumptions underlying this approach to therapy include:

1. Humans have an innate potential for rational thinking.

2. Irrational thinking is acquired by learning, usually at an early age.

3. Perception, thinking, and emoting are interdependent and occur simultaneously.

4. Irrational beliefs when they cause emotional disturbance, are primarily faulty and/or negative self-statements.

5. These irrational beliefs may be supplanted and thus overcome by inducing the individual to verbalize positive self-verbalizations.

(Corey, 1996, p. 225-227).

Eclectic Therapy. The eclectic approach to counseling represents attempts to develop systems of counseling based on all scientific data and philosophical treaties on human behavior. Basically, the eclectic counselor uses techniques derived from a variety of theoretical systems, providing that these techniques can be logically integrated and are philosophically congruent (Corey, 1996).

Gestalt Therapy. Gestalt therapy which was developed by Fritz Perls focuses on a existential/phenomenological approach based on the premise that people must find their own way in life and accept personal responsibility if they hope to achieve maturity. The main goal is for the clients to gain awareness of what they are experiencing and doing. Through this awareness, they gain self-understanding and the knowledge that they can change their lives. Also, they learn that they are responsible for what they are thinking, feeling, and doing. This approach focuses on the client's perceptions of reality, and yet it is grounded on the here and now and emphasizes that each person is responsible for his or her own destiny (Corey, 1996, p. 224).

One of the main contributions of the Gestalt approach is its emphasis on learning to appreciate and fully experience the present moment. Gestalt therapy believes that focusing on the past can be a way to avoid coming to terms with the present. This approach help clients deal with avoidance and unfinished business (Corey, 1996).

Behavioral Therapy. Behavioral therapy focuses on an individual's present behavior. This therapy focuses on overt behavior, concrete specific goals of treatment, specific treatment plans, and an objective evaluation of therapy outcomes. Behavioral therapy is based on the principles of the learning therapy. Acceptable behavior is learned through reinforcement and imitation, and abnormal behavior is the result of faulty learning. The therapist goal is to help clients learn more effective behavior to replace and eliminate maladaptive behaviors, and have the clients take an active role in setting the treatment goals and evaluate how well these goals are being met (Corey, 1996).

Reality Therapy. Reality therapy main focus is to help individuals become more effective in reaching their personal needs. This therapy is active, directive, and didatic. It challenges clients to evaluate what they are doing, and how well their present behavior is working. To do this, therapist use various techniques. If the client finds that their present behavior is not effective and they want to change, the therapist will help them develop a plan to change their behavior, and have the client make a commitment to follow through with this plan. This therapy rejects many notions of conventional therapy such as focusing on the client's past, feelings, insights, the unconscious, and their dreams (Corey, 1996).

Repressed Memory Debate. For many years there has been great debate over the various theoretical orientations and therapeutic modalities utilized by therapists and counselors. This debate has become even more heated in recent years due to the controversy that is arising with repressed memories. Repressed memories are those that have been buried in a persons unconscious, usually for decades, which may then surface, often in dramatic ways. Repression is seen as a natural psychological defense mechanism that serves to keep painful and traumatic material out of awareness. Repression cannot be studied directly, it can only be inferred. You cannot ask someone, "Are you repressing memories of abuse?" If he or she knows about it, it is not repressed. Despite the past trauma being out of your awareness, it's lingering effects on your thoughts, feelings, and behavior can be dramatic. Some very severe symptoms can be a direct consequence of repressed traumas (Yapko, 1994). The controversy that is arising with repressed/recovered memories, is that it has been known to create what are called "false memories". When the memory is distorted, or confabulated, the result can be what has been called the False Memory Syndrome: a condition in which a person's identity and interpersonal

relationships are centered around a memory of traumatic experience which is objectively false but in which the person strongly believes. Note that the syndrome is not characterized by false memories as such. We all have memories that are inaccurate. Rather, the syndrome may be diagnosed when the false memory is so deeply ingrained that it orients the individual's entire personality and lifestyle, in turn disrupting all sorts of other adaptive behaviors. The analogy to personality disorder is intentional. False memory syndrome is especially destructive because the person continuously avoids confrontation with and evidence that might challenge the memory. Thus the memory takes on a life of its own, becomes engrained in the mind and refuses to challenge or correct it. The person may become so focused on the memory that he or she may be effectively distracted from coping with the real problems in his or her life (Dr.Kihlstrom,1995).

The process in which many false memory cases get started is as follows: A woman consults a psychotherapist to seek relief from pain or emotional problems that she is experiencing. The therapist then informs the patient that she may have been molested as a child and does not know it. Due to this disturbance, the client has repressed the material in their unconscious, and it is now causing them emotional problems. Some individual's will find this information ridiculous and will seek another therapist, others will follow this belief and accept the therapist suggestions. They then become motivated for "memory recovery" so they can find the cure for their emotional problems and symptoms. At some point in time, the therapist will offer encouragement that "memories" will return within time. Dreams are also looked at and interpreted by the therapist as proof that repressed memories are lurking, and waiting to come out. As time

goes on, the therapist may refer the client to a “survivor recovery group” where they will be with other individuals who encourage “survivors” to keep trying to remember. Attendance at the various support groups, reading various self-help books, and surrounding oneself with other survivors, all help the client to validate the therapist theories of being sexually abused (Hochman, 1994).

Recovered memory therapy believes in directing the patient towards finding their inner world to discover the proof that they were sexually abused. Many recovered memory therapy techniques include the following:

- Meditation
- Dream work (analyzing dreams for suggestion of abuse)
- Art therapy
- Consciousness journal writing
- Hypnosis
- Guided imagery
- Age Regression
- Reading self-help books
- Reading stories from women who have recovered memories
- Encouraging the client to review family albums to see if any childhood pictures reveal them being sad, because this will confirm that the abuse has occurred (Hochman,1994).

Due to the seriousness of certain therapeutic treatment methods, it has been advised that in any form of therapeutic treatment, the client should be fully aware of the techniques being used and the positive and negative consequences that these techniques

can hold. It is especially useful and advisable to document in the case of special methods or procedures used for the purpose of recovered memories. In these cases the client should be fully informed as to the nature of the procedure, its potential benefits and limitations, and particularly the fact that there may be no scientific proof that the procedure can result in historically accurate memories. Therapists may even wish to give clients a written statement on the current scientific status of recovered memories of sexual abuse (Prozan, 1997).

> Previous research has demonstrated that a substantial number of people will create false memories when they are given modest suggestions about events that did not occur. False memories can be implanted through misinformation, especially from a trusted person. Outside intervention can convince people to "remember". It has been noted that memory can be manipulated by suggestion, by hypnosis, by sodium amythal, and by other drugs (Prozan, 1997).

It has been noted that most clients who encounter the false memory syndrome are women who are white, middle class, and educated. This strongly corresponds to the profile of individuals who enter long term psychotherapy, and who believe that psychotherapy is an important way to solve life's problems (Hochman, 1994).

Therapy modalities and theoretical orientations have always been debated and will continue to be debated due to the fact that there is not one single answer for the most effective therapy or technique. The reason being, is that the mind is a very complex system, and with every individual being unique and having different needs, views and beliefs, there is no possible way to pinpoint the single best therapy technique or theoretical orientation.

Sigmund Freud, who is considered the father of psychoanalysis, developed the theory that the mind is a complex energy-system, the structural investigation of which is the province of psychology (Green, 1998). Freud was one of the first great thinkers to

apply deterministic principles systematically to the sphere of the mind, and to hold that the broad spectrum of human behavior is explainable only in terms of the mental processes or states which determine it. Freud believes that many of these mental processes are usually hidden subconsciously in ones mind (Green, 1998). Due to this belief, Freud treated behavior by searching for and seeking an explanation for these causes in terms of the mental states of the individuals concerned.

One of Freud's main beliefs, was that dreams are determined by hidden motives in the person's in the person's mind, and so they reveal in covert form what could otherwise not be known. Also, whenever an individual makes a choice, they are governed by hidden mental processes of which they are unaware and over which they have no control.

Freud believed that an unconscious mental process or event is not one which merely happens to be out of consciousness at a given time, but is rather one which cannot, except through protracted psychoanalysis, be brought to the forefront of consciousness. The mind possesses a number of defense mechanisms' which attempt to prevent conflicts from becoming too acute. This is where the idea of repression comes into play. Repression is pushing conflicts back into the unconscious. Repression is the central defense mechanism by which one seeks to avoid internal conflict and pain, and to reconcile reality with the demands of life. When things are repressed, they continue to exist intact in the unconscious, from where it exerts a determining force upon the conscious mind, and can give rise to the dysfunctional behavior characteristic of neuroses (Green, 1998).

On the issue of repressed memories the mental health profession is strongly

divided in views. On one end of the spectrum, there are clinicians and researchers who believe that the whole existence of repressed traumas due to sexual abuse can and should be identified from a set profile, in the form of a symptom checklist. They believe that treatment should involve first uncovering the repression memory with a variety of memory recovery techniques, then working with the newly discovered traumatic material. They believe that memories recovered in therapy are essentially true, and need to be acknowledged as such in order for treatment to succeed (Yapko, 1994).

On the other side of the issue are those clinicians and researchers who are skeptical of anyone's professed ability to diagnose repressed memories of trauma on the basis of symptoms that might just as readily be explained by other means. These critics further believe that by jumping to the conclusion that an individual has been abused and is repressing memories to that effect, a therapist can intentionally or unintentionally influence that person to reach that same conclusion, whether it be true or not. They recognize that people can be influenced, especially in vulnerable situations like therapy, to believe damaging things that may have no basis in fact. They are concerned that innocent people will be falsely accused, and that many people's lives will be destroyed in the process (Yapko, 1994).

This debate is highly emotional between both sides due to the fact that clinicians and researchers are both genuinely concerned for the well being of their clients and their families who are caught in this turmoil. Those who are confident that memories of trauma are definitely accurate do not want their abused clients to face doubt or outright accusations of deception from others. They know that abuse survivors need to be believed, and to be treated sensitively and skillfully. However, those who are confident

that untrue memories can be implanted or false beliefs created through poor therapy are equally earnest in their desire to protect vulnerable clients--and their families--from getting absorbed into a potentially destructive and dangerous false belief system (Yapko, 1994).

For those skeptics that believe the false memory syndrome has no basis, supporters will point out that false memories have been happening for centuries, it just hasn't been publicized. Previous literature suggests that Freud made a genuine discovery, which he was initially prepared to reveal to his colleagues and the world, but the response that he received was so negative and even hostile that he altered his findings and offered his theory of the unconscious in its place (Masson, 1998). What Freud discovered that was so disturbing was that there was an extremely high prevalence of child sexual abuse occurring in nineteenth century Vienna. Viennese girls were suffering from trauma that was caused from being seduced or sexually abused at a very early childhood age by older male relatives. Freud's colleagues were so appalled, and he received so much negative feedback that he changed his "seduction theory" to the "unconscious theory". This theory now questioned the actual occurrence of these seductions and suggested the possibility of childhood fantasy (Masson, 1998).

Critics of Freud believe that his patients were not recalling childhood fantasies, but traumatic events in their childhood that were real. They also charge that Freud apparently had stumbled upon this discovery, and then knowingly suppressed the fact that the level of child sexual abuse in society is much higher than is generally believed or acknowledged (Davis, 1999). This theory was placed on the backburner and suppressed due to the negative feedback the Freud received and was not looked at again for half a century.

Counselors who do believe that false memories can be implanted hold the belief that as a result of this approach, some therapist will continue to encourage their clients to believe they are repressing memories of sexual abuse without any legitimate grounds for doing so. They require individuals to label themselves as more pathological than they actually may be. Once the label is accepted, they encourage their clients to cut off contact with their alleged abusers. A result of this is possibly destroying families and

cutting off all avenues of communication that might make reconciliation possible. Counselors also push clients to look at every episode of abuse and give every gory detail. It has even been noted that some therapists will help the client fill in the blanks if they are missing some aspects of their memory (Yapko, 1994).

One of the most disturbing aspects is how the memories start out small and then end up horrendous and gruesome. Many clients who start remembering sexual abuse acts, keep adding details as therapy continues until finally they believe they were involved in satanic ritual abuse cults. The "memories" become more bizarre and gruesome the further clients get into therapy. Clients also tend to get worse instead of better. Most individuals find themselves unable to function or deal with normal, daily life functions, as they had before they started therapy (Pendergast, 1995).

In some cases, repressed or false memories had been used to explain illness, phobias, or problems in the individual's life. In one woman's situation, she had polio when she was a young child, and the therapist helped her uncover memories of incest. So, to rationalize her having polio, it was suggested and later believed that she developed polio in order to escape to the hospital and get away from her father who was sexually abusing her. Another case involved a female client who came to therapy to deal with her compulsive eating. After a couple of sessions of repressed therapy, the lady discovered that her father sexually abused her, and performed a coat hanger abortion on her when she was younger. So, to deal with all of this pain, she repressed the memory and started over-eating to cope and cover up her feelings and memories (Pendergast, 1995).

For individuals who question the accuracy of repressed memories, and who wonder why it takes until adult hood for individuals to remember these horrendous acts, supporters of recall therapy explain it as follows (Frankyl, 1995).

> Memory is said to be stored someplace in the brain or body.
>
> It is claimed that this stored memory "leaks" and caused the child to have symptoms. Yet it appears that neither the child nor those around the child has knowledge of the symptoms or else the symptoms don't become evident until the person is an adult. It is believed that even though the memory leaks, the person is unable to access the memory. It is said that when the person is an adult and becomes a patient who is in a safe place such as a therapist's office, the patient can gain the insight that he or she has symptoms and that these symptoms are a sign of past abuse that the person does not remember. It is said that the fact that the patient does not remember any abuse is a sign that the abuse was so terrible that memories of it were repressed of dissociated. It is believed that with the help of a therapist and such "memory recover" techniques as hypnosis, sodium amytal, dream interpretation, journaling, guided imagery, participation in survivor groups or reading survivor literature, the person is able to remember the abuse and the memory is presumed to be accurate. It is said that in order to "heal" from the childhood abuse, the patient can be empowered by confronting and sometimes suing the alleged perpetrator. It is said that the patient stops being a "victim" by cutting off all contact

> with the alleged perpetrator(s) and anyone who does not validate his or her new memories (pg. 592-593).

Supporters of regression therapy point out that the DSM-IV recognized the existence of post-traumatic stress disorder, dissociative amnesia, and dissociative identity disorder. Each of these terms, which refer to what lay people usually call "repression," describes a fragmenting of the brain during a traumatic experience. This fragmenting process illustrates why trauma victims in many cases cannot relate a cohesive visual narrative of the childhood sexual abuse and why these memories sometimes resemble unconnected and objectively unbelievable pieces of events. These diagnoses reflect a well-established scientific recognition that the mind can avoid conscious visual recall of traumatic experiences (Murphy, 1997). It should also be noted that the American Psychological Association acknowledged that it is possible for memories of abuse that have been forgotten for a long period of time can be remembered (Murphy, 1997). The American Psychiatric Association also went on record to state that children who have been abused will cope with the trauma by using a variety of psychological mechanisms. In some cases, these coping mechanisms result in a lack of conscious awareness of the abuse for varying periods of time. Conscious thoughts and feelings may emerge at a later date in time (Murphy, 1997).

In Murphy's report she also states that the false memory syndrome does not exist as a recognized medical condition. The phrase was coined by the False Memory Syndrome whose purpose is to provide legal and emotional and support to those accused of sexual abuse (Murphy, 1997). Even though this is true, and there are valid and true memories that are uncovered from regression therapy, one needs to keep in mind that

there are many accounts and current court cases today where it is reported that individuals in therapy are having false memories which destroy families and lives.

In 1994, there were more than 200 lawsuits filed against professionals on the basis of repressed memories. Also, in 1995, a number of major court decisions were handed down that declared that recovered memories have no validity unless supported by extrinsic evidence. In May of 1995 in the state of Maryland, a Baltimore judge dismissed a lawsuit brought up by two former students against a Roman Catholic priest who allegedly molested them almost 25 years ago when they were in high school. They claimed that they developed "amnesiac aspect of posttraumatic stress disorder" from the early 1970's until a few years ago. The judge decided that the plaintiffs didn't demonstrate that PTSD "automatically leads one to amnesia, and it is a leap of faith this court cannot make…The court in no way is judging {the woman's}credibility, but their recollection. That did not meet the test of scientific reliability… No empirical studies verify the existence of repressed memory…There is no way to test the validity of these memories" (Freyd, 1997).

In July 1996, the Maryland Court of Appeals refused to recognize "repressed memories" noting that, "studies purporting to validate repression theory are justly criticized as unscientific, unrepresentative and biased". (1) In their decision, Judge Robert L. Karwacki stated, "We are unconvinced that repression exists as a phenomenon separate and apart from the normal process of forgetting" (Smith, 1997).

In Minnesota, August 1995, Vynnette Hamanne and her family were awarded $2.67 million in damages. This is believed to be one of the largest psychotherapy negligence awards in the United States history. Ramsey County Judge Bertrand Poritsky

ruled that the theory that humans are capable of "repressing" or "dissociating" memories of numerous traumas in childhood was not a credible scientific theory and thus could not be presented to the jury (Smith, 1997).

In October 1995, in the state of California, the California Superior Court excluded repressed memory testimony. They found that, "the phenomenon of 'memory repressions' is not generally accepted as valid and reliable by a respectable majority of the pertinent scientific community and that the techniques and procedures utilized in the retrieval process have not gained general acceptance in the field of psychology or psychiatry" (Smith, 1997).

Another case in Minnesota, this one in January of 1996, involved Plaintiffs Elizabeth, David, and Lisha Carlson, who won a 2.5 million dollar law suit against Dr. Diane Bay Humenansky. During the trial, Dr. Humenansky and defense experts testified that "recovered memory therapy" involving hypnosis, drugs, coercion, group pressure, and suggestion cannot produce false memories. Opposing them was Professor Elizabeth Loftus who testified that the theory of repressed memory is a myth without supporting scientific evidence. Professor Richard Ofshe testified that Recovered Memory Therapy is the "worst form of psychiatric quackery in the 20th century…These reckless and dangerous therapists have destroyed thousands of American families." Other experts testified that the RMT therapy techniques were "reckless and dangerous" and had significantly harmed the Carlson family. The Carlson family attorney Dr. R.C. Bardon stated, "the Carlson and Hamanne verdicts send a powerful message to psychotherapist that they must stop using untested and unproven methods on their patient" (Smith, 1997).

More recently, the University of Wisconsin- River Falls settled a lawsuit where the state paid $650,000. The case involved three college students from the University of Wisconsin-River Falls who sought psychotherapy only to end up falsely believing that they were victims of forgotten sexual abuse. The lawsuit was filed in Pierce County Court against psychotherapist Karen Burgoyne. Burgoyne has her own private practice and was counseling these students at the University of Wisconsin-River Falls counseling center. Through therapy, Burgoyne allegedly told all three students that they were victims of "unremembered childhood sexual abuse," and the experience had caused all three psychological problems. In order for these students to "recover" they needed to separate from one or more male members of their families. Two students also were led to believe that they suffered from multiple personality disorder (Associated Press, 1999).

Protection of Clients in Therapy

As one can see, there are many different types of therapy or theoretical orientations and there are even more actual specific techniques. Due to the various therapies and techniques offered, the American Counseling Association ACA has set out guidelines to protect the client. For instance, the ACA (1995) set out the guideline that, "When the counseling in initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed and other pertinent information" (Corey, 1996, pg. 59) By having this guideline in place, the client can now learn more about the therapy and treatment they will be receiving.

It is important that clients understand the treatment they will be receiving, and the benefits and limitations of the therapy their counselor is utilizing. This is one way to protect their rights as a client, and let them have an active part in the therapeutic relationship. One of the best ways to protect the rights of clients is to develop procedures to help them make informed choices. One way to accomplish this is to provide clients with the information they need to become active participants in the therapeutic relationships, this usually begins with the initial therapy session and continues throughout the counseling process. Another way to protect the rights of clients is to provide informed consent. By providing informed consent, it tends to promote the active cooperation of clients in their counseling plan. Many clients don't realize that they have any rights in regard to the counseling process, and do not think about their own responsibilities in solving their problems. Those who feel desperate for help may unquestioningly accept whatever their counselor says or does. Client will seek the expertise of a professional without realizing that the success of this relationship depends largely on their own investment and participation in the process. Most professional codes of ethics provide that clients have the right to be presented with enough data to make informed choices about entering and continuing the client/therapist relationship. Depending on the setting and the situation, this discussion can involve those issues that may affect the client's decision to enter or terminate the therapeutic relationship. Some of the issues that should be discussed include the general goals of counseling, the responsibilities of the counselor toward the client, the responsibilities of clients, limitations of and exceptions to confidentiality, legal and ethical parameters that could define the relationship, the qualifications and background of the practitioners, the fees involved and the service one

can expect, and the approximate length of the therapeutic process. Further areas that should be addressed include the benefits of counseling, the risks involved, and the possibility that one's case will be discussed with the therapist's colleagues or supervisors. Providing this kind of information in writing is a good method of helping clients understand what is involved in the counseling process. Clients can take this written information home and decide if this is the therapist they wish to work with. It also give the client time to think about any questions or concerns they have about the therapy they will be undergoing (Corey, 1996). Client should also be aware of the fact that counselors have an obligation to follow ethical principles. One basic ethical principle is that therapists are expected to recognize their own personal and professional limitations. Counselors who follow the ethical principles do not employ diagnostic or treatment procedures that are beyond the scope of their training, nor do they accept clients whose personal functioning is seriously impaired unless they are qualified to work with those clients. Counselors who become aware of their lack of competence in a particular case have the responsibility to consult with colleagues or a supervisor, or to make a referral to a professional who is competent in the area (Corey, 1996 pg. 78.).

It is important that clients receive services from counselors who are qualified and as noted above, those that follow ethical principles. One way to assure that counselors today are qualified and competent to work in the field of counseling, is to make sure they have graduated from an accredited college, and they are certified or licensed.

Accreditation of a college for graduate rehabilitation counseling is monitored through the Council on Rehabilitation Education (CORE). The CORE standards for rehabilitation programs address the following: 1) the articulation and fulfillment of the

counseling programs missions; 2) the programs curriculum; 3) the knowledge, skills, and job performance of its graduates; 4) the composition, resources, and professional involvement of its students; 5) and the program's support and resources, which includes the building accessibility (Parker & Szymanski, 1992, pg. 30).

To become certified, rehabilitation counselors must sign a statement that they subscribe to the *Code of Professional Ethics for Rehabilitation Counselors*. They must also demonstrate knowledge of the following content areas by achieving a passing score on the national examination. The areas addressed on the examination include: 1) foundations of rehabilitation; 2) client assessment; 3) planning and service delivery; 4) counseling and interviewing; and 5) job development and placement. Once certified, qualified rehabilitation counselors must maintain their certification by completing 100 hours of acceptable continuing education every five years (Parker & Szymanski, 1992 pg 30, 31).

By ensuring counselor's have graduated from an accredited program, and are certified, this will help to weed out those professionals who are not competent, and assure clients they are receiving the best possible services. Even though this system is in place, clients should still make sure they are aware of the therapy they are receiving, and the benefits and limitations of therapy. By being an active participant in the therapeutic relationship, clients will have a better understanding of the therapy process, and take an active role in achieving their well-being.

Unfortunately, even with these systems in place, some clients are receiving therapy that is not therapeutic. This therapy is not only ruining their lives and those that love them, but in some cases, it is making their lives worse than they were before. For

these reasons, and the recent controversy that has been developing with certain therapeutic techniques, this survey has been conducted to determine what type of psychotherapy vocational rehabilitation counselors are purchasing, what therapy techniques are being utilized with their clients, what percentage of their clients receive psychotherapy, the frequency of clients that are uncovering material during therapy, the amount of clients who have been involved in legal actions related to material discovered or developed in therapy, and how effective counselors believe certain therapeutic modalities are.

CHAPTER III

Methodology

Subjects

The subjects of this study consisted of the entire population (n=215) of vocational rehabilitation counselors employed by the Wisconsin Division of Vocational Rehabilitation. The subjects were selected from a current 1999 Directory of Wisconsin Vocational Rehabilitation Counselors.

One hundred and twelve (n=112) questionnaires were returned with useable data, for a return rate of 52%.

Instruments

A two page questionnaire consisting of 16 questions was the instrument of this study. The reliability and validity of this instrument is unknown. The specific questions this instrument addressed were:

1. Please estimate what percent of your caseload usually receives psychotherapy of any kind (psychiatry, mental health, alcoholics anonymous, support groups, etc.) during their rehabilitation process?

2. When you refer your clients out for professional psychological or psychiatric services, what theoretical orientation, if any do you seek in the therapist?

3. Please indicate the approximate number of your clients who have received any of the following therapies within the past several years. Also, in your professional judgement, how valuable are the following techniques?

4. During the past ten years, how many of your clients have ever seemed troubled or disturbed by material they discovered in therapy?

5. During the past ten years, how many of your clients have been Involved in the following legal actions related to material discovered or developed in therapy?

6. During the past ten years, how many of your clients, if any have uncovered material dealing with: sexual abuse, alien

abductions, and satanic rituals?

7. Are you familiar with the current debate regarding repressed memories and "false memories"?

8. Have you ever had doubts regarding the validity of repressed material recovered in therapy?

9. Do you know of any of your clients where it seems likely that a memory of trauma was somehow suggested by a therapist rather than by a genuine experience?

10. Do you believe that hypnosis enables individual to remember things they otherwise could not remember?

The questionnaire also addressed demographics, such as age, sex, educational level, years of experience in rehabilitation, and the type of caseload carried. Pilot testing was completed by two University of Wisconsin Stout professors in Vocational Rehabilitation Counseling, five graduate students in Vocational Rehabilitation Counseling, and two vocational evaluators. These subjects were given the questionnaire and asked to critique and offer suggestions for improvement. After the pilot testing was complete, the questionnaire underwent a few aesthetic changes before is was sent out. Attached in the appendices of this report is a sample of the questionnaire (Appendix A).

Procedure

The questionnaires were addressed to all Division of Vocational Rehabilitation counselors and were sent in packets to their respective district offices where they were distributed. Each questionnaire included a postage paid return envelop to the researcher's faculty advisor at the University of Wisconsin-Stout.

There were no identifiers of any kind so it was not possible to conduct any type of follow up.

Each questionnaire explained the voluntary and confidential nature of the survey as follows:

> I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I am aware that the information is being sought in a specific manner so that no identifiers are used and so that confidentiality is guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from participation at any time during the study will be respected with no coercion or prejudice.

Statistical Analysis

Descriptive statistics will be used to analyze the results. Tables and pie charts will be used to depict frequencies, means, and percentages.

Limitations

A limitation of this study was that it only represented vocational rehabilitation counselors in the State of Wisconsin so it is unknown if these results can be generalized to counselors in other settings.

The reliability and validity of this instrument is unknown.

CHAPTER IV

Results

This chapter will present the findings from the two page, sixteen question, questionnaire that was sent to all counselors at the Wisconsin Division of Vocational Rehabilitation. 215 questionnaires were sent out and 112 questionnaires were returned for a 52% return rate. All questions will be examined and all responses recorded in this chapter.

The first question in the survey dealt with the educational levels of the subjects in question. Out of the 112 respondents, 1 stated they had graduated from high school, 2 had an Applied Associated degree, 24 had a Bachelor's degree, 73 had a Master's degree, and 3 had a Doctorate. Nine subjects did not report their educational level.

Table 1

Education Level of Vocational Rehabilitation Counselors

Level	Frequency	Percentage
Master's Degree	73	65
Bachelor's Degree	24	21
Not Reported	9	8
Doctorate Degree	3	3
Applied Associated Degree	2	2
High School	1	1

Question 2 asked for the gender of the subjects. Of those responding, 44 were males (39%), and 58 were females (52%). Ten did not respond.

Question 3 asked for the age of the subjects. The reported ages ranged from 26 to 65 years old. 14 individuals did not respond to this question. The mean age was 44.71, the median 45, and the mode was 50 with eight individual's reporting this.

Question 4 looked at the years of experience of the counselors in rehabilitation. The years range from 1 year to 40 years of experience. The mean was 15.78 years of experience, the median was 20, and the mode was 20 with 9 individuals responding. All 112 individuals responded to this question.

Question 5 looked at the type of case load that counselor's carried. 64 individual's stated their caseload was general, 22 individuals did not respond to this question, 7 responded deaf and hard of hearing, 4 responded blind and general, 4 responded worker's compensation, 2 responded AODA, 2 responded blind and deaf, 2 responded high school, 2 responded mental health, 2 responded that they were managers, and 1 responded Veteran's administration.

Table 2

Type of Case load that DVR Counselors Carry

Caseload	Frequency	Percentage
General	64	57
Did Not Respond	22	19
Deaf & Hard of Hearing	7	6
Blind & General	4	3.5
Workers Comp	4	3.5
AODA	2	2
Blind & Deaf	2	2
High School	2	2
Mental Health	2	2
Managers	2	2
Veteran's Administration	1	1

Question 6 looked at the percentage of counselor's caseload that received psychotherapy. Please refer to the chart below for the statistics.

Table 3

Percentage of Counselor's Caseload That Received Psychotherapy

Percentage of Caseload	Frequency
Below 10%	17
15%	5
20%	13
25%	12
30%	10
35%	5
40%	3
45%	3
50%	12
55%	1
60%	3
65%	3
70%	1
75%	2
80%	5
85%	1
90%	2
100%	2

Question 7 looked at what type of professional psychological or psychiatric services, and the theoretical orientation the counselors looked for when they refer their clients to therapist. 45 responded Eclectic or General, 42 responded Behavioral, 37 responded Client-Centered, 20 responded Reality, 11 responded Rational Emotive Therapy, 10 responded "other", 2 responded Gestalt, 1 responded Trait Factor. The "other" categories broke down as follows: 2 Direct, 1 responded Freudian, 1 AODA, 1 Holistic, 1 Knowledge of Learning Disabilities, 1 Sign Language, 1 Transactional Analysis, 1 Therapist Orientation Normally Not Specified, and 1 Whatever the Therapist Decides.

Table 4

The Theoretical Orientation Counselor's Refer Their Client To.

Theoretical Orientation	Frequency	Percentage	
Eclectic or General	45	26	
Behavioral		42	24
Client-Centered	37	22	
Reality		20	12
Rational Emotive Therapy		11	7
Other		9	6
Gestalt	2	1	
Freudian	1	1	
Trait Factor	1	1	

Question 8 looked at the approximate number of clients who have received any of the following therapies within the past several years. They were also asked to circle how valuable they felt this type of therapy was. Please refer to the chart below for the statistical data.

Table 5

Frequency of Use and Perceived Value of Therapeutic Techniques During Past Several Years.

Technique	Times Used	Perceived Value (Means)
Biofeedback	553	3.6
Relaxation Therapy	424	3.6
Massage Therapy	214	3.1
Breath Work	136	2.6
Acupuncture	105	2.7
Guided Imagery	89	2.8
Hypnotherapy	61	2.5
Regression Therapy	57	1.8
Aroma Therapy	25	2.1
Rapid Eye Movement	15	2.0
Channeling	13	1.5
Neuro-Linguistic Programming	13	2.3
Touch Therapy	6	1.9
Past Lives Therapy	1	1.4
Trance Therapy	0	1.7

Question 9 looked at how many of the counselors clients in the past ten years have ever seemed troubled or disturbed by material they discovered in therapy. Out of the 112 counselors responding, it was reported that 661 clients they have worked with have seemed troubled by material they discovered in therapy.

Question 10 asked how many of their clients in the past ten years have been involved in legal actions related to material discovered or developed in therapy. The following data was obtained:

- **68** client's claims against parents, siblings, clergy, teachers, day-care workers, etc.
- **37** Client's claims against own therapist
- **29** parent's counter claims against sons/daughters therapist

Also, one counselor added to the survey that 1 of their clients filed a claim against their massage therapist.

Question 11 asked how many clients in the past ten years have uncovered material dealing with sexual abuse, alien abductions, and satanic rituals. The following data was obtained:

- **833** cases of Sexual Abuse
- **56** cases of Satanic Rituals
- **12** cases of Alien Abductions

Question 12 looked at how familiar counselors were with the current debate regarding repressed memories and "false memories"?

- **9** counselors responded "No"
- **30** counselors responded "Somewhat"
- **61** counselors responded "Yes"

Question 13 asked counselors if they ever had any doubts regarding the validity of repressed material they discovered in therapy.

- **3** responded "No"
- **25** responded "Undecided"
- **70** responded "Yes"

Question 14 asked counselors if they knew of any of their clients where it seemed likely that a memory of trauma was somehow suggested by a therapist rather than by a genuine experience.

- **13** responded "Yes"
- **32** responded "Undecided"
- **54** responded "No"

Question 15 asked counselors if they believed that hypnosis enables individuals to remember things they otherwise could not remember.

- **9** responded "No"
- **34** responded "Yes"
- **54** responded "Undecided"

CHAPTER V

Summary

Psychotherapy and counseling hold out the promise of help for people who are hurting and in need. When the process works as it is supposed to, lives can be changed in lasting and profound ways. Clients can gain awareness and understanding of themselves and also their lives. They can confront traumas and tragedies and come to terms with these events in a way that will not leave them numb, paralyzed, or disturbed. They can become happier and more fulfilled or at least less miserable. Also, they can become more aware of what values they appreciate and affirm, and what makes their lives meaningful (Pope & Vasques, 1991).

Research has shown that counselors should have a theoretical orientation to guide them in their therapeutic process to help make sense of what they are doing. There are also standards and ethics that counselors must follow when providing services to clients. Without having the proper training, licensure, or competency, counselors can be sued for malpractice. Standards were developed to help aid in the effectiveness of psychotherapy and counseling and to assure that clients were receiving the best services possible. As stated above, psychotherapy and counseling are suppose to help better individuals lives and help them come to terms with issues that are pressing on them emotionally. These standards and ethical guidelines help to assure that this process is being carried out.

What this study set forth to accomplish was to determine what type of psychotherapy vocational rehabilitation counselors in the state of Wisconsin were purchasing, what specific techniques were being utilized, and what percentage of their caseload received psychotherapy. This study also was interested in finding out the

frequency with which clients are recovering memories in therapy, and how many of these clients have been involved in legal actions related to material discovered or developed in therapy.

This study looked at the amount of psychotherapy that was being utilized by DVR clients. A simple arithmetic analysis indicated that, overall, 36% of the DVR caseload was receiving some type of therapy, including self-help groups such as A.A. However, the data suggest that there is enormous variability in the amount of therapy being received depending on the type of caseload. Seventeen counselors reported that less than one tenth of their clients received psychotherapy, while at the other extreme, four counselors reported that virtually all of their clients received psychotherapy. This is a consistent with the general observation that AODA and mental health clients will, by definition, be getting some type of therapy while general caseload clients may receive very little.

In analyzing the survey results of those counselors who responded to the questionnaire, the typical Wisconsin DVR counselor "profile" would seen to be a 45 year old female with a master's degree and 16 years experience in the field.

In determining the type of caseloads of these counselors, 57% reported that their caseload was general. This was by far the most commonly reported caseload.

The counselors also reported in this study that when seeking a theoretical orientation in psychotherapist, 26% look for an eclectic of general theoretical orientation, 24% look for behavioral, and 22% look for client-centered. Based upon this study, it can be stated that DVR counselors in the state of Wisconsin have a strong preference for psychotherapy that is either eclectic, behavioral, or client-centered.

When counselors were asked how many of their clients were referred to certain types of therapy and how effective they felt the techniques were, the most frequent answer was biofeedback. Counselors who responded to this question reported that 553 of their clients had received biofeedback as a therapeutic technique. In looking at how valuable they felt this technique was the mean was 3.6 when using a Likert scale with 1 being low value, and 5 being high value. The second most frequently used was relaxation therapy with 424 clients, and a value mean of 3.6. The third highest technique reported was massage therapy with 214 clients. The counselors gave massage therapy a value rating of 3.1 (mean). Breath work, acupuncture, guided imagery, and the rest were much less frequently used than the top three and had lower value ratings.

Research has shown how effective psychotherapy and therapeutic techniques can be in the rehabilitation and well-being of client. It has also pointed out that ineffective therapy can have damaging and devastating effects on clients lives. It not only ruins the individuals life, but in some cases it also terminates family relationships and family systems. One way counselors can help to assure that their clients are receiving appropriate services is to be aware of the therapist theoretical orientation and what therapeutic techniques they utilize. Counselors should also be aware of the therapists' certification and make sure they are licensed within the state. Without being aware of these factors, the chance of ineffective and dangerous therapy increases.

It should also be pointed out that clients should always be informed of the techniques and conditions under which they may receive counseling. Clients should be aware of the purposes of therapy, the goals, techniques, rules, procedures, and limitation

of the specific therapy being provided. The American Personnel and Guidance Association set forth these standards in their ethical standards section (Van Hoose & Paradise, 1979). This process should be completed before the counseling relationship is entered.

In 1994, more than 200 lawsuits were filed against professionals on the basis of repressed memories. Also in 1995, numerous court decisions were handed down that declared that recovered memories have no validity unless supported by independent evidence (Freyd, 1997). Due to the frequency of lawsuits that have been filed regarding repressed memories, this survey also looked at the frequency with which repressed or false memories were being uncovered in therapy by DVR clients, how many clients have been involved in legal actions related to therapy, and how counselors viewed the validity of repressed memory therapy. This questionnaire also asked if counselors knew of any of their clients where it seemed likely that a memory of trauma was somehow suggested by a therapist rather than by a genuine experience.

When counselors were asked how many of their clients in the past ten years had seemed troubled or disturbed by material they discovered in therapy, it was reported that 661 clients had been troubled by material they discovered in therapy.

In looking at how many of their clients had been involved in legal actions related to material discovered or developed in therapy, it was reported that there were 68 client's claims against parents, siblings, clergy, teachers, day-care workers, etc. There were 37 client's claims against their own therapist, and 29 parents counter claims against sons/daughters' therapist. These numbers alone raise suspicions about the amount of repressed memories and false memories that are occurring in the state of Wisconsin. This

also raises suspicion as to what type of therapy was being provided, and what techniques were being utilized. Another area of concern is that of informed consent. Were the clients aware of the therapy and techniques they were receiving? Did they fully understand the hazards and limitations of the therapy they were engaged in?

This questionnaire also asked counselors how many of their clients in the past ten years have uncovered material dealing with sexual abuse, alien abductions, and satanic rituals. Results discovered 833 cases of sexual abuse, 12 cases of alien abductions, and 56 cases of satanic rituals.

When asked how familiar they were with the false memory debate, 61 counselors responded that they were familiar with the current debate, 30 stated they were "somewhat" familiar with it, and only 9 responded "no" they were not familiar with the debate.

When counselors were asked if they ever had any doubts regarding the validity of repressed material that their clients discovered in therapy, 70 responded "yes", 3 responded "no", and 25 responded "undecided". 14 counselors did not respond to this question.

When asked if they knew of any clients where it seemed likely that a memory of trauma was somehow suggested by a therapist rather than by a genuine experience, 13 responded "yes", 54 respond "no", and 32 responded "undecided", and 13 counselors did not respond.

Based upon this questionnaire's results, it can be stated that the majority of vocational rehabilitation counselors in the state of Wisconsin are knowledgeable about and have doubts regarding the validity of repressed memory therapy.

Recommendations

Due to the high number of cases that have resulted in legal actions, and the number of individuals who have recovered material dealing with sexual abuse, alien abductions, and satanic rituals, it would be very beneficial for a study to be conducted looking at what type of therapy and techniques were utilized with these cases. Further studies should also be conducted to determine how many of these cases were based on actual experiences versus "false memories." It would be interesting to do a follow up study to find out how the clients and their families lives were affected afterwards.

As a recommendation for vocational rehabilitation counselors in the state of Wisconsin, it would be very beneficial for them to continue on with their professional development and understanding of the rehabilitation process and the role of psychotherapy in that process. It is also recommended that they further explore the research on repressed memory therapy and the possible consequences it may have for clients.

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March 15th, 1999

Dear

We are seeking your help with this survey on the use of non-conventional therapies with vocational rehabilitation clients. As you already know, there have been numerous lawsuits and turmoil associated with some newer brands of therapy.

Will you please take 5 or 10 minutes of your time and give us your insight and observations on how these techniques and therapies may have affected your clients.

Thank you for your time and consideration. The results of this survey will be available to you on request.

Sincerely,

Tawnya D. Fier
Graduate Intern
Department of Rehabilitation and Counseling
University of Wisconsin-Stout

Dr. John See Ph.D., CRC
Department of Rehabilitation and Counseling
University of Wisconsin-Stout

I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I am aware that the information is being sought in a specific manner so that no identifiers are needed and so that confidentiality is guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from participation at any time during the study will be respected with no coercion or prejudice.

Questionnaire

Dear Rehabilitation Counselors:

Currently there are over 400 different types of psychotherapy being practiced in the United States. Very few of these have been researched and some of them have resulted in lawsuits. The purpose of this study is to ascertain the usage of such techniques with Wisconsin Division of Vocational Rehabilitation clients.

1. Your Educational Level __H.S. __A.A. __B.S. / B.A. __M.S. __Ph.D. __other
2. Sex: __Male __Female 3. Age_____
4. Years of experience in rehabilitation_____
5. What type of caseload do you carry? _____

6. Please estimate what percent of your caseload usually receives psychotherapy of any kind (psychiatry, mental health, alcoholics anonymous, support groups, etc.) during their rehabilitation process? Approximate %: _____

7. When you refer your clients out for professional psychological or psychiatric services, what theoretical orientation do you seek in the therapist?
   ___Freudian ___Behavioral ___Client-Centered ___RET
   ___Reality ___Gestalt ___Trait Factor
   ___Eclectic or general
   ___Other, please specify_____

8. Please indicate by placing a check if any of your clients have received any of the following therapy techniques within the last year. Also indicate how valuable you think this type of therapy can be.

Check if any have received. ( )	In your professional judgement, how valuable can the following techniques be. Low Value		Average Value		High Value
___ Regression Therapy	1	2	3	4	5
___ Hypnotherapy	1	2	3	4	5
___ Channeling	1	2	3	4	5
___ Touch Therapy	1	2	3	4	5
___ Trance Therapy	1	2	3	4	5
___ Rapid Eye Movement Therapy	1	2	3	4	5
___ Emotional Freedom Techniques	1	2	3	4	5
___ Guided Imagery	1	2	3	4	5

	Low Value		Average Value		High Value
___ Breath Work	1	2	3	4	5
___ Aroma Therapy	1	2	3	4	5
___ Relaxation Therapy	1	2	3	4	5
___ Biofeedback	1	2	3	4	5
___ Acupuncture	1	2	3	4	5
___ Neuro-Linguistic Programming	1	2	3	4	5

9. Have any of your clients in the past ten years have ever seemed troubled or disturbed by material they discovered in therapy?

_____ Actual Number Please

10. In the past ten years, how many of your clients have been involved in legal actions related to material discoveredor developed in therapy?

___client's claims against parents, siblings, clergy, teachers, day-care workers, etc,
___client's claims against own therapist
___parent's counter claims against sons/daughter's therapist

11. How many of your clients in the past ten years have uncovered material dealing with sexual abuse, alien abductions, and satanic rituals?

___Sexual Abuse ___Alien Abductions ___Satanic Rituals

12. Are you familiar with the debate going on about repressed memories and "false memories"? ___Yes, ___No, ___Somewhat

13. Have you ever had doubts regarding the validity of the repressed material recovered in therapy? ___Yes, ___No, ___Undecided

14. Do you know of any of your clients where it seems likely that a memory of trauma was somehow suggested by a therapist rather than a genuine experience? ___Yes, ___No, ___Undecided

15. Do you believe that hypnosis enables individuals to accurately remember things they otherwise could not? ___Yes, ___No, ___Undecided