Individual patterns of mental health service utilization :: a qualitative analysis of retrospective interviews.

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INDIVIDUAL PATTERNS OF MENTAL HEALTH SERVICE UTILIZATION:
A QUALITATIVE ANALYSIS OF RETROSPECTIVE INTERVIEWS

A Thesis Presented
by
PATRICIA A. MCKENNA

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

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Department of Psychology
INDIVIDUAL PATTERNS OF MENTAL HEALTH SERVICE UTILIZATION:
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ABSTRACT

INDIVIDUAL PATTERNS OF MENTAL HEALTH SERVICE UTILIZATION: A QUALITATIVE ANALYSIS OF RETROSPECTIVE INTERVIEWS

MAY 1995

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The repeated use of mental health services over time is a common but poorly understood phenomenon. The purpose of this study was to examine in depth the service utilization histories of a small number of individuals. Nine former clients of the training clinic of a clinical psychology program participated in an interview which focused on each of their past psychotherapies and other mental health services. The interview included the creation of a time line, as well as a discussion of the participant's global views on therapy.

Analysis of the data revealed, one, that early therapies can affect later ones in a number of ways; two, that some individuals could identify one or more "formative" therapies in their histories; and three, that some initially helpful therapies can become less helpful over time. As a group, the participants reported a large number of relatively negative therapy experiences and had rarely returned to prior therapists. Participants' histories are presented in narrative form along with their time lines. Results are discussed in terms of possible areas for future research, as well as the potential clinical utility of the method.
# TABLE OF CONTENTS

| ACKNOWLEDGMENTS | iii |
| LIST OF FIGURES | vii |

**Chapter**

1. **INTRODUCTION**
   - Help-seeking ........................................... 2
   - Termination ............................................. 3
   - Longitudinal Psychotherapy Utilization .................. 5

2. **METHOD** ............................................. 11
   - Sample .................................................. 11
   - Procedure .............................................. 12
   - Measures ............................................... 13

3. **RESULTS** ............................................ 15
   - Sarah ................................................... 16
   - Emily ................................................... 29
   - Ed ....................................................... 40
   - Gerry ................................................... 51
   - Ida ...................................................... 61
   - Karen ................................................... 77
   - Mark .................................................... 90
   - Amy ..................................................... 107
   - Rita .................................................... 123

4. **DISCUSSION** ......................................... 139
   - First Experiences ....................................... 139
   - The Significance of Early Therapies .................... 141
   - Formative Therapies .................................... 147
   - Outgrowing a Therapy ................................... 149
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sarah's Time Line</td>
<td>17</td>
</tr>
<tr>
<td>2.</td>
<td>Emily's Time Line</td>
<td>30</td>
</tr>
<tr>
<td>3.</td>
<td>Ed's Time Line</td>
<td>41</td>
</tr>
<tr>
<td>4.</td>
<td>Gerry's Time Line</td>
<td>52</td>
</tr>
<tr>
<td>5.</td>
<td>Ida's Time Line</td>
<td>62</td>
</tr>
<tr>
<td>6.</td>
<td>Karen's Time Line</td>
<td>78</td>
</tr>
<tr>
<td>7.</td>
<td>Mark's Time Line</td>
<td>91</td>
</tr>
<tr>
<td>8.</td>
<td>Amy's Time Line</td>
<td>108</td>
</tr>
<tr>
<td>9.</td>
<td>Rita's Time Line</td>
<td>124</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

The current state of knowledge regarding how individuals use psychotherapy over the course of time is woefully inadequate. While much psychotherapy research uses the presence or absence of previous treatment as one variable of interest among many, researchers usually do not look beyond this "yes" or "no" level of information (see, e.g., Hoffman, 1985; Yokopenic, Clark, & Aneshensel, 1983), or they examine with some thoroughness only the most recent episode of treatment (cf. Siddall, Haffey, & Feinman, 1988).

The present research was initiated in order to provide a detailed view of the contours of a "full" psychotherapy history. I chose a qualitative design for this project primarily because it would allow me to follow the data which might emerge more freely than would a quantitative design. In addition, I believe that a grounding in the phenomenology of the topic will make for more efficient and effective future research. My central question throughout the research has been, What do these individuals have to teach us about repeated use of therapy over time?

While there is a dearth of research directly addressing the specific topic of longitudinal therapy use, there are some related topics which are relevant to beginning and ending single episodes of psychotherapy. Of specific interest is literature bearing on why and how people approach and leave therapy. Finally, the few directly relevant studies regarding individuals' longitudinal mental health service utilization will lead to a starting point for investigating the cycle of beginning and ending psychotherapy multiple times.
Saunders (1993) found evidence for a four-step process in seeking psychotherapy. These steps are: recognizing the problem, deciding therapy might help, deciding to seek therapy, and contacting the mental health system. For 48% of his sample, this process took more than two years. Problem recognition appeared to be the most difficult and time-consuming step of the four. During the time from steps one through four, most individuals (99% of his sample) reported attempting alternative coping strategies such as trying to work the problem out themselves, keeping busy, ignoring the problem, reading self-help literature, praying and many others.

Why do some people travel successfully from step one to step four while others get stuck somewhere in the process? Kushner and Sher (1989) found that fear of treatment is associated with mental health services avoidance. Such fear could be operative in blocking any or all of the above four steps, particularly the fourth one. Another possibility is that people choose not to seek help due to a self-reliant attitude. This was cited by Yokopenic, Clark, and Aneshensel (1983) as the main reason individuals who have recognized that they are depressed do not seek treatment. They found that one predictor of who would seek help after acknowledging a personal problem is discussion of the issue with family and friends. Many researchers (Kadushin, 1969; Saunders, 1993; Yokopenic, et al., 1983) have emphasized that the attitude and encouragement of one's social circle regarding psychotherapy is influential in the decision to seek treatment.

Braaten, Otto and Handelsman (1993) examined the type of information prospective clients desire most when making a decision regarding entering therapy. Using a sample of hypothetical clients (university students not actually seeking therapy at the
time), the researchers found the most frequent information requested concerned the therapist and the therapy methods, rather than administrative matters (like scheduling and confidentiality issues). Specifically, subjects wanted to know about the therapist's personal characteristics, experience, and credentials.

Approximately 40 to 55% of clients who approach a service delivery system do not return after their first visit, while another 19 to 25% agree to therapy with the intake clinician but subsequently withdraw prior to the first therapy session (Phillips, 1985). Bloom (1981) reports that of cases having only one (intake) interview, 70% reported satisfaction to the extent that more sessions were not needed at that time. According to Phillips' telephone survey of 46 people who came to intake and subsequently decided against therapy, many who use the delivery system for intake only seem to be "checking in" about therapy -- most reported that they would return if they felt the need. Some practitioners have changed their methods in response to these data; for instance, Bloom developed what he terms Focused Single-Session Therapy.

Termination

Termination from treatment can be viewed from a number of different vantage points. Commonly researched categorizations are 1) reasons for termination, 2) nature of termination (ie. mutual or unilaterally determined), and 3) appropriateness of termination (most often from the therapist's perspective). It is possible to generate a multitude of hypotheses concerning the relationship between one or more of these three aspects of termination and repeated use of therapy over time. For instance, one might guess that people who repeatedly use psychotherapy terminate for the same reason each time, or terminate due to dissatisfaction at the end of their earlier treatments and appear to find
satisfaction with their final treatment (that being the reason that it is their final treatment), or that people who use therapy frequently over time consistently terminate "prematurely" and/or without the therapist's agreement, etc.

There have been a number of investigations into why early terminators leave treatment (cf. Acosta, 1980; Hynan, 1990; Martin, McNair, & Hight, 1988; Pekarik, 1983; Schwartz, 1991), but surprisingly few concerning those who remain longer in therapy (although there is a fair amount of theoretical and practical literature covering termination as a natural stage in therapy [e.g., Firestein, 1978; Kramer, 1990]). There has understandably been particular interest in the dissatisfaction level of early terminators; however, the highest level of dissatisfaction reported in the above studies is only 50% (Schwartz, 1991). Early terminators cite dissatisfaction more often, and improvement less often, than treatment remainers as reasons for terminating (Cochran & Stamler, 1989; Hynan, 1990).

Stacy (1993) rated client reasons for termination using a system derived from Orlinsky and Howard's (1987) generic model of psychotherapy. She found the most common reasons for termination cited by clients were "contractual" in nature (particularly financial, transportation, or scheduling difficulties). Next in frequency were claims of improvement, followed by dissatisfaction regarding therapeutic bond, intervention style and technique, or simply a global sense of dissatisfaction. Very few clients left treatment with the explanation that external circumstances had improved independent of therapy. Stacy's three major categories (environmental constraints, client improvement, and dissatisfaction with services) are echoed by other researchers as the most basic breakdown of termination reasons (cf. Acosta, 1980; Pekarik, 1983).
The question of how people terminate therapy has been addressed primarily through the examination of whether the decision to terminate was mutual between the client and therapist. Deane, Kendall, and Todd (1993, June), using therapist ratings of nature of termination in the psychology training clinic in which the present study was conducted, found that among their sample, one-third of the cases were terminated mutually, one-third were client-determined, and one-third were therapist-determined.

The appropriateness of a termination is a difficult concept principally because the inevitable question is, appropriate according to whom? There has been a tendency in the dropout literature to label any termination which occurs before a certain number of therapy sessions have taken place as premature (thus inappropriate). While this practice has been exposed as illogical (Pekarik, 1985), it is still frequent. In some respects this tendency is part of a more general assumption that appropriateness is to be determined by the therapist -- if therapists assume that a certain number of sessions are requisite to the delivery of a "dose" of psychotherapy (Howard, Kopta, Krause, & Orlinsky, 1986), then it is easy to take the next step of labeling those who do not receive this dose as premature terminators without examining the case further.

**Longitudinal Psychotherapy Utilization**

The modal number of sessions per treatment episode in most mental health systems is one. National norms show a mean treatment duration of five sessions for clients in psychotherapy (Phillips, 1985). These are important descriptors of treatment duration for isolated episodes of therapy, but what do we know about patterns of therapy use over multiple episodes of treatment?
Phillips (1985) reviewed data suggesting that help-seeking behavior generally exhibits a negatively accelerating decay curve. For instance, if a group of individuals is observed in treatment over time, almost 100% of them will be in treatment during sessions one and two, but as time goes on, fewer and fewer will remain in therapy. A similar trend describes other aspects of health service utilization. For instance, the number of previous referrals for a group of alcoholics seeking treatment displays the same declining curve: most have had only one previous referral, fewer have had five, even fewer have had 10 or more. Phillips hypothesized that use of the mental health service delivery system over time generally exhibits this decay pattern.

First, there is some evidence that help-seeking behavior is dependent to some extent on whether an individual has had previous psychotherapy. Of individuals who have recognized a personal problem, those who have had prior mental health services are more likely to seek treatment (Yokopenic, et al., 1983). Both Braaten et al. (1993) and Kadushin (1969) found that help-seeking individuals who have had previous psychotherapy ask for more information about prospective therapists and have a clearer idea of what they would like from the therapist. Although one might expect that the time needed to pass through Saunder's (1993) four help-seeking stages would decrease with previous therapeutic experience, he did not find evidence for this assertion.

The nature of the relationship between length of therapy and previous psychiatric contact is controversial. Fiester, Mahrer, Giambra and Ormiston (1974) and Hoffman (1985) found that clients who terminate early have had less previous therapy than those who remain in treatment. However, Brandt (1965) reviewed several studies which were fairly evenly divided on the existence of such a relationship.
A number of researchers have indicated that typically 60% of patients applying for therapy have had previous therapy (Bennett & Feldstein, 1986; Howard, Orlinsky, & Trattner, 1970; Kadushin, 1969; Siddall, et al., 1988). Siddal and his colleagues found that those with previous therapy and those without were equally likely to seek additional therapy within one year of terminating brief therapy at their clinic. If this is true, then Phillips may be right in hypothesizing a decay curve for the frequency with which people seek out services (i.e., 100% have one treatment episode, 60% seek out therapy a second time, 60% of those clients seek out a third treatment episode, etc.).

Some researchers have attempted a follow-up of cases after psychotherapy to look at possible reentry into the service delivery system. One such study was conducted by Patterson, Leven, and Breger (1977) in a one-year follow-up of two types of brief psychotherapy. Sixty percent of their sample of 20 sought additional therapy within one year of termination from brief psychotherapy.

As noted above, a similar one-year return-to-therapy figure of 61% was reported by Siddall, Haffey, and Feinman (1988) for a sample of 70 patients who had received prior treatment at an HMO setting and were returning to the same HMO for further psychotherapy. In both the Siddall et al. and Patterson et al. investigations, a possible explanation for the high return rate is the brevity of the treatment that was recently terminated. Patterson et al. set out to follow up brief therapy, and Siddall et al. observed that the length of the most recent prior treatment episode was 10 sessions or fewer for 82% of their sample. Furthermore, Patterson et al. noted that half of their sample believed their therapy had been too brief. A slightly longer treatment of 16 weeks of cognitive-behavioral or interpersonal therapy for depression yielded a return-to-therapy rate of 42%

Bennett and Feldstein (1986) studied a sample of 124 HMO members who had had at least one contact with a mental health professional within the organization between January and early spring of 1977 (five years before the study). Fifty-eight percent had received therapeutic services in the five years following the 1977 treatment episode. Only 16% of the group indicated that the 1977 contact had been their sole use of professional mental health care (i.e., they had had treatment neither prior nor subsequent to the 1977 episode). Those who had had prior contact were more likely to have also had subsequent contact.

It is possible to go beyond simple return rates to investigate the relationship between multiple treatment episodes and variables such as reported satisfaction with services received. Bennett and Feldstein divided their sample into three categories: clients reporting satisfaction with services received in 1977, those reporting dissatisfaction with those services, and those who were unsure about their level of satisfaction. Satisfied and unsure patients were more likely to have had treatment prior to 1977, whereas all three groups were equally likely to have sought additional treatment since 1977 (although where they sought treatment varied predictably with their level of satisfaction). One interpretation of these data is that a client's first therapy is more likely to be dissatisfying than subsequent therapies, perhaps due to his or her relative inexperience in help-seeking (particularly in knowing what he or she desires from therapy and how to find a setting which can meet those needs). This dissatisfying experience, however, does not appear to deter clients from seeking further treatment.
To gain a sense of the scope of this understudied phenomenon, we might consider that while Siddall et al. were interested only in clients' most recently terminated treatment at their HMO, they noted that 39% of their sample had had more than one previous course of treatment at their clinic. If one were to add the unknown number of cases who also had had previous courses of treatment at other clinics, it becomes clear that the repeated use of psychotherapy services over time is substantial. Indeed, while Lambert and Bergin (1994) noted that "... there is clear evidence that a portion of patients who are improved at termination do relapse and continue to seek help from a variety of mental health providers ..." (p.152), there is no evidence cited in their chapter or in the remainder of the Handbook of Psychotherapy and Behavior Change (Bergin & Garfield, 1994) addressing the multiple-therapy-episodes phenomenon. With the exception of Phillips (1985), all of the articles cited in this section are limited in that they either measure the simple presence or absence of multiple treatment episodes, or investigate with some detail only two adjacent therapy episodes. We appear to be in need of a holistic view of the cycle individuals go through when they seek out and terminate therapy multiple times.

Perhaps the ideal method of investigation into this area would be a prospective study which would follow a large number of individuals over time as they receive services from a variety of providers. However, before we invest the time and resources to design and execute a study of that sort, there is a great deal of groundwork that needs to be completed in order to make the best use of such an extensive endeavor. The present research was designed as one way to lay some of that groundwork. It was hoped that the intensive qualitative method used would suggest preliminary longitudinal utilization
patterns as well as identify important factors which should not be overlooked in more extensive future studies of the multiple-therapy-episodes phenomenon.

Some of my original research questions were as follows: How do previous therapy experiences influence subsequent therapy, particularly with regard to methods of help-seeking and termination? What are the clients' views of their lifetime experience of therapy and how does this relate to their plans for further therapy? Do some clients who terminate after very few sessions eventually receive a "complete" course of therapy, and if so, how do they view this treatment history? Do some people find the "right" therapist early on and return to that therapist in later times of crisis?
CHAPTER 2

METHOD

This project takes a discovery-oriented research approach. By intensively analyzing a small number of individuals' retrospective self-reports concerning therapy use, it was hoped that patterns would emerge which could serve as a basis for further study. The major advantage of this design is the ability to examine in detail how individuals think about their therapeutic histories. This advantage comes at a price, however, in that only one of many possible sources of data is being used. Not represented here are the perspectives of others who might be involved in any given mental health service (i.e., service providers, health insurers, and family members). It is crucial that findings be interpreted accordingly.

Sample

The sample consisted of nine Caucasian adults (two men and seven women) who had previously applied for adult individual psychotherapy at the Psychological Services Center (PSC), the training clinic for the clinical psychology program at a large northeastern university. The pool of possible participants included only those for whom the PSC database indicated that they had received psychotherapy elsewhere prior to their contact at the PSC. Participants ranged in age from 20 to 38; five participants were enrolled as students at the university at the time of their PSC therapy.

Individuals were recruited in two ways. One participant agreed to participate at the time of her termination from therapy at the PSC; she was contacted for the interview one month after the date of her termination. The other participants had terminated their PSC treatment in the past and were contacted by telephone. It is unlikely that these nine
participants were a selective sample of the population of PSC clients who have had multiple therapies, since only one individual contacted by telephone declined participation. However, it is unknown how many individuals may have declined to participate at the time of their PSC termination; letters requesting that terminating clients participate were not distributed consistently to all therapy terminators, nor were all of these letters followed up on after distribution. Due to the nature of the study, it was not considered a problem that these recruitment methods would result in a sample of individuals who varied with respect to length of time between their termination at the PSC and the research interview. This variable, along with participants' current psychotherapy status, was examined alongside the rest of the data.

Sampling was nonrandom. The qualitative analysis method which served as a basis for this study advocates the use of theoretical sampling in order to capture all the major variations of the phenomenon to be found in a given population (Glaser & Strauss, 1967). However, theoretical saturation and the exhausting of groups to fill out the theoretical sample were beyond the scope of this project and will be left for future research. The practical result of this limitation is that only some of the possible variations of the phenomenon are represented in this sample -- more extensive and rigid sampling methods will be needed in the future to achieve a comprehensive mapping of the phenomenon. Ideally, the present project can be used to inform such subsequent research.

**Procedure**

All interviews were conducted by the investigator. Participants were fully informed of the purpose of the research and encouraged to be as accurate and thorough as possible in recounting all previous contacts with mental health professionals; they were
also asked to indicate when they were unsure about their memories. There were three stages to the procedure. First, the interviewer talked with the participant to gain a sense of his or her overall therapeutic history. This information was used as a starting point for the second step: the creation of a pencil-and-paper personalized time line for the relevant period of the participant's life (these time lines are presented in Chapter 3). During this second step, the interviewer probed as necessary for therapy episodes not previously mentioned. Once the time line appeared to be as accurate as possible, the interview proper began in which each therapy episode was discussed in detail, beginning with the earliest remembered therapy and ending with the most recent (or current) therapy. Occasionally participants were able to identify forgotten therapy episodes during the course of the interview; these episodes were also explored. All interviews were audiotaped and transcribed in full; interview duration varied from approximately 90 to 120 minutes.

One week after the initial interview, participants were telephoned at a prearranged time for a brief (5-10 minute) follow-up interview. The purpose of this contact was to capture new or revised memories of therapy episodes reported in the first interview, in addition to exploring any thoughts participants had had about the topic in the intervening week. The rationale for this second contact was openly discussed, and participants were assured that new or changed memories from what had been previously reported were acceptable and not unusual. Follow-up interview responses were recorded by hand.

Measures

The materials used were a blank time line on which participants mapped out their mental health service histories, and semi-structured initial and follow-up interviews created
by the investigator for use in this project (see Appendices A and B). The time line not only facilitated the interview process, in that it served as a common reference for participant and interviewer, but also was included in the design because of literature indicating that such an aid can reduce memory errors (Kessler & Wethington, 1991; Sudman & Bradburn, 1974).

Interview questions were intended to elicit information for each treatment episode regarding help-seeking behavior (i.e., duration of problem, how the therapist or clinic was chosen), the therapy itself (including presenting problem, particular session memories, and impressions of the clinician), how and why the therapy ended, and plans regarding further treatment at the time of termination. The end of the interview gave participants a chance to reflect on their individual time line by describing any sequence or pattern they might see in it, rating the therapies from most to least important, and discussing psychotherapy more globally in terms of its place in their past, present, and future.

While caution must be used in judging the validity of people's memory for time and past events, there is reason to believe that their recall can be fairly accurate. For instance, Bennett and Feldstein (1986) assessed the possibility that former clients might have poor recall for their reason for seeking treatment five years earlier. In fact, their recall matched the 1977 therapists' assessment of presenting problem from patient records very closely. Furthermore, Burt (1992) found a correlation of .76 between college students' estimation of dates for events occurring three to eight years in the past and the true dates of those events recorded in the students' diaries.
CHAPTER 3
RESULTS

In the interviews, participants told their stories of therapy use. Each presented with a unique perspective, and often a distinguishing theme ran through their therapy histories. In this section I present the data for each participant in story format in order to preserve the cohesiveness of their individual histories. It is important that readers continuously keep in mind that these narratives are the participants' retrospective views of their histories and no attempts have been made to bring in other perspectives from different sources such as therapists or family members.

Each individual's episodes are presented in rough chronological order. Episodes are not only psychotherapies but also include services such as one-visit referrals, medication-only visits, assessment-only visits, and hospitalizations. One methodological difficulty was determining how to define a single episode. There were a number of instances where a contact could have been construed as either one or multiple episodes. The two factors I considered in deciding how to assign episodes in these cases were 1) how the participant discussed the contact(s) in the interview, and 2) how the contact(s) could be represented most clearly on the time line. I have noted in the text the episodes which required such a decision. Because there are other plausible ways of defining episodes, another researcher might have arrived at a different number of total episodes for a given individual.

Following an individual's history of episodes is a treatment of the participant's more global views of therapy, my impressions of recurring themes, and the individual's plans for future and/or current therapy. To illustrate each story, the time lines developed
during the interviews are provided. The next chapter will address themes as they appear across individuals; therefore, the full development of some themes is left until later.

Sarah

Sarah was a 33 year old woman whose therapy history at the time of the interview consisted of six episodes over a period of seven years (see Figure 1). Her first contact with a mental health professional occurred when she was 25 years old; her most recent was one year before the interview. One episode was a couples therapy, one was for medication only, and the other four were individual psychotherapies.

Sarah's first therapy experience (Episode #1) was a short one (either two or three sessions) with a counselor at her company's Employee Assistance Program (EAP). She had been dissatisfied with her job for a few months and recalled friends and family thinking her crazy to consider quitting the job because of her feelings. In seeking a therapist, she explained, she was looking for someone outside of her friends and family with whom to discuss this decision. One day she was particularly upset and called the EAP; they offered her an appointment that day and she "just took whoever they had." Seeking therapy this time was moderately difficult; she recounted "grilling" the personnel there in order to

---

1 Names and identifying information have been changed in order to preserve confidentiality.

2 I have assumed that all participants were born on January 1st of their year of birth. Participants reported their therapies in terms of the year in which they occurred and/or their age at the time of the therapy. The above assumption seemed the most accurate way to integrate these different reporting styles to produce one picture of their therapy histories. The drawback of this method is that some participants may be up to twelve months older than their ages reported here.

3 For easy reference, I will identify each mental health service episode in bold lettering as it is introduced into the history. Episode numbers correspond to the circled numbers on the individual's time line.
Figure 1. Sarah's Time Line. These are best estimates of the number and duration of mental health services reported by Sarah during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
determine whether her visits would be reported to her employer. Confidentiality concerns were a significant theme through much of Sarah's therapy history.

Sarah recalled not knowing what to expect when going to this first therapy, and said she thought it was "bizarre" that there was a couch in the therapy room; it made her think, "Oh my God, is this really what it's like?" She went on to say, "But he was a very nice man and he could see I was very upset and he was very comforting." She described his style in words that make him sound reassuring and paternal:

He said, "You aren't this wacked out person, and you have some valid issues here, and maybe we can't work it out today, and this isn't gonna be something long-term, but maybe we could help work it out. And if we feel you need to go any further, then we'll deal with it maybe next time or the time after that."

Sarah acknowledged that she is not very good at decision-making in general; she reported that the therapist helped her to feel that a decision to quit the job would not be "ridiculous," but he also made it clear that the decision was hers to make and live with in the end. Sarah was unsure just when she made the decision to quit her job, whether it was during the course of this therapy episode or at some point soon afterward. She was also unsure how it is that they decided to end the therapy there, but assumed it was because she had made up her mind or was close to it.

In Sarah's eyes, this therapist provided her with a feeling of "validity" that she was not getting from friends or family. In addition, it sounded as though he provided a stable presence for her during their "emotional and intense" sessions. Sarah described the therapy as "moderately helpful," though she preferred to look at it as "assistance" rather than therapy because she defined therapy as something longer ("coming to someone once a week for a year or whatever"). Related to this idea of a differentiation between
assistance and therapy was her description of the ending of this episode: "It was there, it did its job, I got a lot of things out, let's move on." This leads me to wonder if there is some kind of dependence which she associates with therapy which was not present in this assistance. Another possibility is that therapy in her mind cannot be something so brief (there is some evidence for this in her dissatisfaction with later time-limited therapies).

According to Sarah, the therapist had stated that it would be a brief therapy from the outset; while such a limitation was upsetting to her in later therapies when her presenting problem was fairly vague, it seems that for this first therapy she presented with a circumscribed issue and was accepting of a time-limited model.

The next time she thought about seeking therapy, Sarah decided to try the EAP at her new job. This decision seems to have been partially based on her past positive experience at her former employer's EAP. However, upon calling the EAP she learned that services would be provided by the same HMO that she was working for, although there was the possibility of going to another of the HMO's multiple sites. This arrangement was surprising to Sarah, as she had expected something similar to her first EAP experience; referring to that first therapy she said:

That's what made me think of it having to be an outside organization because this [former EAP] stressed the fact that they were a separate organization, that it was confidential . . . . So I thought that [the HMO] would probably do the same thing for their employees.

Upon learning of the in-house setup, she decided therapy there would not work for her due to confidentiality concerns.

Unable to afford the rates of outside clinicians and still wanting therapy after six months during which she "sat on it," Sarah decided to "bite the bullet" and use the HMO's
services (Episode #2). Again, she took "whoever was first available," which happened to be a man whom she disliked from the very first session. What prompted her to seek therapy was that she "felt inadequate within [her]self" and "knew that something was wrong" but didn't know what. She contrasted this presentation to that of her first therapy: "I had an agenda when I went in [to the first therapy]. With [the second therapist] I had no clue and I really kind of was looking for some guidance from him to maybe pull some stuff from me." She described his general attitude as disinterested and disrespectful. She felt that he "made [her] feel inadequate to be there and that [she] was wasting his time," and recalled leaving the second-to-last or last of the six sessions in tears.

Shortly after this therapy ended, Sarah decided to try therapy again, and because her employment and financial circumstances had not changed, this led her back to the same HMO clinic (Episode #3). She requested a female therapist and was placed on a waiting list for a couple of months. Sarah considered the third therapy a continuation, to some extent, of what she had been trying to do with the prior therapist. However, there were some differences; she recalled in particular that money was an issue they discussed a great deal. Sarah explained to me that one of her "prime issues" at the time was money. Nevertheless, Sarah was troubled by the way in which the therapist made this a focal point of the therapy:

I was having a hard time keeping up with the copayment. And she basically told me that if I didn't pay it, she wouldn't see me. And she thought that was part of my problem . . . . I said, "OK, I find this kind of odd, but I will do this." But she was just very rigid and she kept going back to the money thing . . . and again [I felt like], "Guide me a little bit here. Help me out." And it kind of felt like when she laid that ultimatum on me, that she was kind of labeling me like a deadbeat.
Due to the conflict over money, as well as continuing discomfort concerning confidentiality, Sarah ended the therapy.

Sarah did not "click" with this therapist either, although her attitude toward her was slightly more positive than toward the male therapist before this one. She also noted that this therapist suggested Prozac early on in the therapy, which seemed premature and inadequately discussed or justified to her as a client. Nevertheless, she tried the drug briefly (for which she saw a psychiatrist two or three times [Episode #4]) and was displeased with the effects. Sarah was unclear as to the details of how the psychotherapy and the drug treatment ended, but guessed that the two endings coincided.

This third therapy lasted approximately ten sessions. Sarah recalled that she had been very aware of the time pressure on the therapy with both psychotherapists at this HMO. It sounded to me as though she was hoping for a long-term therapy despite the policy limits. Also related to both of these therapies was Sarah's feeling of disappointment and let-down. She felt they were both very difficult to seek out because of the risk she perceived herself taking with confidentiality. She also suggested that these therapists did not hold up their end of the bargain; she felt she had made great efforts to be there ("biting the bullet" and "going that extra mile"), but they were not responding in kind. She stated that both of these experiences left a "sour note" and that they "haunt" her, making her "delay" when thinking about seeking help again (although at the time of the research interview, she was not only thinking about seeking help again, but also was thinking of returning to this very HMO).

In general, Sarah did not feel cared for in these HMO psychotherapies as she did in her first therapy; she felt both the male and female clinicians at the HMO were not
"interested" or did not find her "interesting." Sarah particularly questioned the judgment of the HMO with relation to the brevity of therapy and their early suggestion of anti-depressant medication. She felt that they did not know her well enough to have a basis for prescribing drugs nor for determining that short-term therapy was appropriate (Sarah considered their maximum of twenty sessions to be short-term). The HMO did not appear open to long-term therapy even if it were deemed necessary. It is interesting that Sarah did not express dissatisfaction with the time limit placed on her very first therapy, at which she presented with a very circumscribed problem. Perhaps it was because of the vagueness of her presenting problems at the HMO that she found the time limit distressing.

It was several months, possibly a year, before Sarah was in therapy again (Episode #5). She had sought help once soon after ending Episodes #3 and #4, however she found she could not afford what was available and delayed for about a year. At the end of that year she experienced another "down" period, decided to seek help, and found the Psychological Services Center (PSC). It seems that the PSC fit a number of criteria for her: it had a sliding fee scale, it was separate from her employer, and it offered open-ended therapy. The fact that the clinic was separate from her employer seemed to make the help-seeking experience much easier for her (she rated it between "a little easy" to "neither easy nor difficult").

Sarah requested and was assigned a female therapist. While she believed that she presented her goals more clearly in this therapy, she also acknowledged that they were still

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4 This is the only clinic which I will identify in these histories; as noted in Chapter 2, all participants were selected as a result of their prior contact with the PSC.
vague. The issues she mentioned were financial problems, vague memories of child abuse, and difficulty managing her weight. Her hopes for therapy were as follows:

Again, I was looking for some guidance to draw something out. And I think at that point, I was more specific on: "Hey, I don't really know where I'm coming from but can you ask me some questions to get the answers out of me or can you give me things to think about that maybe I can work on."

A number of times during the interview, Sarah wanted my input on whether such expectations for therapy were appropriate, and whether I could help her both seek and use therapy more effectively.

Compared to the two HMO therapists, Sarah believed that the PSC therapist "really tried" and that she did "click" with her. Sarah was frustrated that they did not seem able to "get any deeper"; she said they "hit a wall" and could not seem to go further.

There was one session in which Sarah got so frustrated with "going over the same questions over and over" that she got up and wanted to walk out. The therapist requested that she wait and talk about it, which they did; this incident seemed to leave Sarah feeling hopeful that "from there on in it would get a little better." She stayed another six months in the therapy, but was dissatisfied that they did not, in fact, get any further (this persistence is reminiscent of her staying in the Episode #2 even though she disliked the therapist from the beginning; she seems to have also exhibited some persistence in Episode #3).

The therapy ended when Sarah's mother, who had been helping her pay for the sessions, said that she could no longer do so; this external reason was possibly a relief to Sarah in that it served as an external reason for ending a therapy which she thought was unproductive. Despite Sarah's frustration with the therapy, she recalled that the therapist
did convey to her that she believed Sarah had legitimate issues; she commented on the absence of feeling "unvalidated" by this therapist (though noted that there were certain issues around which she did not feel "validated" because she felt the therapist was steering her away from them). To me it sounds as if her disappointment with this therapist was greater than with the two HMO therapists because she had held out more hope (and held out longer) for this one. She said, "Out of all three, I really had thought something was going to come of this. I thought I was more specific this time."

Her mix of conflicting feelings surrounding this therapy provides a good example of why rating a therapy as globally "helpful" or "unhelpful" is a difficult task of questionable utility. Sarah's rating for this therapy as a whole was "a little helpful."

Sarah's most recent therapy contact (Episode #6) occurred roughly a year after the prior one ended. She recounted that she sought out couples therapy with the EAP at her boyfriend's employer because of his drinking problem. They were initially assigned a woman, however they canceled the appointment and set up one with a man instead at the request of her boyfriend. Before their initial appointment Sarah was "having a particularly bad day" and called the EAP to see if perhaps she could come in to see the woman with whom they had originally scheduled (Sarah's "bad day" coincided with the day of their original appointment). She explained:

[I had a] really nice session with her . . . and she basically told me that I was doing pretty good and I wasn't the basketcase that I thought I was and that a lot of the issues were his. She suggested that the counselor that we had the appointment [with] on two or three days later was going to be a really good guy.

She left feeling "really psyched" about their coming appointment.
So far, this therapy contact reminds me of her first one, in which she was looking for a little reassurance, got it, expected no more, and was pleased. However, the story becomes more complicated. The woman therapist encouraged Sarah to meet the man she and her boyfriend would be seeing in a few days. Even after Sarah had voiced her reservations about meeting him without her boyfriend present, the therapist introduced Sarah to him on her way out of the office. They spoke briefly about the coming appointment and presenting problem.

Sarah did not want to tell her boyfriend that she had met the therapist without him, so she kept it to herself. When they arrived for the appointment, Sarah recalled, the therapist "completely honed in on [her boyfriend] for forty-five minutes and I had the last ten." Both she and her boyfriend were upset with the session and did not return for more therapy.

Episode #6 is one of a few reported by participants which could potentially be coded as either one or two episodes. In the interview, Sarah treated the two visits as one entity (she noted it on the time line as a couples therapy which had lasted for two sessions). On the other hand, this "episode" involved two separate clinicians and two different formats (individual and couples). I have chosen to remain consistent with Sarah's portrayal of the two sessions as one entity, however other investigators might well have come to a different conclusion.

I interpret some of Sarah's therapy history as revolving around a theme of betrayal. This is particularly evident in the last therapy, where it seems that she felt she had developed an implicit agreement with the therapists -- for instance, that she did not want to be introduced to the couples clinician, or that the couples clinician understood the
problem and would deal with it appropriately -- which they later seemingly disregarded. The theme also crops up in the HMO therapies where the therapists, in her eyes, failed to meet her half way (they did not seem to "go that extra mile" as she did).

In fact, there seems to be a third "betrayal" which Sarah reported in the follow-up interview, concerning a group therapy she was in the process of seeking at the time of both the initial and follow-up interviews. Sarah recounted that when she had inquired about the group she had described her confidentiality concerns to the prospective therapist in detail, and believed that they reached an understanding that there would not be any HMO staff, nor patients from her site, in the group. However, she learned between interviews that the group had been delayed because there were not enough members; in addition, one prospective member was an HMO patient from her site. She described her first reaction as "disappointment," and at the time of the follow-up was debating whether to do the group despite these complications.

Two other themes which I see in Sarah's history are her persistence and vagueness. Not only did she exhibit a persistence with regard to particular therapies (as noted above), but also she appears to have a persistence that spans the entire time line, in that she continued to hope that future therapy would be more beneficial to her than her past experiences. With respect to her "vagueness," not only were her presenting problems often vague, but also this characteristic was evident in the interview itself. She said a number of times that she wished she could be more specific, that she wished she could remember the specific questions that she and the PSC therapist "went over and over," and that she wished she could remember specific therapy sessions better.
What about Sarah's view of her therapy history as a whole? Although Sarah seems to have learned something from her experiences in therapy (at the time of the interview, she was able to judge that the male HMO therapist could have been better, whereas at the time of that therapy, she didn't know whether to think it was him or therapy in general), she also asked me questions that a frequent user of therapy might already know (or that a novice might ask). For instance, she wondered if her expectations were unrealistic, if she was presenting herself correctly, how to interview a therapist (i.e., can you do so on the telephone or is that not proper). She wondered if she was "giving the right perceptions or asking the right questions," as if there might be some code that she needed to unravel so that therapists would be forthcoming with what they have been keeping from her.

Looking back on her therapies, she described herself as "maybe two or three steps closer" and she seemed to base this on what she described as "initial feelings cropping up; I think one of the issues that I am finally just realizing is that I may have been abused as a kid." This and other statements lead me to believe that she may be searching for a source for her problems; she herself questioned whether she was "trying too hard." However, she reported that she was still holding out hope that she would find the right person to work with on these vague uncovering issues.

Sarah's statement that "maybe I'm just not going to be happy with it, whoever I go to," sounds like she had forgotten how happy she had been with her very first therapist. During the interview, there were times when she sounded as if she had forgotten the existence of the first therapy altogether. This seems peculiar in that the first therapy was her most positive so far, however there are many possible explanations for such an oversight. For instance, it could be because she thought of it as "assistance" rather than
therapy, or because she felt that the issue addressed there was over and done with. Other possible reasons could be that the therapy was very brief and occurred a long time ago, and/or that most of the research interview concentrated on her negative experiences with therapy and this first therapy did not fit well into that set.

When explaining her ratings of importance (most important to least: Episode #5, #6, #1, #2, and #3)^5, Sarah said that the reason for the PSC being first was that she "went the furthest" at the PSC. She explained the third place ranking for the relatively positive first contact at the EAP as follows: "[T]hat's so far back, that it's not that important anymore." Although at one point she stated that she did not consider the most recent therapy (#6) to be "really there" because of its brevity, she rated it as second in importance. I think her ratings indicate that there may be a number of elements besides the success of the therapy which factor into a therapy's retrospective importance or memorability; relevant factors may include the relative salience of the past presenting problem in one's current life, the recency of the therapy, and also the duration of the therapy.

With regard to current and future plans for therapy, Sarah said she would like to try individual therapy again. At the time of the interview she was looking for an individual therapist, though noted that she was (tentatively) planning to start group therapy and thought she might wait on the individual until after the group was over. She was considering looking for a specialist of some kind to explore her feeling that she was abused as a child, however she also seemed to be asking me for advice with regard to what she should seek out:

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^5 Sarah left Episode #4, her medication-only visits, out of her ratings.
I think I need somebody with some experience, maybe in some specific areas to maybe draw that out of me . . . maybe if you can just briefly let me know if I am being unrealistic in that area, or is there any area I should look for?

Emily

Emily was a 37 year old woman whose therapy history at the time of the interview spanned 19 years (see Figure 2). She had just terminated a therapy two months prior to the interview. Two of her contacts were for medication, one was a couples therapy, one was for testing, and the other four episodes were for individual psychotherapy.

At age 18, Emily had her first experience with the psychotherapy profession (Episode #1) when she underwent psychological testing at the request of her parents who were concerned that Emily had been asked to leave college and wanted to know "what [she] is supposed to be doing" and "where is she supposed to be?" The testing was conducted by a couple, both psychologists, who saw Emily at their house for "a number of weekends in a row." This therapy episode consisted of "taking reams of tests," but "there was not real counseling to it." The last session occurred at the end of the testing, and Emily attended with her parents. She explained, "... again it wasn't really counseling, it was more a stating of fact; it was their interpretation of the results of the tests." Emily reported that there was no follow-up to that session, only "disbelief that they could come up with such absurd theories, like 'You're dependent on your parents.' So that was the end of that."

Her next contact (Episode #2) with any form of psychotherapy was at age 22 or 23 when she sought therapy at her university's Student Mental Health Center. She stated, "I just thought about getting some help and probably found that the clinic was there, but it never occurred to me to go elsewhere, somewhere private or anything else like that."
Figure 2. Emily’s Time Line. These are best estimates of the number and duration of mental health services reported by Emily during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only. In Emily’s case I have added (T) = testing.
Emily described her help-seeking this time as "extremely difficult." She was assigned a person who she remembered as a "very large, African American male," as well as "serious and quiet." She recalled her goal was "to stop feeling so upset and hurting," however she could not recall how she presented herself to this therapist: "I'm almost assuming that I stated that I was very unhappy that I had broken off in my relationship, but I can't even swear to you that is what I said." In retrospect she believed she had been feeling depressed for three years, "but not really ever recognizing it." She saw the depression as having possibly started when she was asked to leave college at age 18.

Emily suggested that she did not return for more therapy with this man or at the clinic because of fear:

I tried it that one time and I think it was very scary for me and I think that I wasn't mature enough again to say to someone, to go back and say, "For whatever reason, I wasn't comfortable talking to a man, or an African American man, can I try someone else?" . . . I was too scared to pursue it again, and figured, "Oh, just buck up, just do it." So that was the end of that.

Emily felt that for her to remember going that one time meant it "must have made an impression" and "must have been real emotional." The emotion she remembered was the fear. When asked how helpful or unhelpful the therapy was for her, she replied:

[My] immediate reaction was going to be "extremely unhelpful," and then I'm thinking, "I don't think it did anything unhelpful for me." I think maybe a "3" [a little unhelpful]. I mean, somewhere in my head it maybe broke ice or something later on.

At age 30 or 31, Emily sought therapy again (Episode #3) after what she described as a "massive panic attack." In the time between this therapy and the last, she had thought and talked with others about possibly getting therapy. Despite feeling that she "was a candidate to get help" during this time, she "just couldn't do it" due to her fear.
For a few months after the attack Emily coped with the problem by adjusting her life around it; she continued to have panic attacks. Within a few months of the "massive" panic attack, she contacted a behavioral therapist who was one of a few clinicians recommended to her by a doctor with whom Emily worked. Describing her decision to seek therapy with this man, she said, "I said OK [to the referral]; there was not even a question in my head."

Emily stated that her goal for this therapy was to stop the panic attacks, which for her included determining why she had "gotten to the point where [she] was now having panic attacks." She viewed them as the "culmination" and "physical manifestation of something." In fact, she reported feeling "reassured" and "safer" in seeking therapy when her problem was of a concrete nature: "I really felt like I was going because there was a problem and I really needed to get it fixed, and it was tangible, I could put my finger on it." The therapy consisted of four sessions of learning ways to cope with the panic attacks. She also noted the absence of talking "personally" with this therapist. Although the skills she learned did reduce the problem and give her some "functionability" back, they did not eliminate the panic attacks, and Emily was partially dissatisfied with the therapy because she thought the therapist "steered [her] away" from exploring why she was having the panic attacks. However, Emily also wondered aloud whether at the time of this therapy she was still "scared of going deeper" herself.

Emily ended the therapy after the fourth session, when the therapist apparently referred to a brother whom she did not have. She reported that he had made similar mistakes in earlier sessions, and felt this showed a "lack of common courtesy to review [her] chart before the session." She described him as generally "disinterested."
Emily left this therapy with the thought, "OK, I've done it." In addition, she told me that she would never go to a behaviorist again. Noting the helpfulness of the skills she learned, she rated the therapy as a 5 (a little helpful). In her ranking of therapies, she vacillated between making this one second or third in importance, finally settling on a rank of third.

Her next therapy contact (Episode #4) occurred approximately one year after the behavioral therapy. This turned out to be the longest contact of her therapeutic history. Emily had been given the business cards of two therapists by her homeopath and had carried them around for well over a year. When she finally used one of the referrals, she described herself as physically ill, "at home, out of work, with nothing to do"; she added, "I can't tell you why, [but] I started seeing [this therapist]." It was a weekly therapy which began by focusing on her panic attacks, however it broadened into a weekly discussion of current life events. Emily explained that there was nothing "horrific" going on in her life at this point, and that she and the therapist had "a nice relationship."

In the last year of therapy, there was a change: "I really was having a lot of problems emotionally and I was probably for the second time in my life really started becoming depressed again." Her increasing feelings of depression, as well as escalating difficulties in her marriage, were not being dealt with in the therapy. She reported:

I was not dealing with those problems with her. She was not seeing it, she was not dealing with it with me, and I wasn't letting her see it -- I'm sure it was a combination of the two. But, even when I did open up and talk about things . . . she didn't press me, she didn't push me. . . .

Emily was able to be fairly clear about what she saw as wrong with the latter part of the therapy:
By the time I stopped seeing her, I realized that I was no longer really seeing her as a therapist, and it wasn't good. I felt that there were things that I did or didn't want to say to her because she would be disappointed in me, I felt like -- I mean, there was never any contact outside of her office, it was purely professional contact, the relationship that I had with her, that I felt like when I was in her office with her that it was more of a nontherapeutic-let-me-just-sit-down-and-talk-with-you-for-however-long-a-week. And I don't know, if I hadn't made the decision to go off to [school] I don't honestly know how long it would've taken me to get the courage up to say you know, "I'm not getting anything out of this anymore. I mean, I like you very much and all that sort of thing..." So it was kind of a relief to have a reason to leave that.

Emily saw her fear of disappointing the therapist as follows: "I guess it kind of stemmed from the fact that our relationship became kind of too personal." Following this remark, Emily described how her knowledge of the therapist's private life interfered with the therapy:

[It was] kind of intimate, personal stuff that made her more like in the category of someone that I didn't want to disappoint versus kind of a more clinical relationship that it's safe, I can say anything, you're not going to judge me... I felt like I was now talking to someone who had an opinion of me, I mean I knew that she was very fond of me and that I had the potential to disappoint her, I had the power, I guess, to disappoint her.

With feelings of this sort, it is easy to understand the relief she may have felt as a result of having an external reason to stop therapy (attending school would entail moving out of the area). Ending the therapy was made easier not only for this reason, but also because toward the end of the therapy she had begun to see her primary care physician for a prescription of a "dual antidepressant/antianxiety" drug (Episode #5). She noted that she felt some reassurance in knowing she would still be going to her physician for medication monitoring, even though those visits did not entail in-depth discussion of her difficulties.
Perhaps a couple of months after leaving the individual therapy, she and her husband attended couples therapy (Episode #6). They had begun to discuss seeking marital therapy while she was still seeing her individual therapist (#4), however they did not act on the idea for some time. Emily thought the idea of turning to couples therapy was partially a result of the lack of progress in her individual therapy. The couples therapy lasted two sessions. They saw her husband's psychiatrist, who offered to "try it out" for one session to see if she thought that she could be unbiased (Emily was certain that her former individual therapist would be biased, and they were having difficulty finding recommendations for local therapists).

Emily described the couples therapist's approach as "classic psychiatry" in that the therapist "did not say anything." Apparently Emily decided this psychiatrist definitely would not work out when she was in mid-sentence toward the end of the second session and the therapist interrupted to say that time was up. She compared this experience to how different things had been with what might be called her "reference" therapist (at least up to that point) which was the therapist from Episode #4. Emily described the therapy as "weird" and "not my style"; she rated this therapy as "neither helpful nor unhelpful."

Her husband continued to see this psychiatrist individually and they "vaguely" sought out another couples therapist, but "not very vigorously" (they did not find one). Interestingly, Emily viewed the couples therapy as just one possible way to work on their marriage problems; "what happened instead" was that they worked on things separately in their respective individual therapies and then "brought it together." She summarized, "So, it worked out OK."
Within a few months of the couples therapy ending, her primary care physician closed his practice, leaving her with enough medication refills to carry her through to finding another prescribing clinician. Rather than finding a new doctor, however, she decided to stop taking the medication. Emily's final help-seeking experience occurred about one to two months after stopping the medication on her own.

Emily became deeply depressed shortly after discontinuing her medication; she was later told that her abrupt manner of discontinuing the antidepressant may have helped precipitate the depression. At this point, Emily decided that she "really, really wanted good therapy, and [she] really, really wanted to take control of whatever was going on in [her]." She sought services at the university's Student Mental Health Center where she was told that they did not do long-term therapy but could refer her to a clinic that would for an affordable price (the PSC). She took this referral in addition to continuing to see the referring psychiatrist for brief medication consultations (Episode #7).

When asked to describe the psychiatrist, Emily had a hard time:

You know I never tried to describe him before, uh, he was pleasant enough, kind of, I always felt like he didn't quite have anything to say to me. And I never felt like comfortable enough to really start into some, like, issue with him and I don't know if it was because you know he kind of told me right up front, "I don't do long-term therapy and this isn't really going to be my role in your life," and I think I always felt like he felt that he was kind of obligated to talk with me a little bit when I would come in so he could check and see how I was doing with the medication but not that he really was there to do any psychotherapy.

She saw him up to ten times over the course of seven or eight months.

According to Emily, the referral (Episode #8) ended up being the best therapy she had ever experienced; she added that the fact that they were a "good match" was "just luck, that was just pure luck." Emily described the therapist in glowing terms, noting her
ability to not only listen but to hear the unsaid. In particular, she described this therapist's memory for the details of their earlier conversations. Following from this, she said, "[T]here was never a time where I got a feeling that she wasn't interested in me, [like I was] just another patient." She continued that this therapist seemed to consider her words carefully and seemed highly experienced whether from "school or real life or whatever."

In comparison to prior therapists, Emily said that this one "had more of an impact on who I am and how I'm able to deal with and cope with stuff more than all these people [pointing to the timeline] combined." Emily also stated that this therapy (whose recency may have something to do with this statement) was different "from one week to the next"; sometimes the session would "follow right along with the week before and sometimes it would be a whole new sort of issue, but each session was helpful, I mean there was never a session when I walked out of there thinking 'Ah, do I really want to go back?'" In sum, Emily said: "[T]hat was probably one of the most wonderful experiences of my life was meeting [this therapist] and having therapy with her. . . ."

This is the therapy which Emily felt allowed her to accomplish what she needed in terms of her marital difficulties. Also, she said this therapy "made a significant difference in the way that [she] is able to deal with things and look at things." Emily believed this therapy could have gone on "a lot longer" since she "didn't sort everything that there is to sort, or even identify everything that there is to identify. . . ."; however she finished the sentence by saying "but, it was a very nice, unhurried process." This last comment brings up the question of how the therapy might have been different had it been a time-limited therapy from the onset -- could it still have felt unhurried to her? I also wonder how long she would have stayed in the therapy had there not been an external reason for leaving.
The therapy ended because Emily was done with her course work and was essentially moving back to her home. She described the termination as a sad occasion (which she initially tried to resist but the therapist encouraged her to be "realistic") yet also a "very happy" one when she recognized that she "felt well enough that [she] wasn't scared that [she] was leaving [the therapist]." She felt as though she "left with a lot of strength."

This was the most recent therapy that Emily had experienced at the time I interviewed her (the therapy had ended approximately two months before the interview). She reported that there were issues that "never came up" with this therapist that she might someday want to go back to therapy to tackle in the same way, however she had no immediate plans to seek therapy, nor did she have such plans when she left this last therapy. She stated that from this last therapy she had gained a much clearer idea of what to look for in a therapist and felt more capable of "recognizing what I know won't work and why it won't work." Emily's increased ability to discriminate among therapists was for the most part a positive thing for her, however, she did wonder if it was "unfair to measure everyone up to that level." This brings up the possibility that there may be negative consequences of a purely satisfactory experience (or, in the extreme, an idealizing relationship) with a therapist.

Emily found it difficult to imagine what might have happened had she met this particular therapist earlier on in her help-seeking process. She said:

I don't know if I would've appreciated the relationship at that point [at the time of her first or second therapies], and I certainly was a lot younger, so I don't know if I appreciated any relationship as much as I do now, but, I mean I feel like I appreciate the relationship with her a lot in part because of these [pointing to previous therapies on the time line].
She concluded this discussion saying that "she belongs over here" and pointed to the location of this therapist at the end of the time line.

Emily rated the therapies as follows (from most to least important): Episode #8, #4, #3, #2, and #6. She did not rate the medication management she received from her physician nor from the university psychiatrist (#5 and #7), nor the testing (#1).

Emily saw her presenting problems, including the depression, panic attacks and marital difficulties, as emanating from the same "underlying issue" (unnamed). In addition, she viewed the episodes on her time line as building up to the work she did in Episode #8:

I finally was really ready to get it out and deal with it with [the therapist from Episode #8], but I don't know if I would've been able to do that had I not gone through these little stops and starts and stuff. And I think that each time I would stop and then start and realize I wasn't really feeling any better that I knew that next time, I've got to go a little farther next time, I've got to be open just a little bit more next time.

This was one of the clearest statements made by an interviewee regarding the time line as a progression.

Emily also noted that help-seeking and therapy had become less frightening for her over the course of time. She stated that in the future she would only see a female, and noted that this represented a change, that she had been oriented earlier toward males because she thought she would be more relaxed with a male. Finally, in the future she would avoid psychiatrists for psychotherapy; she stated her preference for either a psychologist or social worker because "the atmosphere is more relaxed, there is more give and take." At the time of the interview, Emily had no plans to seek therapy.
Ed was a 22 year old man whose therapy experiences dated back to the age of 14. His mental health service history stands out from those of the other participants as being the most heavily medication-oriented. During the interview, Ed recalled a total of 10 separate mental health service contacts (see Figure 3): six consisted primarily of psychotherapy, three were for medication management, and one was a hospitalization. His most recent therapy contact ended approximately six weeks prior to the research interview.

Ed's introduction to psychology and psychiatry came at the age of about 14, in the form of a three-day inpatient stay (Episode #1). He suffered an anxiety attack that felt different to him than those which he had experienced before, and when he sought help from the school nurse, she called his mother and he was taken to the local hospital. He recalled feeling "embarrassed" about seeking help at school, and "frightened" and "intimidated" by the experience at the hospital where they "experimented" with different medications.

The treatment he received was primarily drug therapy; after an initial period of experimentation, he was sent home with a prescription for Valium. He continued this prescription through his physician (Episode #2) until no later than the Fall of 1991 (we did not concentrate on this episode during the interview). Ed seemed to think that the Valium was both helpful and unhelpful: it apparently lessened the severity of the attacks themselves, but brought on feelings of "depersonalization," depression, and a more generalized anxiety. The hospitalization was the mental health contact ranked lowest by Ed; he felt that it "completely misdirected [his] efforts to try to stop the anxiety..."
Figure 3. Ed's Time Line. These are best estimates of the number and duration of mental health services reported by Ed during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
attacks" by pointing him in the direction of psychology, and "prevented [him] from getting good help sooner." Ed also stated: "Thinking in terms of psychology caused me to think in terms of self, guilt upon myself."

Ed particularly disliked the psychiatrist he saw at the hospital. He recalled being confused by the psychiatrist's "irrelevant questions" and suggested that he had felt "intimidated" by psychiatrists ever since. As an example of a confusing question, Ed said the psychiatrist asked, "Do you feel your mood swings as the weather changes?" Ed "didn't know where [the psychiatrist] was coming from" with such questions. In addition, he felt this psychiatrist was "pompous," as indicated by his dress: "He made no effort to get rid of the mystique of psychiatry in his mannerisms, the way he dressed." Ed made similar comments about the majority of the mental health professionals he had seen: he used descriptors such as "immoral," "manipulative," "sadistic," "reading from a script," and "putting on a show" to describe a number of them.

Shortly after returning home from the hospital, Ed began to read a little about psychology "for the same reasons that people say that they should read about spiders to not become afraid of them." The fact that he remembered this reading as he was telling me about the first time that he sought therapy on his own (Episode #4), leads me to guess that some of his post-hospitalization help-seeking, particularly his first self-sought therapy, has in part been his attempt to overcome his initial negative impressions of psychiatrists and psychologists.

Ed was required to go to a follow-up session (Episode #3) with his parents, at the request of the hospital. He described this as "obligatory." To him it "seemed completely superfluous"; he continued, "I was just hoping they wouldn't think they had found
something so that I'd have to go again." When he left the therapist's office he had no further plans to talk to a therapist (and apparently no one else had plans for him to see a therapist again either).

The first time Ed ever sought out therapy on his own (Episode #4) was in the Fall of 1991, a little more than a year after graduating from high school. Apparently, he had been thinking about seeking a therapist for over a year in order to decrease the anxiety he was continuing to experience. He was looking for a therapist "to try to have one for a period of time," however the therapist he chose saw him only once and referred him elsewhere. Ed recalled choosing the therapist as follows: "I looked in the Yellow Pages and I just picked out the most flashy name which was someone who came from some, ah, institution in Switzerland." Ed believed this clinician did not understand him and misinterpreted his problem, perhaps construing it as a drug abuse problem.

Ed joked that this clinician's decision to refer him out was "the worst thing that could happen." When I asked Ed if he thought he would have stayed with this therapist had the therapist not referred him out, Ed replied, "Yes, because I had no other choice." He clarified that at that point in his life, he was not aware that "it makes a difference" who the particular therapist is: "I can see from the history that it makes a difference, but I didn't know that it would really make a difference."

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6 I was unable to clarify what he meant by this statement -- he insisted it was simply a "play on words." Ed felt misjudged by this psychiatrist and felt the effects of that misperception to be "detrimental," so perhaps he was simply trying to manage his feelings regarding the incident by joking about it.
Ed left this therapist feeling "pretty much set" on using the referral he was given. He did so within a week (Episode #5) and began a weekly therapy which lasted up to six months. At first, the therapy seemed as follows to Ed:

I found that things did seem to be helpful because he seemed like one of those legendary Freudian psychotherapists or psychoanalysts who could read your mind, but eventually he showed himself as just reading from a script like all the rest.

It is tempting to speculate on his observation that at first the man seemed to be reading his mind, and then turned out to be reading a script. There is a certain fit between this statement and his more general complaint that the clinicians he saw "didn't know what was wrong with him" and "didn't get it." I wonder if perhaps Ed was concerned about feelings of being somehow fundamentally different from others; this could explain his desire for a "legendary" analyst who would be able, unlike others, to understand him.

Looking back on the therapy, Ed's impression was that this therapist's psychological approach (and the approach of psychology in general) was not useful for a problem like his: "Through his psychological tackling of my problem [he was] trying to say that with my mind I could make everything in my body just fine, and that wasn't the case at all." Ed frequently used the word "absurd" to describe this and other psychotherapies. Nevertheless, he recalled:

[A]t the beginning, it seemed kind of nice just to have someone to talk to about whatever because I'd never had that before . . . but in the end something had to be done eventually about why I came in the first place, and nothing was happening and other issues were starting to be brought up in lieu of why I came, and things were getting absurd.

Ed rated the beginning of this therapy as high as "a little helpful," but said that at the end it came down to "extremely unhelpful." This was also the therapist whom he described as "manipulative" and "presenting no sign of any morality in the comments he made."
Part of his disappointment with this therapist (#5) was that when "he finally did send me to a person who could possibly give me the chemicals that I needed, he didn’t give me any good ones." The referral to a psychiatrist occurred in the last few weeks of the therapy. To Ed, the psychiatrist (Episode #6) seemed careless and unknowledgeable. He did not like this psychiatrist’s style either: "He put on a show like most of the therapists that I’ve seen, and had this way of talking and being, the bombastics and so forth about him and his room decor." Apparently, Ed saw this psychiatrist two or three times before "storming" to the next psychologist and psychiatrist pair (Ed not only rejected this psychiatrist, but also the therapist from Episode #5 who had given him this referral). As with the hospital, Ed noted that this agency "would not even admit" that they could not help him.

What Ed described as the trauma of his experience at the agency just described became part of the content early on in his next therapy. He planned to seek help immediately upon leaving the above agency, and did so within a week. He selected a clinic in the Yellow Pages and started to see both a psychologist (Episode #7) and psychiatrist (Episode #8) there.7 Perhaps because he had "a lot of hope because they said they specialize in anxiety disorders," Ed felt that seeking help this time was "extremely easy."

The therapy with the psychologist lasted between six and nine months, however he stated that this part of his treatment at the agency "definitely didn't work." Nevertheless,

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7 Although these two "episodes" began at the same time in the same clinic, I have chosen to separate the two in keeping with the way Ed and I discussed them in the interview. Again, this is just one way of viewing them; they could justifiably be viewed as a single episode.
he rated the therapy as "a little" to "moderately" helpful; I think this rating was based not on how helpful the therapy was for his anxiety, but his greater comfort with her "more physical, less psychological" approach and her more active style (as compared to his prior experiences). His most complimentary words for a therapist were used to describe her: "She seemed honest, or at least if any of them were honest." Toward the end of the therapy, Ed and the therapist mutually decided to space the sessions further apart until it ended completely. According to Ed, the psychotherapy ended because the drugs the psychiatrist was prescribing were working well; it seems that this was the most positive conclusion to a therapy in Ed's history.

At about the time that this therapy ended, however, Ed also sought out therapy at his university's Student Mental Health Center (Episode #9). In the interview, Ed did not seem to integrate well what was going on in his life that led him to the Student Mental Health Center and what was happening with his anxiety and his ongoing therapy, therefore it is difficult to surmise what the sequence of events was. Ed gave conflicting stories in the interview: at one point he suggested that the lengthier therapy had actually ended by the time he sought out Student Mental Health Center services, but at another point he said he was "trying to get out of the therapy" he was receiving at the other agency and had been looking for "some sort of new therapy." Apparently, the university clinic told him to "stay with what you have," referring to the therapist from Episode #7. In addition to this Student Mental Health Center contact, Ed referred extremely vaguely to another attempt he had made to get services at the university clinic; he could not place that attempt on the time line.
As for the psychiatrist at the agency specializing in anxiety disorders (Episode #8), Ed was still seeing him for medication at the time of the research interview (over two years since he had begun with this clinician). During his visits to this psychiatrist (which were very infrequent, perhaps between two and six times a year), they discussed only medication. This limited focus pleased Ed:

The atmosphere is much more detached, but that's because there's nothing pretentious about the atmosphere . . . . I feel that at most he understands and at least he's not putting on any pretension to think that he does understand . . . . he's not trying to be anything other than a psychiatrist.

He described this psychiatrist's work as "adjusting dosages, doing very, very fine working on very fine details" in contrast to the psychiatrist just before this one (Episode #6) who "didn't seem to have comprehension of that." He also noted that this most recent psychiatrist has been very responsive when there have been problems with the medication.

Although I had the impression many times in the interview that Ed had sworn off therapy at various points in his life, and certainly at the time of the interview itself, this did not seem to be the case. Six weeks before the research interview, Ed sought therapy at the PSC (he said he did not return to the university Student Mental Health Center because of his prior rejection there). Ed had an intake interview and one therapy session (Episode #10), after which he "immediately stopped going" when the therapist said, "That's a very significant thing for you to have said." This was, to Ed, a clear sign that the therapist was "reading from a script." Looking back on this therapist's "script-reading" style, Ed stated, "So it's just another proof that [therapy] definitely isn't an option."

Unlike the other mental health contacts Ed had had (possibly with the exception of Episode #9), the PSC therapy was initiated primarily due to troubles other than his anxiety
problem. Ed sought the therapy because he was feeling upset about his relationship to a friend who "was using a lot of heroin." Ed reported that he had not thought of seeking help at all until the day that he did so:

It was just that day. It was just shortly after we had our little tumultuous event in our relationship, so I went to the library to get a book, I found one to start reading about it to see what may be going on inside of her mind. And then I thought, "Oh, geez, this is kind of stressing me out," so I wanted to come [to the PSC]. . . . It was spontaneous.

I suspect that his help-seeking at the university's Student Mental Health Center (Episode #9) also involved little or no planning.

Ed's hope was that the PSC therapist "might be able to help [him] sort out some problems that [he] had in [his] relationship at that time." Instead, he "found out that they were really just logistical problems like most problems in life," which meant to him that he was not in need of a psychologist. Looking back on the therapy episode, he called it "silly."

When I told Ed that I had the impression he had decided therapy was "not an option" and then proceeded to seek therapy at the PSC, his reply was, "Yes, but it was for a different reason." Ed did believe that there were certain problems for which a psychologist might be helpful, however he was not clear as to what those might be. It is possible that he was still trying to figure that out himself, and was trying to frame and reframe what troubled him in terms which might be appropriate to bring to a psychologist. Nevertheless, it is difficult to understand how he could think a therapist useful in any way when he characterized them all as dishonest and "reading from a script," and globally attributed this style to their training. Toward the end of the interview, Ed insisted that there was "absolutely no reason" he could think of why he might seek out therapy again.
Ed interpreted my request to rank these therapies in terms of their "importance" as a "how helpful" question. He proceeded to rank them in reverse chronological order (most recent as most important, etc.), with the exception of the Student Mental Health Center contact (#9) which he left out of his ranking initially and then when reminded put it as a tie for sixth place (he also left the PSC [#10] and his physician [#2] out of his rankings). He termed the ones with the lowest rankings as "anti-important" and "detrimental." When I questioned him about the chronological order of his rankings, he replied, "Well obviously I can see that improvement has happened through time." He agreed to an interpretation of his experience as "making [his] way through a system" and added that he saw it as "finding the best that I can." Later he noted that his experience of seeking therapy was "like moving through a tangled forest," and referred to the "rigmarole" of going to all these different clinicians.

Regarding his two longest therapies (#5 and #7), Ed pointed out that "both times I stayed with it at first." This indicates to me that he felt he gave these two a fair try. Perhaps he also felt it was important to tell me that his negative views of therapy and therapists were based on substantial experience. Supporting these hypotheses was his comment that in the week prior to seeking Episode #7 he decided "since I only really tried it once, I'll try it again." Possibly his attempts to stick with therapy for a period of time were part of his effort to move beyond his negative first encounter at the hospital to find something valuable to him in the psychological approach.

One theme that pervaded Ed's view of the talking and medication therapies he has received was that the people trying to help him did not really know what was wrong with him (nor, as he pointed out, did he). To make matters worse, Ed believed they pretended
they did understand what was going on rather than admitting that they were unsure. For instance, this was how Ed interpreted what was going on with the clinicians at the hospital; he expressed anger when remembering how "uncomfortable it was to sit there and listen to this person who thought he actually knew, had some idea of how to help me, when in fact he had no idea." Looking back at the hospital experience in light of his entire time line, Ed suggested that the treatment he received may have "prevented [him] from finding good help sooner." I think that the major obstacle in his eyes has been clinicians "pretending" to know what was wrong when they did not (particularly pretending that they knew it was a psychological problem, such as in Episode #5).

Regarding therapists in general, Ed said:

Logically, they can't be fully honest because they're supposed to be looking around the person's life, not face to face . . . . The whole profession of science of the mind or whatever you want to call it does have that fundamental contradiction, that is of another person being able to almost so to speak walk around another person's psyche while the other person's psyche is working.

Ed's preference was for a more "physical" and scientific therapy approach where "there are not conflicts between the therapist's and patient's philosophies, or if there are they are clearly absurd since there would be no basis for these conflicts." Ed believed that when philosophy is removed from the interaction, there is "more room for thoughts and openness." He saw ideal therapy as "a business transaction but more profound," where there are "no presumptions of false authority." He particularly contrasted this ideal with clinicians of an "analytic bent" who consider themselves "authority figures of the mind" and influence their patients through their "power position, even when they interpret something absurdly." Toward the latter part of the interview Ed alluded to what he termed the "romanticism" of psychotherapy; he believed that this romanticism was
amplified in his mind because of the nature of his first experience. It is possible that some of his later therapies were, among other things, attempts to dispel the myth shrouding psychology in his mind.

Ed felt that his current treatment relationship with his psychiatrist fit his ideal fairly closely. Nevertheless, his plan with respect to continuing on medication was unclear. During the main research interview, Ed said that he "saw [him]self stopping" the medication in the future, though very slowly, and reportedly had already begun to skip some doses (though "without trying"). However, at the time of the follow-up interview, Ed said that while he wondered about stopping his medication, he had no plans to do so, adding that it "wouldn't feel good." This apparent contradiction reminds me of the discrepancy I sensed between his attitude toward therapy (that it has no future in his life) and the fact that six weeks before the interview he sought therapy after only a day's contemplation. What all of this means for his pattern of psychotherapy utilization is probably that it will be quite unpredictable in the future.

Gerry

Gerry was a 33 year old woman whose therapy history at the time of the interview (see Figure 4) was the shortest of all participants in terms of the number of years since her first therapy contact (4 years), as well as her total number of therapy episodes (3 episodes). Two of her therapies were a mixture of individual and couples sessions; the third was purely an individual therapy. Gerry's most recent therapy ended 18 months prior to the research interview.

Gerry's first therapy experience (Episode #1) occurred when she was about 29 years old and going through a great deal of stress in professional school as well as at
Figure 4. Gerry's Time Line. These are best estimates of the number and duration of mental health services reported by Gerry during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only. In Gerry's case I have added (I/C) = mixed individual and couples format.
home. Her presenting problem was her feeling that she lacked support from her then-fiance with respect to managing their household and planning for their upcoming marriage. She decided to go to therapy individually because her fiance was unwilling. Gerry chose a counselor who was covered under her employee benefits (these benefits were limited to between six and ten visits, Gerry could not recall the exact number). After going twice individually, her husband agreed to attend the third session with her; the third session was the last one.

The content of the first two sessions seemed vague to me. She explained that in the last session, "I cried, and [my husband] did a lot of listening; he was very sympathetic and understanding." She reported that they decided to end therapy because her husband did not want to return, and because she had gone in with the idea of "just playing it by ear, and after three visits [the] major stresses were over, I felt better, so I thought that was enough, so I just let it go at that." Gerry said she didn't feel like "sitting there talking was going to do [her] any good." However she later rated the therapy as "a little helpful."

Retrospectively, Gerry believed her expectation for this first therapy was "[j]ust to feel better. Just to, just because I had never had any experience. Just to at least begin to know maybe? Find out, what [I/it/you?] could do."

Gerry described this therapy as "lightweight," explaining that the presenting problem was "nothing major or significant really" and she was only dealing with her "superficial, immediate problems." She continued, "[The therapy was] beneficial, but, I can't really say it was some eye-opening, gut-wrenching thing that really helped me." I think this comment points to her ultimate expectations and/or idealizations of therapy.
She explained that after the first therapy "[t]hings were good for a while and you can, you know, then you just regress back into your old habits a lot of times." This seems to have been true of every therapy she sought out; they were all crisis-oriented, short, and ended because things "seemed better."

Her second therapy experience (Episode #2) occurred when she mentioned thinking about divorce to her husband; she told me that this time it was he who decided they should seek therapy. Although he brought up the idea of seeking therapy, she described him as being "mediocre about the whole damn thing" and presented an account in which she was much more involved in the therapy than he. Gerry chose a "man and woman team" for this therapy, in part because her husband had expressed no opinion about whether he wanted to see a man or a woman. In addition, she attended the first two of the three sessions individually. She was fairly sure that it had been her idea that she go alone to the first two sessions, partially to "scope out the situation," something that her husband didn't like to do. She also mentioned that she did wonder if it was all a personal problem of her own.

Again, after the three sessions (two individual, one couple), "things were better for a while. He was much more understanding and supportive. . . ." This sounds like the same type of temporary relief she felt after the first therapy. She further explained:

So once again it was like it got me through a crisis and my husband was better and we cried after the therapy session and, you know "Oh, I love you so much," and "Oh, I love you, too." And he was very supportive for a while again. . . .

When asked how she felt about leaving therapy, she replied, "Fine. I must've felt good enough so that I didn't need to go back . . . I know money was an issue, but if I felt really
desperate still, I'm sure I would've gone [back]." It sounds as if she was automatically assuming that she would not have left unless she had felt better.

Again, she described this second therapy as similar to the first in that there was "nothing that really was a revelation [sic] or a really, something that really jarred in my memory that I was going to remember." However, this therapy differed from the first in that she did not see it as similarly "lightweight." She said:

I think that it was a little better, because I think that there was a deeper emotional crisis between the two of us, and for some reason he was more involved this time. He actually spoke more, expressed more feelings, I just felt like he had a better grasp on the therapy.

She wondered about possible reasons for the difference in her husband's participation in the first and second therapies; she thought that perhaps this time he felt the issue at hand was more serious, or he simply felt more comfortable with the idea of therapy, or perhaps it was easier for him to express himself in the therapy because he had played a part in initiating it.

For the third therapy (Episode #3), Gerry also described the problem that brought her in as "a crisis," this time with school. She decided to come to the PSC because of the sliding fee scale and because the therapists were students-in-training: "I thought, 'Well, it's students, practicing, and I'm a student, so, why not? I owe that to them.' Somebody was letting me practice on them while I'm a student. . . ." Incidentally, she reported that my training status was a major factor in her coming to the research interview.

She described the therapy as follows:

[We discussed] strategies to help me get through stress and what I felt could help me get through things and who I could turn to for support systems, and in that respect I felt that the process was more thorough because she was actually help[ing] me connect in my own brain solutions, even though those were hard to
do, at least I [have/had?] sort of a map to go by.

Nevertheless, she also reported feeling before, during, and after the therapy, that "there wasn't a lot I would be able to do" about the stress; she felt she would have to "live with things the way they are and then try to work them out when school was over." It sounds to me that she felt this was not the time for her to open herself up to changing, and instead was looking to the therapy to help her contain difficult feelings until another time.

This third therapy lasted approximately six sessions. Gerry described how she decided to end the therapy: "[T]hirty-five minutes into the session I had run out of things to say -- I guess I was all expressed out." She later came back to this ending, saying:

I think once you get more comfortable talking to a person, you can just come in, and it just kind of flows off and, then I wouldn't have anything else to complain about, that I'm stressed out about, or anything, and then we'd be, we'd just be done. So I felt that that meant that it was done.

This therapist requested that Gerry return for a "closing session" in which she asked "once again if there was anything else I needed to talk about, but that was it."

In explaining how she rated the importance of these therapies (she rated them as follows: Episode #3, #2, #1, from most important to least), she said:

The last one [was most important] only because it was the most recent, and it was more visits . . . or because I was asking for specific things. Probably because it was the most recent, and the school stress was more of a challenge, and probably more important to me than my marriage which the other [therapies] were about. Because you know, I can live through the relationship but, to flunk out of school would have been extremely detrimental to my ego.

She also stated that her rankings reflected the severity of the crisis she presented with at each therapy (i.e., the most important therapy was the one at which she presented with the most severe crisis).
For both the first and second therapies she explained that she did not remember any particular conversations:

I can remember really specific conversations that I had with my husband over the years that really meant a lot to me, what I was saying meant a lot, and I can remember those conversations. But those [therapy conversations], those no. It was just like you talk, when you get to a dead spot they kind of prod you in some way to get you to keep expressing.

For the third therapy, she also did not remember any particular conversations:

I think if I go through hypnotherapy and I find something that helps me evolve or a new enlightenment about myself that conversation I'll probably remember, but these [Therapies #1-#3] for me are just really, they're meeting my immediate needs and helping me get through a hard period.

In my opinion, Gerry has been working from a crisis intervention model of therapy.

In describing how the second one ended when "things were better for a while," she generalized:

It's funny, once you finally get to the point where you can say exactly what you feel it's like that big burden has been lifted, you feel much better, so you can continue for a long time I think before all that builds up again, before you reach the point where your communication isn't effective anymore.

She continued by saying that perhaps she should "pay more attention" or "keep a copy of the tapes" to review; in a way it sounded as though she was considering how to prolong the effects of therapy beyond this initial relief.

Despite this crisis intervention approach, it also seems to me that in some way Gerry was expecting a profound experience in therapy. When asked why she did not choose to return to the therapists from her second therapy when she sought out treatment the next time, she said:

I could speak profoundly about my acupuncturist and my chiropractor, and just can recite how wonderful they are night and day. I guess since nothing really profound happened to me in therapy, I guess I didn't feel the need to [return to
them]. It's just wanting to get more knowledge base, another perspective. I'm very experimental about that, and I still am going to be.

Yet, the quality of her therapies to the present was anything but profound, and Gerry had clearly played a role in making them that way. Perhaps the shortness of her therapies was related to her "experimental" attitude -- she has just been seeing what is available when various crises come up, and has been hoping that eventually she will know enough to find what she needs for her major, profound work. The fear, though, might be that she will never get beyond experimenting.

A related theme across Gerry's therapies was what I perceive to be a high degree of control she maintained over her therapies. She described her general approach to health care as follows:

I want to know exactly everything that's going on, why, and I want it explained to me on a chemistry level what's going on in the cells of my body. And so it's through my own informed consent and my own need for knowledge that'll help keep me safe. That's important.

She felt that she "could do [her] own self-analysis much more effectively" if she had tapes of her sessions. In addition, Gerry ended all her therapies in a unilaterally determined way after a short period of time.

Gerry talked about therapists in a way that sounded like she was judging their skills as a colleague (though she also admitted that she does not know enough to judge them). For example, she said:

The people [therapists] and their personalities and their skills and techniques I was never really with them long enough to really be a true judge of their ability to do their job. And a lot of it is me not having any experience and my openness, and my ability to be the other party in that conversation, has a lot to do with it probably, too.
When I asked if she meant that had a lot to do with it being therapeutic, she said, "Yeah, right."

One reason she may have sounded as though she considered herself a potential peer of these therapists, could be her own career as a health professional. At times, Gerry seemed to speak about seeking help and providing help in the same breath (she spoke of her husband having a problem with her talking to a professional about personal things, at the same time that she spoke of her level of professional intimacy with her own patients). Later she stated that some of what she had learned in therapy she could apply in her own career. "It's a learning experience for me, it's something that I can keep utilizing with myself and the things that I learn by observing that therapist I can also use in nursing." In addition, she referred to her "interest" in hypnosis and particularly noted her lack of understanding of "the process of hypnosis." She also noted thinking in the past of formally incorporating psychology into her career (i.e., studying psychology). Continuing in this line, she said:

I definitely want to see a hypnotherapist, someone who can teach me self-hypnosis for stress reduction and, I just think it's a new approach that will help me get involved in meditation, and will help me find my inner self, somehow, I think that's the approach that I need.

Gerry continually referred to therapy in conflicted ways. She sometimes sounded as if she didn't think it could do much good ("I didn't think that sitting there talking was going to do me any good"), at other times it sounded as though she idealized it ("I think therapy is a wonderful thing"). At one point she criticized it for being "lightweight," and at other times said she "doesn't really expect a lot, I'm just really sort of mostly experimental." She was the only interviewee who said that seeking help was "very easy"
every time she sought help, yet her therapies only lasted 3-6 sessions. It is possible that only the initial part of seeking help is easy and the rest (the follow-through) is extremely difficult for her.

It may be what I perceive as her expectation that therapy will be a "gut-wrenching" process which has kept her from remaining in therapy longer than she has. She stated:

[F]or many years I've, for at least the last ten years, especially since I became a vegetarian in 1986, there were a lot of other emotional issues that I'd definitely like to discuss with somebody, but it's going to be a long intensive process probably of maybe a year or more of continued therapy. . . .

She felt hypnotherapy would be particularly useful because she says she has a memory lapse that she wants to find out about. I suspect that anyone thinking for so long that they have such deep emotional issues to explore would be extremely conflicted about remaining in a therapy.

Gerry agreed that all of the presenting problems related to her marriage were still present for her at the time of the interview. She said she had put them off until now (the time of the interview), and would put them off a little while longer while her husband finished school, but after that she hoped to make a change. She explained, "Now something has to be done . . . I'm at another crisis." Yet in the next sentence she said, "But now he's in school, so I'll give it this year. . . ."

Nevertheless, at the time of the interview, Gerry was in the process of seeking therapy. In fact, she said:

I'm really happy, I can't wait, you know, my insurance is effective October first, today's my day off and I'm going to just call around and I want [someone] who can get me in the soonest who I see, because I wait until the last minute until I'm just ready to just explode.
I question whether this might be another short episode, since it sounded as though she was feeling some desperation as she had prior to seeking previous therapies. In the follow-up interview, she reported that she found someone who does Neurolinguistic Programming and hypnotherapy, both of which she wanted. She expected the therapy to last at least ten visits, and said she would not be surprised if it were over twenty.

As for the more distant future, Gerry said, "I'd like to go to many, many more [therapies]. I think it's very, sort of a self-exploration of other techniques and things, just like hypnotherapy and all kinds of, I'm interested in that stuff." I have no doubt that Gerry has felt and will continue to feel free to "shop around" for a therapist who she feels is a good match. She stated that help-seeking would always be "very easy."

Ida

Ida was a 39 year old woman whose therapy history at the time of the interview spanned a period of 22-23 years (see Figure 5). During that time she had had at least 17 different mental health episodes. These episodes consisted of one family therapy, at least one (and possibly two or three) medication-only episodes, two couples therapies, one group therapy, and twelve individual psychotherapies. The last of these individual psychotherapies was ongoing at the time of the research interview.

Ida's first memory of a therapy was that of a family therapy (Episode #1) primarily focused on her brother. This occurred "just before" she went to college, and she attributed her lack of a "strong impression" about the therapy to the fact that she was in the process of leaving home. She went to the therapy between three and five times total; after she left for college it continued without her.
Figure 5. Ida's Time Line. These are best estimates of the number and duration of mental health services reported by Ida during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
Looking back on the therapy, what was prominent in Ida's mind was that she had not been interviewed separately before being put in the family sessions:

It had occurred to me, not then but much later, that I think they interviewed my parents separately but I don't remember being interviewed, which must have been some kind of oversight, unless something was being done very poorly or I didn't realize what was happening, but I don't think so.

Later she noted that "some things could've been done differently. I think things are probably better now [in family therapies]." Overall, Ida described the therapy as "unhelpful," due both to the way things were done by the therapist and what she perceived as a lack of interest on the part of some of the family members.

In college, Ida sought out therapy on three different occasions (Therapies #2 - #4), all of which were at the university's Student Mental Health Center. She remembered them all being very short in duration (1-3 sessions), and found it difficult to differentiate definitively between them. Ida recalled that they were "supposed to be short-term... they don't want you to be in therapy for months and months." While she described her presenting problems as rather focused problem-solving or decision-making dilemmas ("what academic direction do I want to go in?"), she reported that there was also "a lot of baggage" she had been carrying with her at that time. In her eyes, it would have been beneficial to have dealt with that baggage back then; she suspected that it may have contributed to the explicit problems she was presenting to the therapists at that time.

Whatever the case, Ida also seemed to wonder whether she would have been prepared to deal with the underlying issues at that stage in her life:

So there were other things that I probably would've found it useful to talk about, but all I could find was I didn't really, I couldn't figure out what I wanted to do, what my direction was. I wanted some help focusing on that, and I got, I don't
know how much I got, I think I got a little bit of it, but I'm also wondering about
the other parts that kind of lurk that I wasn't really dealing with.

I wonder about how the choice of treatment focus in these therapies may have
been influenced by what Ida recalled as a time limit placed on the therapies. Ida stated:

Which again I think it would've been helpful if I had been able to see that I had a
lot of baggage, because I think [unintelligible word] talking about the family, and
this was also part of it, too, it was supposed to be short-term and coming there
cause I didn't know what I wanted to do with my life, [unintelligible word] deal
with anything major and so they focused on those issues and they don't want you
to be in therapy for months and months, so if I could go into a different situation
where that limitation wasn't put on it I don't know what would've happened...

The importance of long-term treatment to Ida became even clearer when we discussed her
later therapies (particularly her current one).

Ida particularly disliked the last of these three clinicians (Episode #4) because of
her "passive" style. She wondered if this style was due to the woman's training as a
psychologist or her personality (she noted that the other two clinicians had been social
workers and they were more active). It is my guess that some of her characterization of
this woman as "passive" may have been due to Ida's relatively recent discovery of
information in the psychologist's records that the therapist did not share with her during
the therapy (the information Ida found was that the therapist had suspected Ida might have
been angry at her alcoholic father). Ida was upset that the therapist had not shared this
insight with her; she said that it was years after the therapy before she began to discover
(partially through books she had "picked up") that her father's alcoholism and its effects on
her family had been damaging to her.

8 Ida had requested her records from this therapist for use in a lawsuit against
another therapist (see Episode #6).
Ida realized that she may not have been receptive to such feedback at the time, however she still thought that perhaps it would have "made things click sooner." She suggested that perhaps the therapist could have recommended some books on the topic which might have facilitated her discovery process. One thing Ida said she had learned from therapy (and perhaps from Episode #4 in particular) was that a presenting problem often relates to other seemingly separate issues. Ida stated the importance of presenting to a prospective therapist what she has learned about herself (i.e., her father's alcoholism) "as a piece of information like someone taking a medical history." She expected that this should allow "someone with expertise" to say, "OK, that will color some of what is going on."

Looking back on seeking therapy in college, Ida expressed surprise that she had done so: "I wasn't used to talking to people so I find it kind of interesting that I would pick up the phone or make an appointment . . . even though I don't have a history of doing that." This statement surprised me, given the number of mental health contacts she had had; however, I am unsure how to make sense of the apparent discrepancy between her therapy history and this statement. Ida attributed some of her willingness to seek help for the first few times as part of a more general willingness to "try something different" as a result of being in a new environment and away from home for the first time. She also cited the fact that she would not have to pay for the therapy (it was covered by health insurance) as a motivator for "giving it a try." She believed it was "moderately easy" to seek out these therapies.

Ida noted that the two times she returned to the university clinic she did not request to see the previous therapist, but simply asked to see "whoever was available." I
am not clear as to whether it was clinic policy that they assigned the first clinician available, or whether she did not make a request (either because she didn't remember the clinicians' names, didn't think to make a request, or didn't have a preference). All three therapies terminated with Ida telling the therapist, "I got what I came for," even though looking back she described the first two as "minimally helpful" and the last as "very unhelpful." She left each time with no plans to seek further help.

Approximately seven years later, Ida sought help once again (Episode #5). She went to her physician because she was clenching her teeth at night, and he referred her to a behavioral psychologist for biofeedback training. It was very easy to seek out the therapy because it was a referral and it was for a "particular purpose." In addition, Ida liked the feeling that the therapy itself (and I suspect her progress, too) seemed "measurable." She had three or four sessions with this clinician and her problem seemed to improve "a little." The therapy ended with an agreement that she would practice the exercises and if she needed to come back, she would call.

A few months later, Ida's father-in-law died. She was very upset by his death and decided to go back to the behavioral psychologist "because he seemed OK, he was talkative, and . . . I think it was just because he was familiar." Unfortunately this therapy (Episode #6) was an extremely damaging one for Ida: she reported that she was sexually abused by the therapist. Not surprisingly, this abuse had led to a number of problems in Ida's life and had greatly influenced her subsequent therapy experience. In the interview, Ida focused on this abuse and evaluated her subsequent therapies primarily in light of the extent to which they helped (or did not help) her work through what had happened.
The therapy in which she was abused consisted of about five sessions spaced one month apart; it ended when the therapist went on vacation and Ida simply did not schedule another appointment. Ida was particularly upset that what she thought could have been a fruitful time for her in therapy turned out to be "such a mess." Had she been with the "right" therapist, Ida believed that she could have gone far in working through much of her anger toward her father. She described how she saw her father-in-law as a father figure and said that she "transferred" those feelings onto the therapist who then acted inappropriately. For Ida, this episode was "a terrific opportunity that was lost," and one that left her in need of more therapy "to try to take care of that [the abuse] as well as the presenting problem."

Ida explained that since this incident she had become "really big on information." She recalled that at the time of the abuse, she did not know what the "rules" of therapy were; Ida wondered whether knowledge of such "rules" could have helped her stop the abuse earlier. Another consequence was that when she returned to her physician to seek out another referral, she specifically asked for a female therapist (and had had female therapists with one exception since Episode #6).

The next two therapists Ida saw were clinicians at the same clinic as the therapist who had been abusive. Nevertheless, she did not describe a great deal of difficulty returning to the clinic nor to a therapist in general. Three months after she had ended Episode #6, she began by seeing a woman in individual therapy (Episode #7). Ida described her as "pretty much a reflector." This was "frustrating" to Ida; it seemed particularly problematic in that Ida did not feel able to "label" what had happened to her. Ida's words were:
She [the therapist] was a little too much of a mirror, because I said a few things that maybe should have clued her that something else was going on, and again, they were very vague, the kinds of things that you couldn't pick up on.

Ida described this therapist as "almost one of those classic psychiatrists" in that she "just wouldn't respond." Ida interpreted this as the therapist "pushing" her to "be more solid" and noted "I don't think she understood that there was nothing solid for me to push off of." Despite these difficulties, Ida stayed with the therapist for about 18 months. She commented:

I don't know why I kept putting up with it . . . I think what my pattern was was to stick with things even though they were uncomfortable, and that's some of what I was doing with it, was to stick with it, hoping that there would be an outcome, that things would be better, but not knowing where to bail out, or having the sense that, "Wait a minute, I can bail out of this."

Ida described the eventual ending of the therapy as follows:

I wanted to go off and they were thinking of recommending me for long-term therapy with an outside person. And she gave me a phone number to call, and I didn't, I just went off and didn't do it. And I don't know if it was because I wasn't ready, or I was overwhelmed, or I just didn't want to deal with it.

Overall, Ida rated this therapy as slightly unhelpful in that the therapist's style was "very unhelpful," but she guessed that it "didn't make anything worse."

Toward the end of this therapy, she was referred to a behavioral therapist for 10 sessions (Episode #8) because she was again clenching her teeth. Apparently she was able to be clearer about the abuse with this therapist because someone on the behavioral intake team had asked her point-blank if the "bad experience with a therapist" to which she was referring had been sexual in nature. However, Ida was upset that this behavioral therapist did not relay the information to her other therapist (Episode #7 was ongoing) but instead simply advised Ida that she needed to tell her other therapist. She rated this
behavioral therapy as "mixed:" it was helpful in that the therapist "behaved professionally" after her previous male therapist had not, however it was unhelpful in that he did not relay the abuse information to the other therapist. The unhelpfulness of his failure to disclose seemed to be Ida's predominant memory of the therapy: "So, on the whole, I'd have to say it really wasn't helpful, if you're looking at the long-term." Ida did not reflect on how helpful the therapy was for her teeth-clenching.

In addition to referring Ida to the behavioral therapist, the therapist from Episode #7 also referred her to another clinic for a 10-session women's group (Episode #9) for children of alcoholics. Ida's recollection of this group therapy occurred during the week between the initial and follow-up research interviews. Although I did not obtain specific information regarding this experience (dates, etc.), Ida noted that in general she found the group useful for "validation" and learning to focus on her feelings and experiences.

Ida initiated another therapy approximately a year after ending Episodes #7 and #8. This time she sought out couples therapy, however she wanted a referral to a private therapist because she was not comfortable with her options at the clinic (this was the same clinic where she had seen the abusive therapist, and was the only one covered by her insurance). Apparently after negotiating with the therapist, she decided to accept the clinic's offer of couples therapy in-house (Episode #10) and as a part of that agreement to talk to the clinic supervisor about the abusive incident. The supervising psychologist did his best to "sweep it under the rug," telling her not to talk about the abuse within the couples therapy (a recommendation which she followed). The supervisor also referred her to an outside individual therapist, however she was could not afford to follow up on this referral.
The couples therapy consisted of nearly two years of monthly meetings which were "getting very infrequent" toward the end of that time period. Although the therapy "wasn't really helpful," it "kept things from deteriorating too much." She did not blame the psychiatrist for the unhelpful nature of the therapy so much as she blamed the fact that all participants to the therapy were "not dealing with the issue," the issue being the abuse and its affect on her marriage. Somewhat more negative was Ida's belief that by not dealing with the issue for so long, "some things got more entrenched," making it more difficult for her and her husband to work on their marriage in their next couples therapy.

Approximately one year into the couples therapy, Ida sought out a private individual therapist (Episode #11) with whom she stayed in therapy for about a year. Ida suspected that this therapist did not want to address the issue of the abuse either; she remembered this therapist telling her that it was "water under the bridge." This reaction, plus some personal disclosures on the part of the therapist, led Ida to wonder whether her issues were "too close" to those of the therapist. Ida felt that this therapist's difficulty with her presenting problem was a factor in delaying her therapeutic progress.

With hindsight, Ida stated:

What was helpful with [this therapy] was simply that I had something to go to. It could have been anything -- I would have been better off going to Alanon meetings three times, four times a week really, because [of] the kind of support I would've gotten there in learning to identify my feelings and to own them. . . .

In addition, she thought it would have been "a reasonable thing" for this therapist to have hospitalized her or "at the very least [she] should have gotten me antidepressant medication." Ida described herself at that point as "barely, barely functioning" and having suicidal thoughts.
One month after ending this individual therapy Ida began another individual therapy (Episode #12) with a woman who specifically "billed herself as dealing with clients who have been abused by therapists." Ida believed the woman was trying to serve as both Ida's therapist and as her advocate in proceedings against the abusive therapist; Ida's impression was that she "couldn't wear two hats" and "really should have decided that she would be one or the other and not both." Although this was a fairly dissatisfying experience, too, she did recall that this therapist introduced her to a community of people who had had similar experiences, serving to reassure Ida that she was not "the only one." This therapy ended after about a year.

Approximately a year after ending the previous couples therapy (#10), Ida and her husband sought out another couples therapist (Episode #13). At this point they had switched health plans, and the new insurer was responsive to her request to be seen outside of the clinic where she had seen the abusive therapist.

In the therapy, they discussed the abuse very openly and the couples therapist explained, "When this kind of thing happens, there are results. Of course this has an effect [on your marriage]." Recalling this comment, Ida noted:

It was on a Thursday, and over the weekend I felt so much better, I mean it wasn't as if my troubles were all over, but I was so relieved that, "[Name of husband], you're not the problem. And I knew you weren't. So now I know like certainly that this other had a huge impact." And [the impact] was tremendous. . . .

This therapist also thought Ida should be in an individual therapy along with the couples therapy, so she referred her to another clinician. My impression is that, in general, Ida experienced the therapist as taking matters into her expert hands and this felt reassuring.
The therapist's remark that "of course" this affected their marriage stood out prominently in Ida's memory of this therapist -- she referred to this statement a number of times in the interview. Ida viewed the therapy positively; she was "quite pleased" with the "even-handedness" of the therapist in dealing with her husband and herself as a couple, and said the therapy significantly improved their ability to understand each other's point of view.

During the couples therapy, Ida asked about and began taking antidepressant medication (Episode #14). We did not concentrate on this treatment during the interview except to clarify that she took the medication with little success, went off it "a little too soon," took some more for a few months at which time it "seemed to help," and then fairly recently (in relation to the research interview) had begun to take an anti-anxiety drug which she was planning to taper off of "soon." Thus, she has been on and off medication since 1989 or 1990. I am unclear whether all of these medications were prescribed by the same clinician.

A few months into the couples therapy, Ida pursued the referral to individual therapy. She remembered this therapist (Episode #15) as "very, very nurturing, very warm . . . she's a mother figure, she even looked like a pillow. So it was very good for me to get that kind of support, at that time." Ida described this therapy as initially very helpful, but "then toward the end it started to become less and less helpful [as] I was moving on to something else; there was a transition period there." This therapist's warmth and nurturance turned into "overprotectiveness" in Ida's eyes; she believed that the therapist "wanted to protect [her] from more hurts." She said, "It was like I was becoming an adolescent and I needed to move away . . . and she was keeping me as an 8
or 10 year old . . .

At another point Ida explained, "What she wasn't was someone who would push me to take action, that's what I started needing." I think this therapy is an example of how a client's needs can change during a particular therapy and over the course of the timeline. It seems that she had been seeking such warmth and support in the therapies prior to this one; perhaps this nurturance was just what Ida needed in order to move on to "taking action."

This therapy lasted approximately two years. Ida had told the therapist for a couple months toward the end of the therapy that she "needed to move on to something else." Ida recalled a particular night when she was thinking about how the therapy had not "moved on" despite her request:

[I felt] very angry, and I recognized it, I recognized where it was coming from, so I called up and I said, "I'm cancelling my appointment, and I don't want to make another one." So it was pretty abrupt . . .

Apparently the therapist wanted to have a final session with her, however Ida refused in part because she doubted her ability to terminate in person: "It was easy for me to do it when I wasn't in the office. It think if I'd been in the office, I wouldn't have been able to." Although she said she "didn't handle" the ending the way she "would've liked to have handled [it]," she stated, "I was getting better, because I didn't let it go on that long."

Whereas she only waited through a couple months of dissatisfaction before terminating this therapy, she had endured a year and a half of dissatisfaction (the entire therapy) before terminating Episode #7.

Within a few months of ending with the above therapist, Ida sought out a therapist who could do hypnosis because she had heard it could be effective for her continuing problem with teeth-clenching. Ida had an intake interview at the PSC (Episode #16) at
which time she learned that the PSC does not do hypnosis; she was referred to a few agencies in the area which offered hypnosis. One of these referral locations was where Ida found the therapist (Episode #17) whom she was still seeing as of the time of the research interview.

Apparently Ida requested early on in the therapy that the therapist help her take an "active" approach to her problem (I suspect this was a result of what she had learned she wanted from Episode #15). Although she initially sought out the therapy to deal with her teeth-clenching, while doing hypnosis and deep relaxation exercises with this therapist, Ida found that some of the abuse memories were troubling her again. When Ida disclosed this to the therapist, they agreed to change their focus to the abuse, however they continued with their "active" approach. With a look of satisfaction, Ida recounted:

[The therapist] remembered that the first thing I said when I came in there was that I wanted to be active . . . and she kept reminding me, "You said you wanted to be active, so therefore I'm going to push you a little bit."

Ida cited this as evidence that "she heard what I came in for, and that was very important." Ida also noted that the open-ended/long-term nature of this therapy was very important in allowing her to make this beneficial change in focus.

Ida contrasted this therapist with the one from Episode #15, saying that instead of being "afraid" for her and saying, "Oh, you poor dear, you're going to get hurt if you stick your neck out," her current therapist gave her the message, "If you stick your neck out, then you might get certain kinds of responses, so how are you going to take care of yourself?" Another distinguishing characteristic of this therapist versus some of her prior ones was that she seemed to have a way of being personal with Ida without disclosing personal information in an "invasive" manner. Ida stated, "She seems to have enough
sense of where the boundaries are . . . I don't even know a whole lot about her personal life, so I don't click into, 'Oh, I have to take care of you.'"

Ida was insightful about how the abuse by her former therapist, which had taken over so much of the implicit or explicit content of her therapies, was intimately related to her original difficulties in her family of origin:

I feel like what I'm doing now is doing some of the family stuff that I would have liked to have done earlier but this [abuse] interfered, except that it interfered because it was a reenactment, so in dealing with it, it's helping in some ways. You know, it's put things off much longer, and I would have hoped to have had some of this done sooner . . .

At another point she mused:

[How much of [the abuse] is that ["simple" abuse], how much is maybe what happened in my family of origin, I begin to get confused. It's not clear . . . I don't know whether I want to untangle it as much as I want to deal with it.

Ida rated the therapy she was currently in as "still very helpful" which made me wonder if she expected its helpfulness to wane as she became ready to leave, just as in Episode #15. Perhaps a waning in helpfulness is the sign that Ida uses to know she is ready to leave. As for her plans in this therapy, Ida said that she and her therapist had agreed that another year to 18 months would be a good length of time for her to deal with the "fallout from [the abuse], especially how it relates to whatever is going on in [her] family." Ida added, "I don't want to be in therapy forever."

Although we did not have a great deal of time at the end of the interview to look over her time line as a whole, Ida clearly stated that Episodes #15 and #17 were "the most effective . . . each in their own way" and were "pretty equally useful." Beyond these two, she said, "I don't know how to rank the others, they all get kind of jumbled." She wondered if the others were "almost holding patterns" explaining that "they were useful in
some way because it might be [some of them] kept things from getting worse, maybe, but didn't really do anything to make things better. But I don't really know that for sure"; she went on to explain that perhaps if she had not been in some of those therapies she might have instead attended more Alanon meetings which could have been equally or more useful. As for a progression in her time line, Ida saw that she had become "more and more clear . . . and able to focus" on how she feels.

One central theme worth noting is what I perceive as Ida's desire that therapists be "responsive" and "responsible." I think this takes form in a couple of different ways. First, Ida was disturbed by the lack of responsiveness she got from the therapists in Episodes #7 and #8, as well as the clinic supervisor, regarding the abuse she had experienced. In fact, at the time of the interview she was "starting to be more public with the health clinic and to say, 'This is what happened and you folks need to know and I think you have a certain amount of responsibility.'" Second, Ida stressed the importance of therapists remembering that "maybe people come into therapy and their lives are successful, but on another level, it's like there are kids in there" and they need to "try to figure out where people" with respect to "emotional maturity." I interpret this as a belief that therapists have a responsibility to look beyond the surface of a client's presentation. It is not terribly surprising that someone who has experienced abuse by one therapist, as well as what felt like excessive personal disclosure by at least one other, would express particular concern over therapist responsibility.

9 Ida did attend Alanon meetings on and off throughout much of her time line (probably no earlier than 1980), however we did not focus on this in the interview. Ida did not include Alanon in her time line, nor did she in any other way bring this experience into the interview as a central point of discussion.
Karen

Karen was a 28 year old woman whose therapy history consisted of eight therapies, the first of which occurred 12 years before the research interview (see Figure 6). These were all individual therapies with the exception of one family therapy. Her most recent therapy terminated 10 months prior to the interview.

Karen's first "official" therapy occurred when she was 16 years old. She recalled that before that time, there were two people who had reached out to her in an attempt to help. One was a church deacon who ran groups and other activities with children in the community, and another was a social worker who came to her house at the time that her brother was diagnosed with cancer and offered to talk if anyone in the family so desired. Karen participated in some of the activities that the deacon offered, however she never used the services of the social worker. Karen only brought up these contacts toward the end of the interview, and stated that until then she had "not really considered that as therapy."

The therapy that occurred when she was 16 (Episode #1) was initiated after Karen and her mother had a particularly disturbing argument (in Karen's eyes). Before that time her mother had repeatedly asked her if she would like to talk to a professional, however Karen had refused because she viewed "the problem" as residing within her mother rather than herself. After this argument, however, Karen became frightened at the way her own functioning was deteriorating and decided to accept her mother's offer of help. Looking back on her reasons for finally accepting help, Karen felt that what she really wanted was to find an ally in the therapist who would "side" with her and tell her mother that she was the one who needed to change.
Figure 6. Karen's Time Line. These are best estimates of the number and duration of mental health services reported by Karen during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
Karen felt "pretty confident" that the therapist would take her side, thus she did not recall having any difficulty going to the therapy. Although she did not like this clinician (she described him as having "boorish" attitudes and treating her with condescension), he did, in Karen's eyes, give her exactly what she was looking for. The therapy lasted for three sessions: one with both Karen and her mother, one with Karen alone, and the last with her mother alone. Apparently the therapist told Karen that she was not the problem, that she was "fine," and told her mother that she was the one who needed to change. Unfortunately, the therapist also confided in Karen that he had had sexual feelings for his niece when he hugged her (molestation by Karen's mother's boyfriend was part of the presenting problem) and told Karen that it was perfectly normal. This felt damaging to Karen, and was much of the reason she rated this therapy as "moderately unhelpful." Her mother terminated the therapy in anger after the last visit. In addition, Karen's memory of the experience was negative enough so that she had "resisted" going to a similar type of "family services" situation since.

Karen's next therapy contact (Episode #2) was approximately five years later, when she was in college. She sought out help a day after she had physically assaulted her boyfriend. Karen went to the university Student Mental Health Center to find out if she had an "abusive problem." After telling the therapist why she had hit her boyfriend (someone she described as a "typical college alcoholic" who had borrowed her car and lost it, among other things), the therapist apparently told her, "I would have hit him, too" and reassured her that she did not have an abusiveness problem.

The therapist did, however, note that she was under a great deal of stress and offered to refer her to stress management classes. Karen did not accept this referral, and
seemed annoyed that the therapist had suggested it. In addition, she was dissatisfied with his telling her she had "an analytical mind" and that she "knew what was happening so he didn't know what he could do." She explained:

He was supposed to be one of the best ones there though . . . and I was thinking, "God, you know, he asked me if I wanted stress classes, and I know I'm screwed up, I know I need help." And he just referred me somewhere else . . . . I hated hearing "you have a really analytical mind," because if I have had it all my life, so what good did that do? It didn't help me, I was still where I was . . . . I think he meant it in a positive way, like, "You're strong, you know what's happening, that's half the battle. Go for it." But that didn't help. It really didn't help.

She remembered wondering, "God, maybe I didn't get it across right," as if had she gotten it across right he would have recommended more "serious" treatment (of course, at the same time it sounds like she narrowly focused her presenting problem around her possible abusiveness, so it is difficult to know how to interpret her desire for the therapist to do more).

This therapy lasted just one session, after which Karen had no further plans for seeking help. Part of the reason she had no further plans was that her mother was pushing her to go into therapy at this time; Karen explained, "the more she said that, the more I didn't want to go." She recalled the session as "moderately helpful" and said the part which sticks out in her memory was his agreement that he would have hit the boyfriend, too. She remembered this clinician as "professional" and "clean cut."

Her next therapy contact (Episode #3) took place about 18 months later. Karen was unexpectedly pregnant and experiencing difficulties in her relationship with her partner. The last straw came when she "could not get [her]self" to call an obstetrician; she took this as a sign that she needed outside help. Karen turned to the Employee Assistance Program of the firm for which she was working, and used the six sessions that were
allowed in her benefits. She stated that seeking help this time was not very difficult, although it had never been "extremely easy" at this point on the time line because she "wasn't well enough" to really think it was easy: "I was such a mess, it was just easier than everything else [i.e., calling the doctor]." Karen classified this therapy experience as "extremely helpful." She described the clinician as "motherly," and the place itself as "equalizing, just nice."

She left the EAP with a referral which she intended to use. Nevertheless, she felt "a little unsure" because she had liked the EAP therapist and because she would have to pay a copayment when seeing the new therapist. She remarked, "[T]he idea of doing it for longer than I had already done was just kind of strange, but it was OK, it was alright."

Within a week or two of ending the EAP therapy, Karen began with the psychologist to whom she was referred (Episode #4). Looking back, Karen wondered why she didn't look for another person, though she said at this point in her therapy experiences she "didn't know the idea of shopping around or interviewing people" (an idea which she later said she began to "buy into" after this therapy, when she started "seeing more about it in the paper"). The one positive comment Karen had to make about this therapist was that in the first or second session, the therapist referred her to an Adult Children of Alcoholics book which Karen found helpful. Other than that, she described the therapy as "useless" and blamed herself for staying in it as long as she did (she stayed for about eight months).

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10 I am uncertain what this comment is about, however it seems potentially important for understanding Karen's experiences.
Seeking help at this time was a little bit more difficult for Karen than at other times, a difference she attributed to her boyfriend's disapproval of therapy in general (and her discomfort with his disapproval). Nevertheless, she felt she had "no choice" and went despite his reservations.

The goal of the therapy was to get some insight about why she was putting herself into "bad relationships," especially relationships with men: "My goal was to figure out why I was in this position, how did I get myself to where I was." It sounded as though much of the therapy consisted of Karen "going in and reporting to her everything [that happened] the week before" in her relationship with her boyfriend (what she described as a "hell relationship"). What seemed to make Karen most angry about this therapist was that she did not appear to see a problem. This was particularly true toward the end of the therapy when both Karen and the therapist were essentially wondering what else there was that needed to be addressed. As they began to wind the therapy down by seeing each other less frequently, Karen's boyfriend suddenly moved out. When this happened Karen called her therapist, whose response was one of surprise that he would move out because "she thought things were going so well."

Karen was unable to express her anger with the therapist directly, but her feelings were along the lines of, "What was I here for? You were supposed to see this or you were supposed to help me see this, or at least ask a question about it, do something to make me think about this." Upon saying this, Karen reflected:

I don't know, I kind of felt I was asking for so much, you know, that's why I was going because I wanted somebody to realize that I was going because I had to go and it just didn't seem to make a lot of sense.
To me it seems that Karen, to some degree, wanted a therapist to read her mind, be clear about the things she was confused about, and be able to see things she was unable to see.

Karen thought that, had life circumstances not changed for her (among other things, she was a member of the military and the Gulf War had just begun), she probably would have continued at that time in the therapy. The therapy ended at about the time when her boyfriend left her; there may have been just one or two sessions after that. The therapist had allowed Karen to accrue a large bill, and months later when Karen was sending her final payment she enclosed a letter to say that she and her boyfriend had gotten married and that it "all worked out in the end." I expect that at that time, Karen felt fairly positively toward the therapist. However at the time of our research interview, Karen's assessment of this psychologist was that she seemed "inexperienced," and "unprofessional," as well as "disheveled, confused, scared, and intimidated." Karen laughed thinking back to her belief that marrying this boyfriend had meant "it all worked out" (they later divorced); I wonder if her negative assessment of this therapist was partially a result of her change in feelings about the marriage.

Fifteen months later, Karen began seeing a new therapist (Episode #5). She had waited anxiously for three months to see a therapist as she had just started a new job where the insurance benefits did not begin until after three months with the firm. Not only was she having problems at work, but also her husband had just left her. Seeking therapy this time was "very easy" in that it was a "relief" when she could finally go to a therapist after waiting for three months. However, the therapy only lasted four or five sessions, after which time Karen lost her job (and her insurance).
This brief therapy was one of the most positive therapeutic experiences Karen had had:

When I went there it was just to get me through, have someone to talk to. But once I got there, she immediately, I mean, I got more done in those four or five sessions on myself, than I think I've ever had done, except for maybe [Episode #7]. Part of what may have made this such a positive experience was the serendipitous match of her presenting work problems with this therapist's expertise regarding "women in the workplace." Yet Karen also cited other qualities which were important to her about this therapist, for instance that she "didn't act like she knew it all, and she didn't act like she didn't know it, she just really put herself right on my level."

There was a lasting quality to the work that Karen and this therapist did together which is something I had wondered about when formulating this research. Part of the helpfulness of this brief therapy may have had to do with the work which continued after the therapy proper ended: "I also remember a really long discussion about this whole fake front, which I've read a lot about since I started talking about it to her." She continued:

I use the things I learned with her and talked to her about every day at work . . . . See, all I need is someone to get me going in one direction sometimes, and then I can go on from there. I would have liked to have gone on, to have learned more from her, but I did go on a lot from what she said.

When I asked if the things she learned in the therapy were "still attached to that therapist," she replied, "No, no . . . I took what she said and related it to the [later] experience. . . ."

Karen referred to this therapy and Episode #7 (see below) as "reference tools."

Karen also stated that this therapy had been "extremely helpful for what it was," by which she meant that "being four or five sessions, it was really helpful." In this statement, I think Karen was expressing a degree of surprise that such a brief therapy could have had
such meaning to her (or if not that, there was something about her statement which implied that she sensed a different helpfulness potential for brief versus longer therapy). She thought she would have continued in a longer-term therapy with this clinician if she had been financially able to do so, noting that she "used to fantasize about making enough money to be able to go back and just pay her without the insurance."

When Karen left this therapy, she had no plans to seek additional therapy due to the "unsettled" state of her life and her precarious financial position. At this point, Karen returned to college. One of her classes in the Spring of 1992 was taught by a graduate student in counseling psychology, for whom she also served as a research interviewee on the topic of "family stories." After their interview, the student offered to talk with her on a weekly basis. Karen felt he probably did this because he was thinking "this woman really needs some help" after hearing her life story. Karen took him up on his offer, and met with him a total of four or five times (Episode #6).

She recalled him as "a very physical hands on kind of counselor" which she thought was not a very useful approach for her because she is "too intellectual for that kind of thing, to respond to that kind of thing." According to Karen, this experience was useful to her in later help-seeking because she could be clear that she did not want this kind of "meditation stress therapy."

Karen reflected on the experience as follows:

I either seek out people like that, or people like that seek me out . . . I always wind up with people that want to help me . . . to fix me. They always want to help me, probably because I am just so open about it. . . .

While Karen did not find his techniques very useful, she was appreciative of his efforts to help her (while also recognizing that it was useful for him to "practice" on her).
In July of 1992, Karen was sent by her employer for outpatient counseling
(Episode #7) to help her cope with a crisis at work. Karen was happy to have assistance
in managing this crisis; she found it "extremely easy" to get help this time (perhaps in part
because her employer had set up the contact for her). Karen found that within the eight-
session limit imposed on the therapy, she accomplished a great deal with regard to the
problems which had been troubling her for years. She described the importance of the
therapy to her as follows:

Almost from the beginning there was kind of a definite goal there. We determined
from the beginning that I had grown up without any boundaries at all, and didn't
have any. And that's why all these weird people without boundaries were in my
life. And that was the first time I ever heard that concept. That was probably the
most important thing I've ever learned in therapy in my life, was that when she said
it on an off-handed comment, and I just went, "Wow!" And so I think what we
decided to do, what I decided to do from that point on from her, was to figure out
what it meant to have boundaries, and how to establish them.

The effects of this brief therapy, and particularly the "boundaries" conversation
which occurred in the second or third session, seemed immediate to Karen: "It was just
that one conversation, maybe half an hour in total, just got me thinking in a totally
different way. I mean, immediately, within a month. . . ." The sessions after this pivotal
one were focused on "processing what was actually happening" with the ongoing crisis at
work (there was more to the crisis than just "boundary" problems). Karen also stated that
she may have been generally more receptive to this therapy because of the positive
experience she had had in Episode #5 (another short-term therapy).

Karen described this therapist as "very compassionate, very female, woman-
oriented" which she had "come to realize after [this therapist and the one from Episode
#5] was a big issue in my life." She believed that she would have continued this therapy if
there had not been a preset limit to the number of sessions (this is reminiscent of her belief that she would have continued with Episode #5 had she not been limited by finances).

This therapist referred her to the PSC, where she suggested Karen could find a clinician with a therapeutic style similar to hers (Karen remembered the therapist saying that she would be able to find a therapist who "thinks like I do" -- Karen had shared with the therapist that this was what she wanted). They discussed that the PSC could provide long-term therapy and that it had a sliding fee scale. Thus, Karen left this therapy with the intention of using her referral, which she did within a few weeks.

The year-long PSC therapy (Episode #8) was her most recent at the time of the research interview. She described what it felt like to come in for therapy this time:

Kind of fine. I was a little tired at that point. It was almost like the crisis was over, and I was in kind of a lull, I was like, "Alright, it's time to work on the rest of your life now." And so anyway, I was really raw for a really long time and a little drawn out by the time I got [to the PSC].

Thus, this help-seeking experience she rated as more difficult than many of her others.

Karen stated that she "came to this [therapy] looking at it like it was long-term therapy about my whole life, not just about this crisis and what related to that crisis. . . ."

She also noted that the sessions were "kind of following along the strands of my life, wherever my life was going." Karen described the role this therapist took: "He kind of walked me through decisions, using my new skills. So, I kind of didn't have to do it on my own. I probably could've done it on my own, but I got some feedback on it." She added, "$H[e was there to kind of be there, like to hold me up. . . ." Karen rated the therapy as "pretty helpful," noting that "it wasn't like a major, major change." Along these lines, she
said she does not "use [this one] as a reference, as much as I use like the sessions with [the therapists from Episodes #5 and #7]."

Karen's account of how this therapy ended seems slightly confusing. She said:

We were kind of at the point where it was up to me whether there was anything else to do, and I was kind of frightening him because he kept saying, "Well, you seem to have a handle on this, and you seem to have a handle on that, and how do you feel about that?" and I kept saying, "But I was so screwed up a year ago. When I filled out that [intake] form there were so many different issues on that form. And I feel fine, but how is that possible? Is that possible?" And so we were still in the process of debating "is that possible?" like the second or third time that I went back, that I was just like, "I can't deal with this anymore."

There is a similarity between this ending and the ending of Episode #4, in that with both Karen remembered the therapists as expressing, explicitly or implicitly, the opinion that she did not have anything more to work on. It is unclear to me whether she terminated in the session or by cancelling her appointment on the phone; in any case, she did not choose to accept what she described as the clinic's offer to do an "out-processing." Though she felt "guilty" that she may have "backed out" on something meaningful to this therapist (particularly because he was a student), she did not feel bad about this being the end of the therapy; she felt she was "done."

This most recent therapy ended approximately one year prior to the research interview. As we discussed her possible plans for future therapy, Karen explained her feeling that she was "done" with therapy for right the time being:

Until I come up with some major thing that I don't know how to deal with, or I don't have any idea with, I'll probably feel that way ["done"]. And I am not sure I will, because my decision making is totally different now. That boundary thing did a lot, it really did a lot. And then being [at the PSC], he kind of walked me through decisions, using my new skills.
To me it sounds as though this last therapy gave Karen a chance to consolidate her new-found skills to a point where she felt that her life was different in a fundamental and stable way:

I have to tell you honestly, when I first started talking to [the therapist from Episode #8], there were still episodes where I would feel . . . at the edge of an abyss . . . [I]t was like living your life kind of in limbo. And I have the same situations happening to me now sometimes. And I am put in the same kind of turmoil and I am nowhere near it. I mean, I am so far from that. And it's been a while. And I know why I am not like that, so I can keep doing things to get me further away from the edge . . . .

Karen was currently "toying with" the idea of going to premarital therapy for herself and her boyfriend. However, she spoke of this quite hypothetically and as part of a long-range plan for getting married in a few years. Other than that, she thought she would seek therapy again if she ever felt "totally out of control" or again experienced the feeling of "holding herself back" from doing something that she felt she needed or wanted to do (I think here she was referring to the type of dilemma she faced when she was pregnant and "couldn't" call an obstetrician). Also related to future help-seeking was Karen's comment that she would be more likely to call someone "out of the blue" due to her positive experience with Episode #5, a therapy she had found in this way.

Karen ranked her therapies in the following order of importance (from most to least important): Episode #7, #5, #8, #3, #4, #2, and #1.11 She explained:

I think that it would make sense that the most recent sessions are the ones that meant the most, because I had more to give to it, too. There was more for me to work with, there was more of me there. Plus, I really wasn't in control over a lot of these . . . . I was just responding, it was like putting out a fire.

Karen noted that after choosing her top two therapies, the rest were difficult to rank.
Another theme she saw in her time line was that "they all were people who didn't require a lot of money" from her. By reflecting on this she came to expressing her opinion regarding the importance of having multiple episodes of therapy with breaks between them:

I don't know if I would have done anything differently, if I had all the money in the world, I don't know what I would have done to find a better doctor, or a better person . . . but I know that it kept me from going . . . See, but then again, I have a belief that things happen for a reason, and I was about to say that if I had the money or the insurance continuously, I might have continued and done this sooner. But I really don't think that had I not had all those experiences in between [the therapies], they would have worked that way. If you give me the same people, the same amount of time, I don't think the same changes would have happened. So, it's probably good that I had to keep going back . . . at least for a while.

This last quote makes a good argument for the use of intermittent therapy.

At the follow-up interview Karen added a few thoughts about her overall view of her therapy history. While she used to assume that she simply found better therapists toward the end, she wondered if there were other factors playing into the more positive experiences she had later in the time line. For instance, she wondered if she had stayed in these later therapies longer because she had been more healthy or ready to work. Or perhaps, she said, she chose better therapists later on because she was more healthy; along the same lines, she wondered if her earlier therapists might have been different toward her if she had been healthier at that point.

Mark

Mark was a 35 year old man who had had 10 mental health service episodes during the 19 years prior to the research interview (see Figure 7). Other than one couples therapy and one medication-only episode, all of these were individual psychotherapies. Mark had ended his most recent therapy three days prior to the interview.
Figure 7. Mark's Time Line. These are best estimates of the number and duration of mental health services reported by Mark during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
His first therapy experience (Episod #1) occurred when he was in 9th or 10th grade. His parents had been having long-term marital difficulties for which they were seeing a therapist, and they asked Mark if he might not like to see this man individually. Mark believed his parents were concerned that their marital problems were adversely affecting him. He explained his experience as follows: "The act of going [to the therapist] wasn't very difficult, but certainly there was no way that I was going to do anything there, so I'd say that the therapy itself was intractable."

Mark went to see this psychologist two or three times. He remembered not being comfortable with the therapist, particularly because of his "traditional" reserved demeanor. Mark viewed his distrust of the therapist as having many causes: his own "low self-esteem," what he termed as a lack of prior experience with an "actively caring" adult, the knowledge that the therapist and his parents knew each other socially, and his impression that the therapist was not revealing any of himself but instead was "standing behind a shield."

Mark did not seek out this therapy himself, and he was quite sure looking back that he would not have asked to see a therapist if this offer had not been extended. Despite his distaste for the therapist's style, the sheer exposure to therapy he received during this time was important enough in Mark's eyes to earn the therapy a rating of "a little helpful." He explained, "[I]t was an exposure to therapy and so that probably let me know that there was such an animal, that such an animal existed, that it was possible."

I do wonder how he would have rated the therapy if I had interviewed him closer to the time of this therapy. I suspect he might have had a more negative overall view of the experience. He suggested that his memory of the event has changed over the years (as
I assume many of these memories have). When I asked if he thinks back to this therapy often, he said:

No, not really. You know I go through periods, I mean there was a time when I often thought about my personal history and how it progressed from one thing to another, and as time goes by and I resolve things more and more, as things from the past get resolved more and more then I come more and more into the present and all that stuff loses more and more of its charge.

Mark's next two therapies (Therapies #2 and #3) occurred while he was a senior at boarding school. He knew the first therapist, a minister, as the professor of a religion class he had taken. Mark could not recall the experience of seeking this minister out for individual therapy, but he remembered having at least five or six sessions with him. Mark reported that they "went over the same ground" as he had with the first therapist ("what was going on with my parents, how did I feel about that . . ."), however this time it was more fruitful because Mark felt more able to open up. He explained:

I was able to open up with him in a way, way beyond where I had with the other person, because he's just more warm, more, yeah, more warm and uh, not cool and distancing, and I knew him more as a person kind of beyond the counseling and so I was able to you know touch on issues that were painful to me, and to express my emotions in front of him, and so that was very good.

Mark remembered one session in which he broke down in tears and the minister came to him and held him. During a subsequent session Mark broke down in tears again and this time the minister did not come to him; eventually Mark went to the minister, at which time they discussed why the minister had not come to comfort Mark but waited for Mark to ask for the comforting he needed. Mark was conflicted about his view of this incident: in some ways he thought it was therapeutically appropriate, yet it also was another instance of an overarching complaint he had of his therapies, which was that
therapists move him along too quickly and do not seem to understand the fundamental level of his disturbance. Of the minister, he said:

He might not have understood the level of distress that I had been under and the length of time I had been under it . . . . He might not have realized how in a sense infantile I was and how much basic care and "TLC" I basically needed.

Mark believed that at this point in his life what he really could have used would have been "some kind of very supportive community specifically for helping emotionally abused children rebuild themselves." Mark described his reaction to being moved along quickly as threatening; in response to seeing the minister "withdraw," Mark drew back and shut down. He had had subsequent contact with this minister which was dissatisfying for the same reason: he felt that the minister did not respond to or recognize the extent of his needs. Nevertheless, Mark rated this therapy as "moderately helpful," remarking particularly on his own ability to be open with the minister.

The third therapy also occurred in his senior year of boarding school, and most likely occurred after the one with the minister (Mark was not completely sure of this). He was having a difficult time in his relationship with his girlfriend, and this girlfriend was seeing a counselor in the counseling department of the school; Mark thought it was her counseling which gave him the idea to seek out a therapist. He saw a female therapist, which he described as a positive thing because "women are softer than men and more open emotionally than men, so I felt like she was very caring in her manner." Yet still he wished "she had been more active, had taken more of a voice, again. I guess it's a common theme." I think what he meant here was that he wished she had been more actively caring and mothering.
In seeking out this therapy, Mark believed it was a little more difficult than seeking out the minister, partially because he already knew the minister, but also partly because he was "wondering whether all that [he] was feeling was just self-indulgent and should [he] indulge more in self-indulgence or rough it out." He saw the therapy as "helpful, but no more" (though he also reported that to the extent that she was reserved and withholding, it was unhelpful). The therapy lasted three to four months; it ended when he graduated from school.

The next time he went for therapy (Episode #4) was a year later, as a freshman in college. He was having difficulties in his relationship with his girlfriend and tried to get her to come to the session with him. She refused, and he saw the therapist once individually. During that session, Mark sensed that he would not be able to get what he was looking for from this therapist, therefore he did not return. Mark talked about this in an abstract way (referring to more than just this one therapy), so it is hard to know how much his comments apply directly to this one therapist, however he stated the following when describing the session:

I went there and he just didn't seem to have what it was that I was looking for, and I felt very inappropriate for looking for it. I mean it's one of those funny things, in my case needing a very basic kind of emotional support, and having that pretty close to the surface for some reason and knowing that on some kind of level, and then getting feedback from a therapist by just the way he or she is, that that's not what we're here for, that's not what this is about, but this is all you know that 90% of the communication that's nonverbal, so that you take it that much more seriously. And so you run away. I mean if it really is inappropriate, you're thinking to yourself, then I shouldn't have it.

When I asked how helpful or unhelpful the therapy was for him, he guessed that it was "somewhere in between, because if you're used to muddling through, then you muddle through." It sounds as though it was just another disappointment in a string of
disappointments, so its unhelpfulness did not stand out the way it might have later in his time line.

After this last therapy there was a gap of about 10 years until the next one (Episode #5); unfortunately, we did not discuss what was going on during that time and what his thoughts of therapy might have been. This next therapy began in May of 1989 and continued, once a month, until June of 1990. The counselor was at the university's Mental Health Services Center. He saw two different people, the first for two or three sessions in the summer until that clinician left as planned in late summer, and the second therapist for the rest of the time.\textsuperscript{12} Apparently this arrangement had been discussed when he first came for services.

Mark sought out this therapy because he was having difficulty in his role as the primary caretaker for his son; he felt he had no one with whom he could share the feelings brought up in him by this experience. He described cycling through times of being able to give his son what he needed and times when he was "just holding on for dear life" and it was all he could do "not to inflict heavy emotional harm" on his son. After cycling through this a number of times, he finally vowed to himself during a down period that when he got back on his feet he would remember that it happened and seek help. I suspect that he was unable to seek help during the down period -- he seemed to assume this as an impossibility -- because of his general difficulty revealing his emotions, as well as the possibility that if it was all he could do to stay alive during those down times, seeking therapy was just not physically possible. Recalling his help-seeking experience, Mark said,

\textsuperscript{12} This episode could be viewed as two separate episodes, however I have chosen to treat it as one in keeping with our discussion in the interview.
"I went to Mental Health Services and just kind of walked in the door and sat down and said, 'You know I'm not sure why I'm here, I don't have anything to say.'"

What Mark remembered most about this therapy was that the therapist ended it by saying, "Well I think you're basically self-correcting." This therapist, too, appeared to be erring in the direction of assuming that Mark was healthier and less needy than he felt he was. The therapist was "trying to do me a favor, quote unquote, stretching me out so I could get all my free visits and stretching me out one visit per month over twelve months." Mark seemed to see this less as a favor than as something of convenience for the therapist and the therapist's system, as well as a fundamental therapeutic error in perceiving Mark's needs. Thus, the terms of the therapy (how often they met and when it ended) felt very much therapist-determined to Mark, and he did not feel able to state his opinion of what he needed.

Mark described the therapy as "kind of a symptomatic fix, band-aid kind of stuff." He also commented that "we just kind of went along on that intellectual level." The therapist was familiar with some of the same teachings and language of Buddhism (Mark had requested such a match to his own spiritual views), and they shared ideas about that. This sharing was conflicted for Mark: it was meaningful on one level, but also very frustrating because he believed the therapist's tapping into the "intellectualism" of Buddhism was an indicator that the therapist could not care about him and nurture him emotionally. It sounds as if Mark took their shared intellectual language as code words signalling the therapist's own inability to relate on an emotional level (the level of Mark's self-perceived deep need). Thus, speaking of this therapist and similar therapists, he said,
"They gave me the signals right off that there was no way that I would ever tell them that I had that need," referring to what he termed a "deep need for someone to care about me."

Both the initial summer therapist and the later one gave Mark signals which he read as meaning that he was alright as he was. For instance, the first one "pulled the same old Buddhist rap," saying "just kind of observe yourself as you go along -- that's the place you want to be in." Mark related this attitude to his main complaint about the approach of Buddhism: that there is the assumption that "you're already a healthy individual" and this question never gets addressed.

Mark remembered feeling passive with respect to the therapist's direction: "I didn't really have any voice about what I might want, I was just in that mode." However, six weeks after the therapist terminated the therapy (by saying he felt Mark was "self-corrective"), Mark called the therapist back to say that he did not agree with this assessment and wanted to be referred elsewhere. Mark felt it was not an option to return to this particular therapist, as the therapist had "made it pretty clear that that was the end." Mark appeared to have a sense of pride in the assertiveness he showed by disagreeing openly with this therapist's assessment and requesting what he believed he needed; he reported that there was "a significant qualitative difference or quantitative difference in the initiative I took . . . that was a significant step forward in initiative. So I felt fine about that."

His next therapy (Episode #6) was at the PSC, one of the agencies to which he was referred. Much of the reason he chose the PSC was financial. He saw a male therapist at the PSC for about a year until the therapist left the clinic. Mark said, "I felt at the end . . . more threatened with him than I had at the beginning, because I had kind of
forced myself mechanically to open up things and talk about things but I was very threatened." As he did this, the therapist remained "an unknown quantity."

This therapy was not terribly satisfactory either, and when I asked why he stayed in it for so long, he replied:

The fact that I needed somebody emotionally, the fact that I needed therapy, and just didn't have enough belief in myself, enough self-esteem . . . to say, "Well, I don't feel this is really working out, there may be other kinds of therapists doing other kind of therapy, I think I want to look elsewhere." You know, I was still very much in a mode of starving, and I'll take whatever I can get wherever I can get it . . . so I again got myself back into the same kind of situation again, through a non-choice, unable to realize that a non-choice is as much a choice as anything else.

The ending of the therapy had been set to coincide with Mark's departure for the summer, however when his plans changed, the therapist suggested they stick to their original ending date. Again, it sounded like Mark experienced this termination as arbitrary and emotionless; he associated this ending to his general feeling that the therapist was not relating to him as a "real person," which made it difficult for Mark to disclose his emotions in front of the therapist.

Upon leaving the therapy, Mark knew that he wanted to continue therapy; after some searching, he settled on an "unlicensed" therapist that a friend of his recommended. He saw this therapist for 20 months (Episode #7), at first twice weekly for two-hour sessions, and later once weekly for two-hour sessions (this change occurred after Mark realized during a vacation that he "could handle with less").

Mark viewed this therapist as the one that finally "jump started" his self-esteem, that finally gave him the message that he was "acceptable as a person and not inherently bad." He continued, "Somehow that real seed thought got planted and that is more
valuable than you could say." However, the "irony of it was that the very way he did his thing also became a stumbling block"; once Mark finally got this message that he was acceptable, he then felt uncomfortable continuing in their established mode of working together. He explained that he wanted the "tool" that the therapist had given him, but not the "emotional stickiness or involvement" that seemed to go along with it. I believe that Mark thought there may have been a way to get what he needed without the pitfalls he encountered with this therapist; however, he still seemed grateful for having finally gained the self-esteem for which he had been searching for so long. He felt that the therapist was able to accomplish this task by 1) moving beyond acceptance of Mark's feelings to explaining that there were good reasons behind those feelings and that those reasons could be uncovered and resolved, 2) being "supportive," even physically through hugs at the end of the sessions, and 3) operating from a model of therapy which seemed to stress "the concept of people as living, feeling entities with feelings that can get hurt, and often have been hurt severely by various life experiences," from which followed the therapeutic approach of acknowledging and validating those hurt feelings.

Mark believed that the therapist's personal life might have had to do with his style. He stated, "I wonder if he isn't satisfying, maybe without realizing, trying to satisfy something in himself by the way in which he does therapy with people." He also remembered wondering, "What does he mean, what does [he] want exactly? To be friends?"

Mark wished he could have come out and said, "Well, this is how things are and I'm not comfortable with that," however he felt this would have been too threatening because "it felt like us working well together seemed somehow attached with us having
cordial relations." The therapy ended on Mark's initiative; he did not feel supported in his decision. The therapist said towards the end of the therapy that he felt Mark was "closing him out." Mark wondered, "What was he asking for?" Mark had put the therapy "on hold" during part of the 20 months while he did some couples therapy with his wife; after a while he decided he wanted to end the therapy (#7) altogether. Mark thought it was odd that the therapist was "comfortable ending things there without having a final session."

It sounds, from Mark's account, that the therapist provided something important for Mark, however was unable to remain outwardly separate enough from the process to allow Mark to make use of his new sense of self-esteem within the therapy. Nevertheless, I believe that Mark used the self-esteem he developed in the therapy to move away from the therapy and move on in his life (which, after all, is the ultimate goal).

Mark later reported feeling that he "tricked" this therapist (#7) into believing that his marital difficulties were entirely his wife's fault, and that this therapist's encouragement of Mark to demand more from his wife led to further marital difficulties and finally couples therapy. The couples therapy (Episode #8) occurred toward the end of Episode #7, and lasted for three months. We did not concentrate on the couples therapy during the interview as there were so many other therapies which Mark viewed as more central to his overall therapy experience.

Since the PSC therapy, Mark's father had been encouraging him to consider medication. Mark finally investigated this toward the end of Episode #7, and saw a psychiatrist (Episode #9) for about five months (for medication only). The psychiatrist prescribed Prozac for him, which Mark felt uncomfortable taking:
I didn't like the idea of being on medication and I felt I could do it on my own... I took umbrage at the fact that you can get kicked in the gut your whole life emotionally and then they turn around and go, "Oh, well here, take some medication to make you feel better." That's very offensive to me, very offensive.

I believe that this anger about the medication was directed at both his father and the medical/psychiatric establishment (he did not express dissatisfaction with the psychiatrist).

Due to these feelings about the Prozac, Mark discontinued with the medication and the psychiatrist.

Soon after terminating individual therapy (Episode #7) and beginning to take Prozac, Mark requested to be seen in therapy by the psychiatrist. Because he had no openings, the psychiatrist referred him to a few possible clinicians, one of whom he began to see in individual therapy (Episode #10). Mark asked that the psychiatrist refer him to a woman, particularly one who would be "cool" and "[have] that emotional distance."

This specific request is an interesting one to examine in light of his prior therapies and his feelings about emotionality and women. First, Mark reported on this request as follows:

[I] made a very conscious choice at that point to see a woman therapist, which I had been too afraid to do in the past -- I hadn't thought about the one way back [Episode #3]-- I just felt, I had so many issues with women and that were uncomfortable and hard, that weren't under enough of a leash for me to feel, they were too threatening. So at that point [I/it?] did feel comfortable so I went to her.

Earlier in the interview he had noted that, to him, women were "softer" and "more open emotionally" than men. Putting all of this information together, one possible interpretation is that prior to Episode #7 Mark had felt too frightened of what he saw as the emotionality of women, thus had avoided them as therapists; however, having learned some of how to relate emotionally to himself and others in Episode #7, he felt ready to take the step of
working with a woman. For this hypothesis to be valid, it would have to have been the case that Mark was able to hold onto the value of what he had learned in Episode #7 despite the negative experience with the therapist's "emotional stickiness" toward the end of that therapy. Indeed, Mark referred to Episode #7 as his "seminal work." Finally, the specification that the woman be "cool" may have been his attempt to control to some extent the inevitable warmth he expected to find in any woman.

Mark seemed ambivalent about the quality of the work he did with her, citing in particular a discrepancy between her "family therapy" orientation and his "psychodynamic, or inside [his] own head" orientation. Unlike at earlier points in the time line, Mark was able to "get a handle on that and be brave enough to say to her, 'Well, I don't think that's the way I see it or want to deal with it.'" Despite their differences, Mark described the therapist as being extremely supportive of his expression of individuality and independence. The therapy ended in the following manner: Mark went abroad for two months during which time he had no contact with the therapist (they planned to continue the therapy when he returned to the area). During this time away, he realized that he was able to cope on his own, and when he arrived home he told both his homeopath and his therapist that he appreciated what they had done to help him arrive at "a place where [he was] able to take over for [him]self."

He and the therapist met for two sessions to discuss this ending. During the first session he explained what was going on, and she was apparently very open to it and was "very helpful" about helping him end in a way which felt comfortable to him. She offered to refer him to a more psychodynamically oriented therapist, or to continue in a different way (for instance, by including Mark's father in the therapy), though it did not sound as
though Mark felt pressured to do any of these things. Mark and she instead settled on meeting five weeks in the future (which happened to be three days before this research interview took place) in order to "touch base" and confirm his decision to stop. They in fact followed through with this plan; thus, as of the interview Mark could (and did) declare himself "therapy free."

One theme which appeared repeatedly in Mark's history was that he felt misunderstood by many of the therapists he had seen. Mark emphasized the importance that therapists "look at the person for where they're at, or try to see the person for where they're at . . . and look at themselves and be observing their own models of what they've settled on for how they do therapy . . . " In his case, a frequent complaint he had about his therapists was their use of a reserved demeanor: "[Therapists] may feel comfortable being reserved but they should also know that that is one among many choices." He believed it to be detrimental to "lock onto one concept of professional reserve and use it for all clients, even if you're one therapist." I believe he saw their reserved demeanor as preventing them from doing what his seventh therapist finally did: "Why didn't they just say what [the therapist from Episode #7] ended up saying? . . . What's the big deal about saying that? . . . Is that unprofessional?"

Another complaint which seemed to reflect his feeling of being misunderstood by therapists was that he felt they pushed him through therapy too quickly: "It's like everyone wants to sweep you along to the next grade and just promote you to get you along, you know, and who is there who really cares about you?" He also wondered about some of his earlier therapies, "What they were seeing, that they didn't say, 'Gee, Mark, you could use some more in-depth professional help.'" Particularly bothersome to him was the
university counselor who ended the therapy by saying that he felt Mark was "basically self-correcting."

Another central theme was that Mark felt there was more to his "psychotherapy history" than just psychotherapy. To him, spiritualism was "in the center" of his growth process; in addition, his homeopath seemed an important figure in his life as well. During the follow-up interview, Mark said that part of the reason he had agreed to participate in this study was out of his desire to "share how central spirituality is in [his] 'psychotherapy' experience." Reflecting on his growth and the sources which had helped him along the way, he said he had eventually "gotten the whole; this from him, that from him" (one person he was particularly referring to here was Ram Dass, with whom Mark had spoken; he termed their exchange "a real gift"). Finally, Mark did not overlook himself as a primary source for his growth. He stated that part of the reason he had ended his last therapy was that for the first time he felt: "Nobody's going to rescue me, I have to rescue myself."

Mark's therapy status was changing significantly at the time of the interview -- he was just leaving a long-term therapy with no plans in the near future to seek therapy again. His statement that "nobody's going to rescue me" may have reflected some a recent change in his thinking about therapy. It is possible that earlier in his therapy history he had had hopes of getting from psychotherapy what he felt he had missed in childhood. He noted that he had never received from his parents "a framework for any adult or any person in my life actually wanting to know about me . . . or actively caring about me, I mean to the critical mass that I needed to accrue self-esteem and be a healthy person."
Although he made it clear that he felt he had received some of what he needed in therapy, I believe Mark also felt some disappointment regarding what psychotherapy does not have to offer him and how much of the work is his alone. At one point he said, "[W]ho is there who really cares about you? . . . And, you know ultimately nobody does except for you really, nobody can except for you. But that's a real, real tough realization to come through to." He then added, "A lot of us come to that [realization] and then feel bitter about it, right?" At the time of the interview, he seemed accepting of this state of affairs and pleased that he could finally come to this realization.

Although at the time of the interview it seemed important to Mark that he was "therapy free," one piece of what he said made me think it would not be too long before he returned to therapy. That piece was his description of how his most recent therapist had suggested a four week period before their final meeting, and he requested they meet in five weeks instead, "just to give [him]self that extra little week." I am not clear on exactly what it was that he liked about the "extra little week," however to the extent that he thought this week might make a difference in whether he wanted to continue with therapy, I am willing to speculate that he might have changed his mind in coming weeks or months.

When we discussed his thoughts about therapy use in the future, Mark said he would be open to going back for certain things: one would be "handholding" and the other would be if he needed a certain "tool." In general, though, he said, "I feel it would be a mistake, after accepting myself as my teacher, I can't go back to seeking from others." I think that he might have been saying that the breadth and/or depth of what he was seeking from earlier therapists is no longer something he expects from therapy; nevertheless, asking for smaller pieces from others remained acceptable to him.
As a final note, Mark did not want to rank his therapies in order of importance. We did not discuss why this was, however my impression was that he felt it would not be a fruitful way to look at his therapy history. Instead, he used the time to discuss his view of the importance of spirituality in his therapy experience.

Amy

Amy was a 26 year old woman whose therapy experience at the time of the interview spanned 15 years (see Figure 8). During this time she had been to one family therapy and three individual therapies. Her most recent therapy had ended approximately 18 months prior to the interview.

Amy was unsure what constituted her first therapy contact. She recalled going to the guidance counselor in fifth or sixth grade:

I think everybody had to go and see the guidance counselor . . . to see what was going on, but I don't think a lot of people actually did, when I stop and think about it. I don't know what was going on. Maybe they just came [and] asked me to see if I was well adjusted or something like that . . . . Because I was always supposedly a gifted student, anytime I was called in for going to see a guidance counselor, I always thought it had something to do with my academics, so whether or not it had to do with something calling in or home or whatever, I don't know.

She seemed to entertain the possibility that there had been a psychological aspect to this visit, and certainly the difficult childhood circumstances she described make this plausible. I wonder also how much of her speculation might have arisen from a fantasy of wanting someone to notice that something was wrong, a desire she stated when discussing her family therapy experience below.

Her family therapy (Episode #1) occurred around the same time as the possible guidance counselor contact above; she was between 10 and 13 years old at the time. The identified patient for this family therapy was the younger of her two brothers (both are
Figure 8. Amy's Time Line. These are best estimates of the number and duration of mental health services reported by Amy during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only.
younger than she). He had told a guidance counselor at school that his step-father had molested him, and the guidance counselor pursued therapy for him. The ensuing therapy began with his mother, father and himself. At some point after the beginning of therapy, Amy and her other brother (the two children living with their father) were brought into the therapy, in what Amy described as a "sneaky" way.

Amy recalled her introduction to the therapy: "[W]e were driving down the highway, [and] my father says, 'Oh, by the way, we are going to therapy.'" She also remembered her father "wanted to make sure we understood that the reason [he and their mother] divorced was because of adultery on [her mother's] part." This piece of information put Amy in what she called a "weird quandary" because she was being sexually abused by her father at that time. To add to the confusion, they arrived at the therapy session to find their mother (whom Amy described as "estranged") there as well. This shock seemed to add to her overall sense that this first therapy experience was a painful one for her personally.

Amy expressed the hope that "the field" has progressed since the time of this therapy and that in the present a therapist would not subject a child to the same treatment that she had received. In particular, she felt the therapist should have met with each member individually before putting everyone together. With such a meeting, I believe Amy felt she might have had a chance to 1) understand what the rules of therapy were (she noted in particular that she didn't understand about privacy and "being able to say anything"), 2) feel more comfortable and trust the therapist, and 3) safely disclose the sexual abuse she was suffering. In addition, she may have felt that a different introduction
to the therapy could have prevented everyone from "clamming up," which she saw resulting from the "shock" the family felt upon being "thrown together."

Amy's desire for such an individual meeting with this therapist and a better introduction to the therapy may have also been an expression of her more general wish that this particular therapy had better addressed and respected her as an individual. At one point in the interview she said:

[I]f I could find that first therapist and go through her records, she might have written down, "It was a wonderful session and everybody did great," or that, "it was a terrible session and everybody did," you know, "they need more help." But for me as a person, as an individual, those two were not good experiences.

Amy also wanted to be "treated special" [sic] the way her youngest brother was: "It was like he was getting special treatment and I wanted some of that, too." I think this latter expression is probably a typical one for a child in such a situation, but what is more interesting about it is the possibility that this frustrated desire for individuality in an early therapy might have affected both her global view of therapy and her subsequent therapies specifically.

Amy described the therapist as "acting like a buoy" between the family members. The therapist not only seemed "false" to her, but also appeared to have "no idea what was going on." Amy felt the therapist was continuously "prodding" her, and finally Amy blurted out to her mother, "Why didn't you take me [to live with you]??" When she was asked in the therapy why she had said this, she simply could not tell everyone that her father was molesting her. She recalled, "I wish somebody would have read my mind and figured something out, but they didn't. And nothing happened." Amy looked back on the therapy as a permanently damaging experience for her. She described her view of the
method of the sessions as, "It was just peel back a layer and- I don't know why the counseling stopped..." It sounds as if the therapy made things feel more painful and raw to her and then arbitrarily stopped, leaving her to her own resources.

In addition to the therapy failing Amy, it also proved unhelpful for her brother's problems. Amy reported, "My brother was still fucked up; he is still fucked up. Nothing came of it." Amy felt negatively affected by the therapy's lack of success with respect to her brother's problems; she reported that when he moved back to their father's after the therapy ended, their home life disintegrated. It sounded as though she attributed her brother's moving back in part to the therapy (in answer to my question regarding how the therapy ended, she said, "I have no idea about that. All I do know, is that several months after that he moved back in with us.").

Amy's theory as to why the family therapy stopped was that "it didn't seem like progress was being made." She believed the family was looking for a "quick fix" and decided things were "all better" when that quick fix did not occur. She was unsure if the therapy ended for her brother at the same time as it had ended for her.

Amy noted that the family therapy affected her later help-seeking. In the abstract, Amy wondered if the experience had "scarred [her] to where [therapy] can't do anything" for her. More concretely, at about age 15 or 16, Amy was suicidal and wanted her parents to take her to therapy; however she "shied away from that therapy thing because [she] didn't get anything from [the family therapy]." Her desire to go to therapy remained until she moved away from home at age 17, at which time "it all started fixing itself."

At age 25, Amy sought out therapy on her own initiative (Episode #2). Amy appeared to have difficulty in the research interview describing what she was seeking from
the therapy; on one level the presenting problem was a career decision, on another it was a broader and/or deeper problem. Regarding the career decision level, Amy was in her second semester of graduate school and was feeling "frustrated" and "scared" because she was questioning her choice of graduate programs. She said:

I knew that I couldn't ask a total stranger, a therapist to say, "Oh, this is what you are supposed to do." But I was looking for a separate person, a neutral person, a sounding board type of thing, someone who could help me better see things from a more objective point of view and then determine what was going on.

She also stated, "[I wanted someone to] help me make a list and point out my good points and my bad points, my strengths and my weaknesses, and try to figure out where I wanted to go." When she described the presenting problem on this level, it sounded to me like she thought she ideally should have been able to get what she needed from the university's Career Counseling Service and/or her academic department. In fact, she had been previously dissatisfied with both of those sources so she turned to the university's Mental Health Services Center.

At another point in the interview she described something that sounded more deep and pervasive than the above presenting problem:

It felt like I had black icar in my head and when I felt like that, I knew it was time to- that I couldn't get rid of it, I tried to get rid of it. I tried meditating again, I tried doing all this other stuff. Basically I'd gotten out of practice, which is why it's all built up . . . . It's like having black syrup burning around inside of your head, it just goops everything up like bad oil. I needed an oil change.

She went on to explain that this was the reason she went to the Mental Health Services Center first, rather than to Career Counseling. Her inconsistency in describing her presenting problem during the research interview may indicate that she was still confused about what the problem had been (or continued to be) at the time of the interview.
The psychiatrist who saw her at the Student Mental Health Center referred her for longer-term therapy after seeing her for one intake session. Amy had only expected that she might need about two weeks of therapy. This referral added to her feeling that "everybody was trying really hard to get me into therapy . . . and that's not what I was looking for." By using the word "everybody," she seemed to be including her stepmother, who had encouraged her to seek therapy because she felt Amy was "looking for love in all the wrong places," and her departmental advisor, who had agreed with Amy that it might be a good idea and relayed his own story of a useful past therapy.

Amy reported that seeking out therapy this time was "very difficult because of the previous bad experience." She went on to describe her ambivalence about the psychiatrist's recommendation:

It was very difficult to look for help, and then when I finally did it, I thought I was on the right track and a part of me knew and understood that these guys know more about this stuff than I do, so I should just follow through with what they are saying.

"What they were saying" was apparently that she could benefit from long-term therapy.

Amy said there was another side of her which disagreed with their assessment. This part of her said:

But they don't know you. And you are the one who has to figure this stuff out . . . . They might know how somebody thinks but what's it going to take for them to get to know you, and do you want them to get to know you? Because that's so weird . . . . I just wasn't ready to give up [my] privacy, and that's what made me say, "Figure it out. It will figure itself out."

Mixed in with the above conflict was her feeling that the reason this psychiatrist was recommending long-term therapy was related to money. Although she said this with a hint of sarcasm, she continued:
The money thing works out to be a big factor, because I don't have much and I paid into medical insurance and I come to find out that the one thing that's going to really help to keep me healthy is to try to figure out what is going on up here, they are not going to cover it because it's not psychiatry.

It upset her that what she saw as possibly preventive work (talking to a therapist rather than "driving [her]self crazy by continuing to sit in depressive bad thoughts") was denied, and what was suggested instead was that she pay money on top of her insurance to see someone not covered by her insurance. It is unclear to me how much of her refusal to take the referral was because of resentment of the system, and how much was her inability to pay.

Although this help-seeking experience sounds like a very negative experience, Amy felt very positively toward the psychiatrist himself. She said, "He was very warm. I felt like I could have real confidence in this guy. There was just some kind of nice initial thing with him. I don't know how to explain it, I just had a good feeling." She recalled that he had a painting in his office which reminded her of her religious roots, and he had books in his office which led her to think, "Hey, I've got these books. This guy has read this stuff. This guy is going to understand, have a general better understanding of where I'm coming from. . . ." In addition, she reported that he reminded her of her uncle, who is also a psychiatrist.

Apparently Amy asked if she could work with him, and he said this was not possible. It was her impression that because she was presenting with "confusion" rather than "mental illness," she was not "sick enough" to be seen by a psychiatrist. Though she felt "rejected" by the system, she did not seem to blame the psychiatrist; this attribution appeared to allow her to regard the therapy and the therapist positively despite her feeling
that she did not receive what she had sought. Amy described the episode as "moderately helpful," explaining that she "didn't feel more confident about what [she] was trying to fix, but felt more confident about taking that step to actually try to fix it, which, compared to the first experience, that was good."

Amy described her plans for further therapy upon leaving this psychiatrist's office as follows:

That eventually I'd do it, you know there's still that back of my head saying, 'This is bullshit,' but the other side of me, I came out of there feeling a lot better about, "Well, maybe I could do this." . . . [A]nd knew that I was eventually going to have to do something to deal with some of this stuff. . . .

She clarified "this stuff" as referring to underlying difficulties related to her step-mother; it was unclear whether also included was the sexual abuse which she believed clinicians (except for the family therapist) had been pushing her to examine throughout her time line.

Amy waited another year before seeking help again. She returned to the university's Student Mental Health Center (Episode #3) and had a visit with the same psychiatrist she had seen a year earlier (she described this as a coincidence). Her reasons for seeking help sounded identical to those from the previous attempt; apparently she had been able to cope during the intervening year until things "built up" again. Amy said her goal this time was to "understand how to deal with the frustration and anger [she] was feeling while going through those last four to six months before [graduate] exams." She described the way she presented herself to the Student Mental Health Center this time as follows: "I went in to say I've been here and never followed through but now I've decided I really need to do it." I believe this suggests an implicit consent to the long-term therapy
the psychiatrist had recommended a year earlier. Seeking help this time was easier than the last time for Amy, however she still felt conflicted about it.

The meeting with the psychiatrist was a short one in which he again referred her to a few fee-for-service agencies in the area. She tried one of these agencies which a friend of hers had also recommended, but found they were full. Next, she turned to the PSC.

Although Amy expected to stay in therapy through the semester (about four months), the therapy at the PSC (Episode #4) lasted for only six weeks. She left because she felt they were not focusing on what she came in to discuss: her feeling taken advantage of by her students, the lack of support she was receiving from departmental faculty, and more general problems dealing with conflict.

Amy explained what happened in the therapy as follows:

[The therapist] was trying to find the source of my anger and frustration due to what had happened in the past, and at first I let it happen, I let it go on and I spilled my guts about my childhood and stuff like that . . . but it was actually the third or fourth week I realized, "This is not dealing with what I wanted it to deal with."

At this time Amy was still struggling with her feelings of anger and frustration. She continued:

I may have offered the information, about my having been molested, sort of like I offered it to you so you could understand why I was so frustrated with those first [family] counseling sessions because I couldn't say it . . . . I sort of felt like it was my fault because I went in with this one idea and I ended up saying stuff and I think she took it and she ran with it and went the other way and I was still wanting to go in the other direction.

It is easy to imagine a therapist interpreting this disclosure as indicating that the issue needed to be addressed. There are certainly clinical reasons why a therapist might believe this sexual abuse was tied to her current difficulties with anger, conflict, and
feeling used. Finally, I would speculate that Amy was somewhat aware of the flags that might arise in a therapist's mind upon hearing such a disclosure.

Amy reported that she asked the therapist why they were talking about these issues, and the therapist responded that getting to the "root of her problem" would be helpful. However, Amy also stated that she was unable to openly discuss with the therapist that this was not what she wanted. Therefore, I would infer that part of the therapeutic failure was due to a lack of clear dialogue within the therapy (for whatever reason) regarding the client's dissatisfaction and the therapist's expectations.

At the time this therapy ended, as well as at the time of the research interview, Amy was adamant that she had "overcome" her earlier abuse and firmly believed that it was "not necessarily the root of the problem." She said she "deals well in the world," and explained that she did not have "flashbacks" nor was she "debilitated" by what had happened. At one point, she also stated that there was something to be gained by keeping the experience accessible in her memory so that she could draw on it:

I wish it had never happened, I wish that I could totally black it out and forget it, but I myself know that in remembering, that I will never do it and I will do whatever I can to prevent it from happening to other people.

On the other hand, she said, "So when this stuff came up in the third session, it was like, "I haven't really dealt with this, I don't want to deal with this, I don't need to deal with this." My interpretation is that at the time of the ending of this therapy, as well as in the research interview, Amy felt conflicted about approaching the topic.

With respect to the PSC therapist as a person, Amy did not feel the same sense of "connection" she felt with the Student Mental Health Center psychiatrist; she did, however, describe the therapist as "nice." Amy may not have felt in the most expert of
hands:

What she did reminds me of what my ex-boyfriend did . . . . He started studying psychology, and then he started trying to put me through psych sessions, trying to counsel me himself, and he was trying to call up stuff much in the same way that she was calling up stuff.

When I asked what she thought might have happened had she been able to see the psychiatrist instead, she replied:

At the risk of stereotyping people, I think I would've gotten along and been able to make my point clearer about what I was going through if I had talked to -- this is going to sound so ridiculous -- a black female counselor . . . . I don't know what this woman's background was, but I come from a background of pulling myself up by the bootstraps and doing things myself, and I don't think that this person understood that.

In fact, not only did she feel misunderstood, but used:

I didn't think this at the time, but I've had a year and a half to think about this. I think she was trying to find something else, for her own research and for her own understanding of what psychology is.

However, in response to my question of whether the psychiatrist could have given her what she needed even if he had not "pulled himself up by the bootstraps," she suggested that his experience could have compensated (whereas her PSC therapist did not have a great deal of experience).

This is an interesting case to speculate on with regard to recurring use of psychotherapy and what the future may hold for her, since in the first therapy she was "unable" to talk about the abuse, and in this therapy she disclosed it very early on and then is "unable" to continue the therapy. Rather simplistically, Amy seems to be (potentially) gradually approaching a longer-lasting and/or deeper therapy. Amy would likely disagree with this assessment, however, out of her belief that "I don't need to remember it, I don't need to work it through."
Amy's global view of her therapy experiences was as follows:

[There were] two big ones (Episodes #1 and #4) and the second one in the middle (Episode #2) was sort of like a transition period trying to figure out if I actually wanted to go back into therapy because of that experience [in the family therapy].

She left out Episode #3 which seems understandable given that she really used it as a referral (this again brings up the question of how to properly define one episode; perhaps #3 and #4 should really be viewed as one). She described them all as "good learning experiences," even the family therapy:

[The family therapy] was an introduction to the fact that it [therapy] does exist . . . . The second and the third fit together because one led to the other . . . . The second one resulted in the third one [#3 and #4 together] actually occurring, the realization that, "Yes, help can be provided for you." . . . Because the first [family] one had me thinking, "This sucks."

Amy's responses to my request that she rate the therapies in terms of their importance to her, led to an interesting exploration of the different ways a therapy can be important. She seemed unsure what to do with this question: at one point she said, "They were all important . . . I got the most positive response out of the second one, and the other two [Episodes #1 and #4] were negative." After further questioning she stated that the family therapy (#1) was the most negative experience, followed by the PSC therapy (#4). The negative experiences were important because they taught her that "there's good, bad, and ugly. I've learned what to look out for." It sounded as though she believed that learning that there is bad therapy in the world is an inevitability for anyone seeking therapy, and she was "glad" that she could learn this and go on to (possibly) find a better therapy experience.

Perhaps there was also a feeling of pride, similar to her pride in pulling herself up from her childhood, in her persistence to see her way through a bad therapy experience.
and get herself to a better one (from Episode #1 to Episode #2). This hypothesis is supported somewhat by her statement that:

A part of me could say, "Well see, after the first experience you're absolutely right about this whole thing, it's all bad, it's all negative, they all try to think back to what happened to you when you were twelve, and sex is at the base of all this other stuff." But the second one- [and she cuts herself off in mid-statement].

I think a plausible end to this sentence is "but I didn't give up that easily." Of course, this is speculation.

One other dimension of her discussion of the importance of a therapy episode concerned the difference between whether a therapy was important in terms of later help-seeking versus important in terms of giving her what she was seeking. While above she said they were all important in terms of guiding her in further help-seeking, she just as confidently stated that she got "squat" from all of them in terms of what she was seeking: "I got nothing, which is a big disappointment."

Twice in her account Amy associated the attempts of loved ones to make changes with more formal psychotherapy. While relaying her story of the "sneaky" way the family therapy had been introduced to her, she was reminded of "one supposed therapy session" that happened at approximately the same time as the family therapy. Amy recalled that her father had sat down with her brothers and herself and asked them to talk about their step-mother to "try to find out the truth of how [they] felt" about her. She continued, "All of the sudden I looked over and saw the tape recorder was going." Then she "clammed up." When she asked what he was planning to do with the tape, her father apparently said that he was going to play the tape for her step-mother. Her summary of the episode was, "My father was trying to get us to open up, but it backfired in a big kind of way."
Amy reported another "pseudotherapy" was the episode described earlier where her ex-boyfriend tried to "call up stuff"; this one she remembered while she was describing her PSC therapy. That she remembered these events in relation to her psychotherapies, as well as associating them with therapy by calling them "pseudotherapy" and "supposed therapy session[s]," indicates that incidents like these can have a bearing on an individual's use and experience of formal psychotherapy.

Amy tended to think of therapists as people who are possibly malevolent and do not have her best interests in mind: they do not hear her presenting problem, they do things in therapy which were for their own research and education, they would laugh at her idea that she does not need to "work through" her childhood trauma, and they all want to go back to "what happened to you when you were twelve and sex is at the base of all this other stuff." Therapists' concern with earning money also seemed part of her suspicion of their motives:

Going back to the money side of it, not only am I a client, but I'm a customer . . . . When you pay for something you expect something back, you expect what you've paid for. And as much time as it may take to get what you want, then you have to be prepared to pay, and the person that really wants that will pay because that's the only source, the only resource to get there.

It sounds as if she felt that the system has put up money as an obstacle, that the therapists in the system will not help clients until they have earned a certain amount of money, and that she in particular is targeted because of her difficult financial situation. Finally, Amy stated that, "I think I could've worked out a lot of different problems, if, like I was saying earlier about the insurance thing, [the therapy with the psychiatrist] had been covered."
Another central point in Amy's history was her belief that she had done her own "self-therapy" by moving out of her family's house as soon as she was old enough. Along these lines, she said:

At the risk of dissing your trade, the world out there has been my best therapist, just learning how to deal with it. And good friends who can just listen, be good sounding boards, just to get it off the chest, then go out and try again.

In the back of her mind seemed to linger the idea that therapy is not always something one chooses. While describing the circumstances under which she would seek out therapy in the future, she included the following statement:

I think the whole idea for me, if ever I was to seek therapy as opposed to being told by a court that I have to get therapy for whatever reason, the difference between the two, I think for me it would be looking for a sounding board and a mediator. ... I wonder whether this is a consequence of feeling pushed into therapy in a variety of ways: the first guidance counselor contact was not self-sought (if it existed at all); the family therapy was sprung upon her and was not "for" her; a number of people were either encouraging her to go to or continue in therapy. It also seemed as though some of this "seek therapy" voice had been internalized; at one point in the interview she sounded as if she were describing another incident where someone was telling her to get therapy, and then clarified that it was not someone else telling her, it was she herself.

As for her plans for therapy, Amy said that if she "ever feels the need to go back to therapy," she will look for someone like the Student Mental Health Center psychiatrist she saw: "Just the whole idea that finding that one person whom I could have a confidence in, that's important." She also explained:
I'm going to shop around next time, and if I walk into a therapy session, if I don't feel comfortable with that therapist in the first time, I'm just going to say, "I'm sorry, I don't thing that this is going to work."

This indicates that what could be called her "corrective therapeutic experience" (Episode #2) persisted despite negative therapy experiences both before and after it. Perhaps more surprising is that despite the fact that she believed she "got nothing out of all three of [these therapies], as far as what [she] was seeking," she still believed there could be a place for therapy in her future, perhaps solely because of this one good connection she had made with the psychiatrist (although it is also possible that she would still feel therapy could be potentially beneficial even if all of her experiences were completely negative). At the time of the research interview, Amy had no current plans to seek therapy.

Rita

Rita was a 20 year old woman whose mental health service history began at the age of seven or eight, encompassing 17 contacts (see Figure 9). The variety of services Rita received was greater than any other participant. They included one hospitalization, one shelter program, four family therapies, three group therapies, one medication-only contact, and seven individual psychotherapies. Her last therapy ended four months before the research interview.

Before presenting Rita's psychotherapy history, there are a few points which I should make clear about my view of her overall presentation. Rita's interview was unlike any of the others in that she seemed to have difficulty focusing on the task at hand. In addition, I have more familiarity with her PSC therapy than with the PSC therapies of the other participants. We spent the least amount of time summing up her global view of therapy as she seemed to have difficulty detaching herself from other issues enough to
Figure 9. Rita's Time Line. These are best estimates of the number and duration of mental health services reported by Rita during the interview. Circled numbers correspond to the Episode Number in the text. The duration of an episode is noted in terms of number of sessions (i.e., 3X = 3 sessions) or, for longer therapies, in terms of weeks, months, or years. When known, non-weekly meetings are noted (i.e., 1X/mo.). If the service received was other than individual outpatient psychotherapy, the type of service is noted as follows: (C) = couples therapy, (F) = family therapy, (G) = group therapy, (H) = hospitalization, (M) = medication only. In Rita's case I have added (I/F) = mixed individual and family; and (S) = shelter program.
speak of therapy in the abstract. I found her accounts of individual episodes to be fairly shallow compared to those of the other participants; it was also more difficult than with the other participants for me to feel confident about her sincerity.

The interview seemed to contain a number of stories with "shock value" which were fairly tangential to the stated focus of the interview. For example, Rita told of a therapy which took place in fifth grade in which she had been playing with a Raggedy Andy doll and decided that the doll had "a different blood type in each limb." She went into detail about how she had used a syringe to check all the blood types, and she gave him shots so that he was "half and half" for a while and then "finally he was OK."

Toward the end of the interview, she rolled up her shirt sleeve to show me a scar on her arm where she had cut herself three years ago. Upon her statement that "it would take a lot to get me back into therapy," I asked her whether, if she were to feel suicidal again, she would go back to therapy. Her reply was as follows:

Nope. I am right now, nope. Cause, I know I won't. It's like I get really self-destructive and really violent, I'm not going to commit suicide and I'm not going to kill anybody, so, I've never done, killed anybody before. I just keep thinking about it, and I'm like, nope, bad idea. Because one, it's not fair to the person and two, jail looks a lot worse than where I am right now. Cause I don't think, I'm not good enough to not get caught.

When I followed up with her about feeling suicidal at the present time, she stated that she had decided "physical harm is not an option" and softened her language on the topic considerably.

In addition, Rita made a number of extraneous comments deriding her mother and her mother's extensive use of therapy. She described her mother as a "wicked unique case" and seemed to want me to follow up and ask for clarification about what was unique
about her. When I asked her toward the end of the interview to look over her time line and tell me what impressions she had of therapy in general, she replied solely in terms of her mother's psychotherapy rather than her own:

Therapy is something that some people need and some people don't. And different people need different kinds of therapy. My mother, I think, should be done by now. She's like, she's been in therapy so long she doesn't see how she can live without it, and it frightens; she keeps creating reasons to be in therapy. And she really could move on with her life, at this point. Except, if, if she was willing to, but she's not. She doesn't have the social skills she needs to just have friends. You know, she can't be with somebody for any length of time without telling them her life story, which scares most people away; you don't share yourself that openly with people, especially if you've only known them for two months.

The content of this statement may also reflect on her views about herself, however I do not know enough about Rita to do any more than speculate on such a possibility.

Despite the differences between this interview and the others, I have put together her mental health service history in much the same format as the others. I hope that clearly stating my perspective will shed light on the flavor of this story as it contrasts with the preceding ones.

Rita's first therapy experience (Episode #1) was a family therapy which occurred when she was in second or third grade. Rita recalled that the therapy was initiated by her mother:

I guess she'd just gotten a divorce and got remarried and she wanted to make sure, you know, the kids were OK, so my brother and I went in and we were like, "What do you mean, why would it be our fault, I don't understand." And they said, "You kids are fine, never mind." That's what I think that was about.

Thus, the therapy lasted only one session.

Rita described the therapist as "a pretty nice guy." She did not remember a lot about this therapy, but believed that it was not at all difficult for her to go there. She also
stated that having the therapy end after one session was "fine." Rita rated the therapy as "neither helpful nor unhelpful" and explained that "it kind of wasn't anything."

The next therapy (Episode #2) was two to three years later, when Rita was in the fifth grade. It began as follows:

My mom decided that [my brother] and I should probably be in therapy, she'd been in therapy for a couple years and she was going through a really rough divorce . . . and so they wanted to have us see somebody for a while.

Both she and her brother attended individual therapy with different clinicians at the same clinic.

Rita stated that it was fairly easy to go to the therapy, however she also noted that she was "nervous at first, [she] was afraid of being molested or something, after all the stuff on TV." She said she "insisted on having a woman so [she'd] be OK, and it ended up being pretty neat." When I asked her to describe what made it "pretty neat," she explained:

I'd get to go in and play with toys. They had like a lot of stuff, I remember talking, and then she decided we were going to do a time line of my life, of stuff that had happened, and she discovered my memory. I started putting down pretty much everything that had ever happened that I could remember and I'd go back and [unintelligible word] stuff and she finally gave up.

Rita also stated that this therapist "listened really well" and that they were able to talk fairly openly. She rated the therapy as "kind of helpful."

Both Rita's therapy and her brother's therapy ended after one year. Rita recalled, "They said, 'We've never worked with any children for over a year, more than a year. You two have been in here the longest of anybody we've ever worked with. You must be all better by now. Bye.'" Rita stated that this "hurt" and was "hard": "I didn't like that at all."
During and after Episode #2, Rita was seeing the school counselor both individually (Episode #3) and in a "miniature group" (Episode #4). We did not concentrate on these two episodes as Rita did not feel they "counted": "I keep dismissing my school therapy kind of things because it doesn't really count." It did sound as if she sought out the therapy herself because "it seemed like a way to be special," however she also made note that she "didn't have much choice" in going to therapy: "They'd send down a slip saying, 'You're coming in today.' And I'd be like, 'Oh, OK.'" With respect to this and other therapies, it is difficult to distinguish the factors which led Rita to therapy.

When describing the individual therapy with the school counselor, Rita said:

He decided I, I, every now and then I talk, like my voice shifts over to like a younger kind of voice, and he told me I should stop without trying to figure out why I did it. He just told me I better cut it out.

Later in the interview, Rita agreed that some of her therapy seeking had been "attention seeking"; I assume that this therapist's reaction to her behavior was unsatisfactory for her in that he did not respond with the kind of concerned attention she may have desired.

Her description of the group therapy in school was quite perfunctory and superficial: "You take an office about half the size of this, put in a desk and a large bookcase, about three or four girls in here and a guy, it was kind of crushed." She stated that this therapy ended when she "graduated from elementary school."

In the sixth grade, Rita was in another group therapy (Episode #5) which she believed followed from the termination of Episode #2. She recalled that both her brother and she were moved on from their individual therapies into group therapy when the clinic terminated with them both and stated, "OK, we're going to put you into group therapy now, we think you're ready to move on past us to something else."
Rita recalled being beaten up by other girls in the group and the therapist being "very weak and very easily intimidated" and not intervening to stop the abusive behavior. She experienced group therapy as a place "where everybody's allowed to go in . . . and attack each other." Rita rated the therapy as a "little unhelpful." The therapy ended after about a year when Rita and the other members of the group decided "it wasn't really convenient" to meet anymore as they were moving on to junior high school. Rita believed that the other members of the group did not like this therapist either.

Her next therapy occurred when she was in eighth grade (Episode #6), and while it began in an individual format, it soon turned into a family therapy (this is another example of an episode which could be considered two episodes; I am following Rita's discussion of the experience by treating it as one entity). This was a therapy which Rita said she sought out herself (though Rita also noted when recounting this therapy that her mother "thinks that therapy is the best thing since sliced bread and that everyone should be in therapy"). Rita's stated goal was to "magically be better, I'd magically get better and people would like me."

The therapist she went to was a woman that her mother "sometimes saw when her therapist was away on vacation." Rita recounted the therapy as follows:

I went in to see this woman and it was just, it started out as OK, I could go in there and talk and she's like, "Well, you talk about your mother a lot, let's bring in your brother and see what he thinks." So my brother and I went in for a few sessions and talked about our mother, and she was like, "Well why don't we bring in your mother and see what she thinks." And suddenly I was in family therapy. You know, without having been told that it was going to be family therapy. And basically what was involved is we would go there and my mother would curl up in a chair and cry about how my brother and I didn't care about her at all . . . and then she'd go on like that for the entire session and then she'd clean herself up and get up and go home. And after a few months of this my brother and I started quietly starting to talk back, and you know we got a little bit more aggressive and finally
my mother said, "That's it, there's no more family therapy, you guys use it as an excuse to yell at me."

This sounds very much like Rita felt the therapy really became her mother's instead of her own. In addition, Rita reported that she later came to learn her mother had planned that the therapy eventually involve the entire family. The individual portion of the therapy lasted approximately two months, and the family portion was between six and twelve months. Rita rated this therapy as "very unhelpful."

Her next contact with mental health services consisted of attending one session of her brother's therapy (Episode #7). Rita recalled that her brother's therapist "wanted to meet the other members of the family." When she went to the session, the therapist suggest that she consider therapy for herself, to which Rita agreed. Rita's mother said she would talk to her own therapist about finding someone for Rita; the search for a therapist became a point of contention between Rita and her mother, as Rita wanted someone within biking distance from school so that she would not have to rely on her mother to drive her. Her desire was based on the belief that her mother would "blackmail" her if she had to drive her to the therapy.

As in Episode #5, the therapist chosen for this therapy (Episode #8) had some connection to Rita's mother. Rita stated: "[My mother] had never actually seen this person in her life. He knew practically nothing about my mom, except that my mother's therapist had consulted with him on what to do with her. . . ." Rita felt it was "pretty easy" to accept therapy at this time. She also said:

It was like, "OK, somebody thinks I need to be in therapy." And if you're in therapy you're special, you know. If you have to be in therapy then there's something up with you, you're not, my mother's big thing was, "There's nothing wrong with you really, it's all me, me, me, me."
I think this last statement is particularly informative of Rita's help-seeking in general; she stated in the next sentence that getting therapy was her "attention-getting scheme," and noted, "[it] didn't work." From what Rita told me of her mother's self-destructive behavior, Rita would probably need to go to great lengths to win more attention than that received by her mother.

Rita described the therapy as follows: "I went in and gossiped about my life . . . and I'd complain about my mother, and gossip about, like, guys, you know." When I asked if that is what she wanted, she replied, "I don't know what I wanted. I wanted to get better and I didn't know how to do it and neither did he . . . but it was somebody to talk to." She described him as fairly "active," and rated the therapy in general as "a little helpful."

Just over one year into this two-year therapy, the therapist suggested and Rita agreed that she should be hospitalized (Episode #9) due to her suicidality. She recalled that her mother was "very sad and upset and she's like [Rita said the following in a mocking voice], 'Oh, what have I done? I feel so horrible.'" Rita said it was "very easy" to go to the hospital because she "saw it as an opportunity." Rita felt that her week and a half at the hospital was very good for her. She described it as a place where she "fit in pretty well" and was given enough "structure" and "choice" to allow her to gain "some self-respect, some self-worth."

Rita received both individual and group therapy in the hospital.13 The individual therapist was "a complete loser"; Rita did not feel understood by this social worker. She

13 These therapies could potentially be considered separate episodes in their own right, however we discussed them fairly separately in the interview.
particularly noted that the therapist did not agree with Rita's assessment of one of her sexual encounters as a rape. However, she felt quite positively about the group therapy at the hospital. She recalled that it was better than her previous group experiences, in that people did not "attack" each other, there was some focus to the groups, and she was able to "learn about other people and things that happened to them in their life." Rita rated the hospital stay itself as "moderately helpful," however also noted that the effect of the hospitalization on her relationship with her mother and her life in general was detrimental ("it really caused a lot of havoc in my life as well as my mother, like my relationship with my mom").

Rita wished she could have stayed for another two or three weeks at the hospital, however her insurance company would it. Instead they gave her the option of going either to a shelter program, or to a hospital at which Rita believed the quality of care was much poorer than the first hospital and that she "could've been in there for a couple months." She was not allowed to return home immediately.

Rita chose the shelter (Episode #10), which turned out to be a fairly negative experience for her. She stated, "When I was in the shelter program, everything that I'd been able to achieve in the hospital, which had been a lot for being there for a week and a half, got crushed completely, I lost everything." The "house parents" at the shelter were "hypocrites" in Rita's eyes, though she did not describe what made them seem this way.

During her three weeks in the shelter, she received family (Episode #11) and group therapy (Episode #12); both of these continued after she had left the shelter (they
each lasted approximately two months). One of the co-leaders of the group therapy was also the family therapist.

Both therapies sound as if they were relatively mandatory. Rita explained:

The family [therapy] was not of my choice, but the group was kind of, it was kind of offered to me as a choice. I don't know what they would've done to me if I'd said no. So it seemed like a good idea at the time so I said, "OK."

Rita's brief description of the family therapy sounds very similar to Episode #6:

[The therapy] was very bad. And it ended for the same reasons as the first family therapy had. My mother said, "You use it as an excuse to yell at me and tell me how horrible I am." And I'm like, "Well you do the exact same thing there, but I won't be able to tell you that, because you won't listen."

As for the group therapy, Rita reported it in similar terms to the hospital group by saying it was "useful because none of the girls were out to attack any of the others"; however, she also noted that "nobody got much of anywhere." The group was apparently for girls who had been physically and/or sexually abused. Rita was not clear on why the group therapy ended, however she explained that "it didn't really matter" to her that it ended.

Upon leaving the family and group therapies, Rita continued with her individual therapist (Episode #8 was ongoing) until the end of high school (approximately another six months after the family and group therapies ended). At this point in her life, she felt some confidence about going off to college, and believed that her mother was "not being quite so hard on [her]." Thus, she did not report this being a difficult ending for her.

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14 Episodes #10 - #12 could be considered one, as the hospital episode incorporated the therapies which occurred during the hospital stay. However, I present them separately here so that they could be more accurately represented in Rita's time line.
Toward the end of her second semester of college, Rita sought out therapy at the university's Student Mental Health Center (Episode #13). She explained, "I was in bad shape again. I was like really stretched out and stressing and I was still having problems with sexual relationships and wanted to be able to not have them anymore." Seeking help this time was "harder than before" (but still "fairly easy") because Rita worried that she might tell the therapist her problems and the therapist would respond by sending her to the hospital.

This therapist Rita "liked a lot"; she found her "easy to talk to" and "very helpful." What she particularly liked was that the therapist pushed her to talk about things and saw through Rita's resistance to discuss certain issues. Rita noted that in therapy she generally tends to "go in to gossip unless the person cracks down on me, and the thing is that most therapists don't." As with the hospital, Rita "did not like the fact" that she had to end this therapy after only two months; however, the school year was ending and the therapist would not be back in the fall.

This therapist suggested to Rita that she find a therapist for the summer and then go to the PSC in the fall; Rita took her advice and sought out a therapy for the summer (Episode #14) which would be covered by her health plan. She recalled that there were "a lot of channels and things" to go through to get to an approved therapist, including an interview with "somebody" at the health plan who assessed her needs and sent her to a therapist in the outpatient department of a hospital. Rita reported that she experienced the health plan as saying, "You need lots and lots of psychological treatment but we're not going to pay for it and none of your family's going to pay for it, so you're not going to get it." Rita connected this to the insurance plan's earlier refusal to let her stay at the hospital.
She reported that seeking therapy this time was only "a little easy," explaining that it was not extremely easy because of the process she had to endure in order to get an approved therapist.

The therapist to whom she was sent was "really bad . . . [she] was completely insecure." Rita recalled that the therapist told her she felt "awed" by Rita, whose response was, "You are worse off than me. You go to therapy and get yourself like normalized."

Rita stayed in the therapy for approximately one month; she explained that she "did not like [the therapist] much from the start, but [she] was willing to give her a few weeks."

Rita ended the therapy because of her dissatisfaction and because it was "interfering with [her] summer."

Approximately three months later, early in the fall semester of her sophomore year, Rita sought therapy at the PSC (Episode #15). Apparently, her semester was going poorly; she explained, "I was in some really bad classes and I had no idea what I was doing and I really started to flounder and I didn't have anybody to lean on."

Rita felt that having to "fill out [a] stack of forms" at the PSC made the help-seeking experience particularly difficult. Although she liked the PSC intake interviewer, she was again dissatisfied with the therapist. She explained:

The woman did not ask questions ever, her only question was, "What do you want to do?" And I was like, "I don't know what I want to do." She's like, you know I'd say, "These are my problems," and she would say, "What do you want to do about them?" I was like, "Make them better." And she was like, "How?" . . . I was like, "This is not working." And she wouldn't even notice that it wasn't working.

For someone who prefers an "interactive" style, this sounds like a frustrating experience.
After two or three sessions of therapy, Rita stopped going. She explained, "I think I kind of did that deliberately to see whether or not she’d care and she didn’t call and I was like, 'Nope, never mind.'" Rita dwelt on the fact that the therapist never called:

She knew that I was very suic-, that I’d had a history of suicidal tendencies, a history of depression, I was going through some really rough times and I kept, I skipped several sessions and she never wondered about it. It's like, it didn't seem like she cared, which made it worse.

On the helpfulness scale, which spans numbers one to seven, Rita rated this therapy a zero (more than extremely unhelpful).

About one month after this therapy ended, Rita asked her mother to find out if her therapist knew of anyone Rita could see in the area. Her mother's therapist found someone and Rita began an eight-month therapy with her (Episode #16). Again, Rita felt that her fear of being rehospitalized made help-seeking more difficult than it had ever been before her hospitalization. Rita explained what she hoped to accomplish in the therapy:

I wanted to work on the fact that I get guilty over the slightest thing, I wanted to work on my problems with sexual relationships, and just having relationships with people in general. Um, I wanted to work on like my past with my mom, that was about it.

When recounting this therapy, she noted that she "couldn't get any therapist to say, 'No, I won't put you in a hospital.'" She felt this made it "really hard to be open about how bad I felt." I suspect that she brought up this general statement when discussing this therapist because being open was particularly conflictual for Rita in this therapy.

Rita described this therapist as "pretty helpful at the beginning getting me stabilized and saying, 'You don't have to be in these classes if they're hurting you.'" I understand these to be the same classes that she had troubled her during in the PSC
therapy. It is possible that the caretaking she experienced from this therapist was what she felt unable to get from the PSC therapist.

After this initial period of "stabilization," Rita "stopped talking about what was serious" and "started rattling on about [her] personal life and not getting anything done, and [the therapist] wouldn't get [her] back on track." She continued:

[B]asically towards the end what happened was I started, I just babbled about my personal life and I got stuck on a bunch of different medications, none of which worked, so that got me really frustrated because I was like, "You can't get me medication that helps me."

Rita's therapist had referred her to a psychiatrist (Episode #17) who prescribed an antidepressant for about a month, and antipsychotic medication for approximately two months. Rita apparently ended both the psychotherapy and the medication treatment out of dissatisfaction.

Rita rated her therapies in three levels: "most important" were Episodes #8 and #13, next in importance were Episodes #2 and #9, and the "bottom ones" were Episodes #6, #14, and #15. The rest of the episodes she left out of her ratings altogether.

Rita reviewed the pattern of her history as follows:

I got progressively more nervous about being thrown, like being locked up. I think after the hospital I was much more nervous about being put in the hospital than I was before . . . because it caused, it was more the repercussions after the hospital. 'Cause I got thrown out of the hospital before I was ready and also realizing the fact that I could never go back there because I don't have the money and [my insurer] would never pay for it.

Indeed, her ratings of the difficulty of seeking help reflected this pattern.

Rita was not currently planning to seek therapy. She said, "I honestly don't know what anybody could do for me right now, that I couldn't do for myself." She also stated, "I'm not in danger of committing suicide, so I don't particularly see any reason to be in
therapy." Rita seemed unsure what therapy could do for her, but felt there was
"something there that I don't got." She was clear that she wanted a therapist who would
"crack down" on her; when I asked how she would recognize such a therapist, she said, "If
I wasn't spending an entire session gossiping about my life, but actually getting something
accomplished." When I pushed for further detail, she said: "I don't know, I have no idea."
CHAPTER 4
DISCUSSION

In a project such as this, there are practically limitless possibilities for analysis. The depth of the data can pull the reader in many directions, and differences between readers make some themes more salient to one person than another. It is my hope that the presentation of each individual's story in the preceding section provided enough of the richness of the participants' histories so that readers can use them to work with some of their own hypotheses. At this juncture, I present some of the themes which appear most compelling to me when looking across these mental health service histories.

First Experiences

All nine individuals interviewed had as their first outpatient psychotherapy experience a contact of very brief duration (1-5 sessions). Two individuals had had experience with the profession prior to their first outpatient psychotherapy contact: Ed had been hospitalized for three days, and Emily had undergone psychological testing. Not only were these first therapies very brief, but so was each individual's second contact (with the exception of Rita).

One point to consider regarding the first mental health contacts of these participants is that often the individuals did not choose (or fully choose) to make that first contact themselves. Ed's first contact with the profession was in a hospital stay as a 14 year old (and his first outpatient contact was a mandatory follow-up to this stay). Emily's first contact was psychological testing at the age of 18, which her parents requested because of her academic difficulties (although her first true psychotherapy contact was sought on her own initiative). Ida and Amy were both brought into a family therapy for a
sibling who was the "identified patient." Karen's mother asked her many times if she would like "help" and finally Karen consented (with the hope of getting her mother fixed, not herself); similarly, Mark's parents asked him if he would like to go talk to their therapist and while he agreed, he also remembered his attitude as: "[T]here was no way I was going to do anything in there." Rita's mother thought that her two children should see a therapist to "make sure they were OK" following her divorce and remarriage. Only Gerry and Sarah completely began their therapy histories of their own free will (a point I will return to shortly).

Yokopenic et al. (1983) found that among individuals who recognize a personal problem, individuals who have had prior mental health services are more likely to seek help than those who have not had prior services. Results from the present sample of nine suggest the possibility that even the existence of prior "forced" therapies in someone's history might increase an individual's likelihood of using therapy in the future. Of course, a different research design would be needed in order to properly test this hypothesis.

In Chapter 1, I suggested an interpretation of Bennett and Feldstein's (1977) findings as follows: that a client's first therapy may be more likely to be dissatisfying than subsequent therapies, however this dissatisfying experience does not deter clients from seeking further therapy. The present data suggest this might be a valuable line of inquiry in the future, since the mandated therapies these individuals had early in life did not seem to be positive experiences retrospectively; however they also did not deter them (at least not permanently) from seeking further therapy (although it should be noted that many of these subsequent therapies were not very positive experiences either).
Two individuals, Gerry and Sarah, initiated their first therapy contact themselves. We might ask what difference this made in their experience of that therapy and in their subsequent histories. Their first therapies were viewed as helpful, while the first therapies of the other participants were viewed as unhelpful. Another difference is that Gerry and Sarah were set apart from much of the sample by their optimism that future therapy might be more beneficial to them than their past therapy had been. Other participants seemed to have expectations of future therapy which were more consistent with their earlier experiences (thus, Ed, with his negative experiences did not expect positive experiences in the future, whereas Ida, Emily, Mark, and Karen seemed to have positive expectations for possible future therapy which were expressed as hopes that they would find a therapy like one of their positive ones from the past). Only Amy does not fit into this schema very well: her first therapy experience was "mandatory," her past experiences have been on the unhelpful side, and her hopes for future therapy are moderately positive (thus her hopes for therapy are futuristic in the way that Gerry and Sarah's are; however her first therapy was not chosen as theirs was). This analysis points to the need to further investigate the effect of a mandatory first therapy on subsequent therapies (and perhaps the effects on future help-seeking of any mandatory therapy, even one that is not a first exposure to therapy).

The Significance of Early Therapies

There are three broad ways in which individuals recalled early therapy experiences. First, some participants described one or more early therapies which were "helpful" primarily (or even solely) because they showed that therapy was an option. This helpfulness was present for some despite a more immediate unhelpfulness of the therapy
with regard to the individual's presenting problem. Mark, Emily, and Amy gave examples of this viewpoint. A second approach to early therapies is to think of them as an obstacle or misleading force affecting one's overall therapy history. Some of the therapies of Ed, Mark, Amy, and Ida were seen by these individuals in this way. The third approach to early therapies is somewhat similar to the first, except in this case the therapies were satisfactory with regard to the presenting problem; thus it would not be very surprising to find that individuals in this scenario later return to therapy the next time they encountered a personal problem. I will concentrate on the first two of these phenomena, as they are most informative with respect to longitudinal therapy use.

Mark described his first therapy experience as "a little helpful" because it was "an exposure to therapy and so that probably let me know that there was such an animal, that such an animal existed, that it was possible." It is unlikely that there was anything else about the therapy which contributed to this helpfulness: he remarked, "...[T]here was no way that I was going to do anything in there, so I'd say that the therapy itself was intractable." In addition, Mark recalled that in the therapy immediately subsequent to this first one, he was "able to open up." This suggests that actually using therapy became a possibility because of this previous exposure which he was able to build off of and go on to the next "stage" or challenge of therapy (opening up).

Emily rated her first therapy as follows:

[My] immediate reaction was going to be "extremely unhelpful," and then I'm thinking, "I don't think it did anything unhelpful for me." I think maybe a "3" (a little unhelpful). I mean, somewhere in my head it maybe broke ice or something later on.
In a way similar to Mark, Emily viewed herself becoming more able to use therapy as the
time line progressed:

[Each time I would stop and then start and realize I wasn't really feeling any better
that I knew that next time, I've got to go a little farther next time, I've got to be
open just a little bit more next time.

Amy's experience lends a twist to those of Mark and Emily; whereas they seemed
to find extremely helpful therapies subsequent to these early "exposure" therapies, Amy's
entire time line up to the point of the research interview was characterized by what I
consider to be primarily "exposure" therapies. For example, Amy's initial family therapy
which she viewed as a damaging experience, she also described as "an introduction to the
fact that [therapy] does exist." As another example, her first therapy sought out on her
own she described as "moderately helpful" and explained that after that therapy contact
she "didn't feel more confident about what [she] was trying to fix, but felt more confident
about taking that step to actually try to fix it. . . ." Because she also stated that after this
therapy she "came out feeling a lot more confident about actually going into therapy," I
believe that the next "step" she was referring to was therapy.

Later in the interview Amy described all of her therapy experiences as "important"
because they taught her that "there's good, bad, and ugly. I've learned what to look out
for." Nevertheless, she was clear that she got "squat" from all of them in terms of her
presenting problem: "I got nothing, which is a big disappointment." Though they may
have all been disappointing, I believe that they also constituted exposure which she
planned to build on in that she expressed willingness (though no specific plans) to seek
therapy again.
The second view of early therapies to consider is that rather than facilitating more positive future therapy (either actual or potential future therapy), they served as obstacles or misdirection to later positive experiences in therapy. Some of the therapies of Amy, Mark, Ida, and Ed were seen by these individuals in this way. Going back to Amy, she wondered if her first therapy experience, a family therapy, had permanently affected her ability to benefit from future therapy: "[B]ecause of this bad experience, I kind of feel in a way I might be scarred to where [therapy] can't do anything for me . . . " Perhaps one reason she wondered about this is that she had not yet experienced a helpful therapy in terms of her presenting complaints.

This view of early therapy as an obstacle was also present in participants who subsequently did have very positive experiences in therapy. For example, Mark repeatedly reported that his earlier therapists did not supply him with what his seventh therapist finally gave him. With respect to the therapy he had as a freshman in college, he said:

I went there and he just didn't seem to have what it was that I was looking for, and I felt very inappropriate for looking for it . . . and then getting feedback from a therapist by just the way he or she is, that that's not what we're here for, that's not what this is about, but this is all, you know, that 90% of the communication that's nonverbal, so that you take it that much more seriously. And so you run away. I mean if it really is inappropriate, you're thinking to yourself, then I shouldn't have it.

Perhaps a clearer statement of Mark's regarding these earlier therapists is the following:

"[E]veryone wants to sweep you along to the next grade and just promote you to get along . . . [W]hat were they seeing, that they didn't say, 'Gee, Mark, you could use some more in-depth professional help.'"

Ida gave three examples of therapies which she believed retrospectively slowed her therapy process considerably. The first was the therapist from Episode #4, the third and
The final clinician she saw as an undergraduate in college. She believed one factor which might have obstructed her overall therapy progress was the time-limited nature of the therapy:

[I]t was supposed to be short-term and coming there because I didn't know what I wanted to do with my life [unintelligible word] deal with anything major so they focused on those issues and they don't want you to be in therapy for months and months, so if I could go into a different situation where that limitation wasn't put on it I don't know what would've happened . . . .

Not only the process, but also the content of the therapy seemed lacking to Ida. She recounted that about five years after this therapy she began to learn from a book about the problems which can arise for people who have grown up in an alcoholic family. After recently looking at this therapist's notes, Ida believed that this therapist had seen the signs of some of these problems but not told Ida about them. She stated:

When I looked back at some of the records she wrote that I seem angry at my father, it was like, "I didn't know that." Because I didn't understand that when somebody drank and alcoholism and all of that and I'm wondering if she'd told me and said, "Maybe there's something you could read," and given me something, because I really learn by reading, if that would've triggered it earlier and it wouldn't have taken so long.

Not surprisingly, the therapist whom Ida reported was abusive toward her prolonged her therapy history as well. Not only did she believe that this incident created additional material to work through in later therapy, but also she said it had the effect of "putting things off much longer." I see this as happening in two ways. She believed that at the time she sought therapy from this clinician who became abusive, she was in an ideal position to work on the "baggage" she had been carrying. Thus, the abuse forestalled this work on the "baggage" within that therapy. It also seems that the abuse became a more pressing issue to deal with in subsequent therapies, and that her "baggage" took a back
seat to it for a while, also contributing to the delaying effect (although Ida also acknowledged that her "baggage" was related to the abuse, so focusing on the abuse was not completely to the exclusion of addressing her "baggage").

Regarding a later therapy, Ida had similar musings about whether her therapist could have moved her process along more quickly by acting differently. In Episode #8, Ida wished the therapist had collaborated more with her other (concurrent) therapist since she had told one about her abuse and not the other. She explained:

What wasn't helpful was that he didn't confer with his colleague, so it's a mixed kind of, it was sort of helpful but it also was unhelpful. So on the whole, long-term, I'd have to say it really wasn't helpful, if you're looking at the long-term.

Finally, Ida believed that her first prolonged couples therapy (Episode #10) slowed things down, too. She explained that in that therapy they were "not dealing with the issue" of the abuse she had suffered and its effect on their marriage. She continued, "[U]nfortunately because it dragged on, some things got more entrenched, so that when we finally got outside the system, there was a lot of catch-up to do, and a lot of hurts that had gotten old."

Ed provided somewhat of a variation from the above examples. He viewed any psychological approach to his problem as misdirecting and saw what he needed and finally received as good medical (drug) treatment. In addition, regarding some of his early treatments which included drug therapy, he said that they had "prevented [him] from finding good help sooner." He viewed the primary obstacle, even in the treatments which included drugs, as clinicians being "hung up on the idea that it was something psychological." Ed is set apart in my mind from the rest of the interviewees by his insistence that he would not seek therapy again (though there were also some statements
in his interview to the contrary). He was certainly the closest of all nine to rejecting the idea of further therapy.

It is interesting that although interviewees spoke of their therapy process being slowed down by misguiding therapies, the possibility that such a misdirecting therapy could be a catalyst in the therapy process was not directly discussed. I think it is likely that upon realizing that a therapy is not going in the desired direction (not an easy thing to realize), one might be motivated to cut the therapy short and find a more appropriate therapy. There is indirect evidence for this hypothesis: Ed recalled "storming" from one dissatisfying therapy to another agency, where he found his current psychiatrist with whom he is quite pleased. Ida explained that as her time line progressed, she was able to recognize her dissatisfaction with a therapy earlier, allowing her to end the therapy and find something more desirable (she saw this as an important lesson of her overall therapy experience, which I will address further in the section on Termination Patterns).

Formative Therapies

Three interviewees, Mark, Karen, and Emily, reported one or more therapies which they described as particularly formative (Mark called his "seminal," Karen called hers "reference experiences," and Emily said hers was "probably one of the most wonderful experiences of my life"). There was a clear absence of this kind of experience in the histories of Amy, Gerry, Ed, and Sarah. Finally, Ida described two therapies which sound as though they verged on being formative (perhaps only because they stand out against her 14 other therapies, therefore I have a desire to make them "formative").

All of these therapies were rather recent in individuals' time lines: Mark's was #7 out of 10, Karen's were #5 and #7 out of 8, Emily's was #7 out of 7, and Ida's were #15
and #17 out of 17. This recency seems suspicious, in that it suggests the possibility that recency is an important component of "formativeness," and that early therapies may have been formative in their time, too, however were too far in the past to be described that way now. Mark provided some indirect evidence for this assertion; he explained that as he works through difficulties, their salience generally loses "charge." I suspect this may be true for other interviewees as well: as presenting problems change and/or become better defined (either more broadly or more narrowly), it is difficult to see them as they once appeared. Some interviewees were reaching 15 and 20 years into the past to reconstruct their histories.

The lack of formative therapies for individuals like Gerry, Amy and Sarah, who had somewhat less extensive therapy histories, suggests another possibility: that there is a progression over time for all of these individuals, and some of them are further along in that progression than others. Perhaps one feature of that progression is that there are indeed no formative therapies early on. Another possible explanation is that there could be individual differences which determine who has a "formative" therapy experience and who does not (ever). Of course, when I say that someone "has" a formative therapy experience, this is really a subjective "has," in that I have no objective criteria for determining what is and is not a formative therapy experience; it is the individual's view of a therapy as formative that makes it so.

The variation between these formative therapies is of particular interest, since it shows the variety of circumstances under which important change can occur. For Karen, what made her therapies formative were particular ideas which the therapists showed her which she had incorporated into her life. Both therapies were very brief, one was time-
limited. For Emily, the formative nature of the therapy derived from a more general feeling she received from the therapist: she felt the therapist attended extremely well, that she did not feel like "just another patient," and that they covered a lot of ground in the therapy. This was a therapy of moderate length (about 6 months, however interrupted by medical problems, thus approximately 20 sessions). Mark's was formative in that the therapist finally provided what he had been looking for in empathy and holding for so long. This was a long therapy (his longest). Finally, Ida's, if they were formative therapies, were lengthy therapies as well. One of them was similar to Mark's: she felt "mothered" and believed this was what she needed at the time. The other was her ongoing therapy, in which she felt the therapist continued to keep sight of her initial request that the therapy be "active."

What might a formative therapy be like for Gerry, Sarah, Amy, or Ed? Do the characteristics of Mark, Emily, Karen, and Ida's formative therapies, in relation to their therapy histories and presenting problems, give us any clues for predicting the characteristics of a formative therapy for the others? I do not have answers to these questions, however they seem worthy of further consideration.

**Outgrowing a Therapy**

One particularly interesting phenomenon is that two of the sample's six formative therapies ended because they came to be experienced as inhibitors of further growth. Both Mark and Ida ended with a formative therapy in a way that suggests they outgrew the therapy. In addition, Ed, and Emily reported variations on this type of shift (from helpful to unhelpful) which can occur in a single therapy episode.
Ida remembered her therapist from Episode #14 as "very, very nurturing, very warm . . . she's a mother figure, she even looked like a pillow. So it was very good for me to get that kind of support, at that time." Reminiscent of Mark's realization that he needed to move on from his therapist (#7) who finally gave him what he had been looking for, Ida said that "what she wasn't was someone who would push me to take action, that's what I started needing." Ida described the therapy as initially very helpful, but "then toward the end it started to become less and less helpful [as] I was moving on to something else; there was a transition period there." This therapist's warmth and nurturance turned into "overprotectiveness" in Ida's eyes; she described this in terms parallel to the relationship between a mother and a growing child: "It was like I was becoming an adolescent and I needed to move away . . . and she was keeping me as an 8 or 10 year old . . . ." Again, there is marked similarity here to Mark's experience of needing nurturance from an "early" therapeutic experience before moving on to needing more independence "later" on the timeline. Unfortunately, what is also similar is that both individuals found themselves with therapists who were unable to make a shift in their therapeutic style to accommodate this need.

Another example of outgrowing a therapy is Ed's therapy #4. He recalled:

[A]t the beginning, it seemed kind of nice just to have someone to talk to about whatever because I'd never had that before . . . but in the end something had to be done eventually about why I came in the first place, and nothing was happening and other issues were starting to be brought up in lieu of why I came, and things were getting absurd.

Ed rated the beginning of this therapy as high as "a little helpful," but said that at the end it came down to "extremely unhelpful."
Emily's extremely long therapy (#3) is an example of a different way of outgrowing
a therapy. In this one, she had a "nice relationship" with the therapist during the first three
years of the therapy, during which time Emily believed she was not extremely troubled.
However during the last year of this four year therapy, Emily was experiencing increased
difficulties in her life. She found that she did not feel comfortable bringing these
difficulties into the therapy, for fear of disappointing the therapist and upsetting the status
quo of their relationship. She finally decided she needed to seek help elsewhere.

It may also be informative to look at what type of therapy these individuals moved
on to following such experiences. Mark, after growing uncomfortable with his male
therapist's closeness, specifically sought out a "cool" female therapist. Ida's subsequent
therapy began with a request that the therapist help her to take an "active" approach to her
problems; this was in contrast to the prior therapist's discouragement of Ida's taking action
for fear that she might "get hurt." Ed and Emily, having left therapies which felt
comfortable but not extraordinarily helpful for much of the duration, seemed to seek out
therapies where they could get more done (Ed found an agency geared specifically toward
anxiety disorders; Emily recalled that after this therapy she sought couples therapy,
believing that her marital relationship had been particularly neglected in the prior therapy,
and after the couples therapy fell through she sought out another individual therapy with
the feeling that she "really wanted to work, I really, really wanted good therapy, and I
really, really wanted to take control of whatever was going on in me").

At first glance, it seems that these subsequent therapies were begun with fairly
specific requests as compared to some (but not all) of the therapies reported by the
sample. This is consistent with the research reviewed earlier (Braaten et al., 1993;
Kadushin, 1969) which established that individuals who had had prior mental health
treatment requested more information regarding prospective therapists and had a clearer
idea of what they wanted from a therapist than did individuals without prior experience.
The present data suggest that it may be particularly fruitful for therapists who are
presented with a specific request to explore the origins of that request within the
framework of past psychotherapy. For instance, perhaps Mark's subsequent therapist
would have been in a better position to explore his feelings about intimacy if he had been
working from a history of what had gone on in his prior therapies in terms of intimacy.

It is clear that a therapy can start out being helpful and end on an unhelpful
footing, but what about the reverse? In these interviews, there was no evidence to
support the idea that a therapy can begin as a relatively unhelpful therapy and turn into a
helpful therapy; the lack of such a finding supports the research on therapeutic alliance
which suggests that the alliance is formed in the first few sessions of therapy and from
there remains relatively stable (e.g., Eaton, Abeles, & Gutfreund, 1988). However, Ed
and Sarah made a point of describing concerted attempts to persist in therapies that were
not working well for them in the hopes that they would improve. Although these
therapies did not improve, there remains the possibility that such an approach could bring
about a helpful therapy.

How much of this "outgrowing" of a therapist is part of a natural phenomenon
which tells a person when to terminate? I suspect that this may have been the case with
Ida, for example, in that she rated the therapy she was currently in as "still very helpful";
this choice of words leads me to wonder if she expected its helpfulness to wane as she
became ready to leave, just as it did in her former therapy. This brings up the larger
question of how people decided when to leave a successful therapy? Did individuals "know" it was time to leave?

My data suggest that a planned ending based on feeling "done" (or "overdone," as with outgrowing a therapy) was not the most common way of ending a successful therapy. There seem to be many ways of ending successful therapies which were represented in this sample: some ended due to external reasons, some because a time-limited contract had ended, some were terminated unilaterally by the client or the therapist, and some were mutually determined. The endings of unsuccessful therapies revealed a similar diversity (see the section on Termination Patterns for further discussion of the topic).

Finally, these examples of "outgrown" therapies all have one thing in common: they were all at least moderately long in duration (the shortest was Ed's, which lasted up to six months). Many of the therapies reported by the sample were much briefer than this. It makes some intuitive sense that the therapies which are outgrown are those with a somewhat substantial duration (it takes some time to first derive benefit and then need to move on from a therapy). Perhaps participants should not have had the chance to outgrow the therapy; for instance, a time-limit to these therapies might have helped to prevent such endings. In the next section, we will examine the more general topic of how individuals viewed different therapy lengths.

Views of Therapy Length

While one danger of a relatively long therapy may be the possibility of getting stuck in it (or outgrowing it and not knowing when to quit), many participants expressed signs of a belief that for significant change to occur, their therapy would have to be a long
one. Amy, for instance, spoke of her family's desire for a "quick fix" during Episode #1, as if such a thing were not possible.

Ida, too, addressed the issue. While discussing her ongoing therapy she said:

[T]he thing about long-term therapy, short-term therapy [is] what's the issue? I think that some issues can be long-term, because . . . I'm still seeing her, I went to her for something else, but it, this came up. It took me about a year to start to figure out what I needed to do to put this experience [with the abusive therapist] behind me.

Ida and her therapist reportedly planned to continue this for another year to 18 months. In addition, she wondered aloud about what would have happened had her early college therapies not been time-limited.

Other examples of individuals with a preference for long-term therapy are Mark and Sarah, both of whom felt pushed through therapy despite their desire for something more substantial. Mark felt that many of his therapists wanted to assume that he was fine, like the one who ended by saying he was "self-correcting"; it is as if they would not acknowledge the fundamental need he believed he had. He questioned, "I guess it makes me wonder what were they seeing, that someone didn't say, 'Gee, Mark, you could use some more in depth professional help.'" Mark himself felt that as a teenager what he really needed was a setting as "in-depth" as a community for troubled children. It is my interpretation that one characteristic of the therapy he wanted was for it to be lengthier; it is possible that he would not agree with such a statement and might believe that, under the right circumstances, he could have gotten this "in depth" help in a brief therapy.

Sarah felt that the time limits she encountered at the HMO (a limit of twenty sessions, which she describes as "short") were inappropriate for her. She commented:
They were very rigid and very, this is, you know, don't forget, this is short-term and you know, so that thing, that pressure is on you, too, because I'm thinking: "God, it's six sessions now and I'm no further along. What's happening here?" It just really, the time thing there was just, you know, to me, "How can you determine, you know, if this is a short-term or not? And is that all you're going to, I mean if I have a long-term problem, you know, you are not going to see me?"

At another point she returned to the short-term issue, saying:

I don't think I'm a short-term problem . . . Not that I want to be here for the next [unintelligible word] years but, you know, I'd like to have a little security in the fact that you are going to work with me and not put me on medication, actually, which is what [the HMO] did.

Here I believe she was associating the briefness of the therapy and the early use of medication with a perception of the agency as more concerned about costs than about her presenting problem.

Sarah voiced a bias toward long-term therapy in a more indirect way when she described her first therapy at the EAP as follows: "I didn't really look at it as like therapy, it was more like assistance. Not like therapy like I've thought about it since, you know, coming to someone once a week for a year or whatever." She also overlooked the therapy during the interview, referring to her second therapy as her "first" therapy as well as stating that she wondered if she would ever be happy with a therapy, as if she had forgotten her satisfaction with this first one. It is also possible that these oversights are related to her view of the episode it as assistance rather than therapy, that her presenting problem was quite different for that first contact than for the others, as well as the fact that this therapy was the most distant from the present.

Gerry denigrated the ten-session insurance coverage she had at the time of the interview, as if that would not begin to satisfy her expectations for therapy: "Now I have insurance again that's good for ten visits and that's like 'Oh, big deal.'" Gerry explained her
expectation regarding future therapy: "It's going to be a long intensive process probably of maybe a year or more of continued therapy . . . ." Gerry, however, had only had very brief, client-terminated therapies up until the time of the interview.

Interestingly, Karen said she would have stayed longer with her therapist #5 if she could have, thereby prolonging what was a very successful short therapy. With regard to her therapy #7, the other brief "formative" one, Karen said this one she would have continued, too, had there not been a preset limit (of course, she did take the referral given at the end of this one, and the year-long therapy that resulted was helpful, however she also noted that she "probably could have done it on [her] own"). Thus, one of the interviewees with the most positive brief therapy experiences might have lengthened those therapies had she been given the chance. Would lengthening them have led to an even more successful therapy? A less successful therapy? Another "outgrown" therapy? What implications might this have for the clinical appropriateness of brief therapy?

As a final anecdote regarding the issue of length of therapy, both Karen and Mark shared the experience of being told that they were "self-correcting" (in Mark's case) or had a "really analytical mind" (in Karen's case). Because they were told these things in the same time-limited clinic, it is with caution that I report this information; nevertheless, it seems a possibility that this is the type of comment which a client might receive from a pressured, short-term therapist and walk out believing that the therapist was primarily interested in keeping them off of their caseload.

This sample is an unusual one in many ways, not least of which is individuals' extensive use of therapy both within single therapies and over their entire time lines. Thus, it may not be surprising to find many of the participants biased in the direction of long-
term therapy. Amy's absence of a stated bias toward either long or short therapy is an important exception to the trend (although one might say she had an implicit bias toward brief therapy because all of her therapies so far have been brief, I believe there is danger in making such an assumption, as Gerry is another who had only had brief therapies but felt that only with a long-term therapy could she benefit more than "superficially"). Amy's experience suggests that there are intermittent users of therapy who do not necessarily favor long-term treatment.

Other Themes

The above five themes are the most well-developed from my analysis of the data. The themes below are others which I find important that did not seem as broadly or fully represented in the data.

Awareness of Alternate Routes

Three interviewees, Emily, Ida, and Mark, showed some recognition of the possibility that there were multiple ways to reach the same therapeutic goal. Emily noted that although her husband and herself did not find success in their couples therapy, they were able to work out their difficulties in individual therapies and then "bring it together." Ida explained that perhaps if she hadn't been in some of her therapies she may have instead been attending more Alanon meetings and noted that the latter might have been equally or more useful.

For Mark, the place for psychotherapy in his life was alongside other modes of healing; he said he had eventually "gotten the whole; this from him, that from him." There was the "jump start" he received from the seventh therapist; he also cited meditation and spiritualism as influential (particularly an exchange he had with Ram Dass which he
described as "a real gift"). Thus, Mark offers an even broader example of how interchangeable a particular source of help can be with other sources.

**Client Expectations**

Although there was no specific interview question addressing client expectations, they often came out in the course of discussing a therapy. Karen told of her desire to express her anger with the therapist from Episode #4; she was angry because she felt the therapist had not lived up to her expectation, and wanted to say to the therapist, "What was I here for? You were supposed to see this or you were supposed to help me see this, or at least ask a question about it, do something to make me think about this." Upon saying this in the research interview, Karen reflected, "I don't know, I kind of felt I was asking for so much, you know, that's why I was going because I wanted somebody to realize that I was going because I had to go and it just didn't seem to make a lot of sense." To me it seems that Karen, like Mark and Ed in some respects, wanted a therapist to read her mind, be clear about the things she was confused about, and be able to see things she was unable to see. Repeatedly in the research interview, Sarah asked how appropriate it was to expect of therapy in these kinds of ways; I think it is a question that many of these interviewees probably asked themselves.

Sarah herself seemed to expect extreme nurturing and validation. She praised these qualities in the first therapist at the EAP and expressed extreme dissatisfaction with later therapists' perceived lack of such qualities. She expected therapists to "pull things out of her" (though, again, wonders if this was appropriate as an expectation). Another expectation of Sarah's seemed to be that her efforts be met in kind: she felt both HMO therapies were very difficult to seek out because of the risk she perceived herself taking
with confidentiality, however despite her "going that extra mile," these therapists did not provide a satisfying therapy (in particular, they did not relieve the pressure of the time limitation). She believed both of these experiences left a "sour note" and they "haunt" her and make her "delay" when thinking about seeking help again (although, at the time of this interview, she was not only thinking about seeking help again, but also thinking of seeking help at this very HMO again).

Returning to Previous Therapists

I was quite surprised to find there were very few instances where an interviewee returned to a prior therapist. Ida did so once, and this was the therapist who was abusive toward her (in their second therapy together). The only other person who had returned to a therapist was Amy, and she reported that it was a coincidence that she was assigned the same therapist whom she had seen the first time at that clinic. I am aware of some instances where interviewees did not return to a therapist with whom they had had a positive experience, even though they were still living in the same area. There were a number of times that individuals reported requesting to see the first person available at a clinic, which suggests that a feeling of urgency might be one reason for not attempting to recontact a prior clinician.

Another factor might be embarrassment at seeking therapy again. This was Karen's answer to why she did not return to one therapist: "I think I was embarrassed to go back to her after I'd gotten married and divorced, you know, it was like, 'Uh, I guess I didn't make the right decisions.'" The therapist she was referring to was the one to whom she had written a letter with her last payment saying that her relationship with her boyfriend had worked out in the end and they had gotten married. It is possible that
interviewees might have feared returning to a therapist with either a new or an old problem; they might have felt this would be admitting failure or would cause the therapist to believe they had failed. It is interesting to note that the one purposeful return to a prior therapist (Ida's) included an agreement at the end of their first therapy that if she needed to return, she should simply call. Others reported similar conversations at the end of some therapies, however it may be that this is an important factor in determining whether a client even considers returning to a therapist. Beyond this I cannot speculate with the help of any data as to what other factors may have been involved in this failure to return to prior therapists.

**Termination Patterns**

There are almost no clear patterns of termination in the data. Those which I looked for in particular were whether termination was different for successful versus unsuccessful therapies (they were both extremely variable), whether therapies of different lengths were terminated differently, whether first therapies were terminated in a consistent way across individuals (there was a slight tendency for these to be client-terminated), whether there was a termination progression common to individuals (earlier therapies terminated one way, later therapies another way), and whether individuals exhibited an idiosyncratic and/or consistent termination pattern. With regard to the latter possibility, I found that Gerry and Sarah had terminated all of their therapies on their own initiative and with no explicit agreement from the therapist (the one possible exception was Sarah's first therapy). While this seems noteworthy, it is not easily interpreted. Perhaps this trend is related to the other trend described in the section on First Experiences, where I noted that Gerry and Sarah were set apart from the rest of the group in that they had both initiated
their own first therapies and that, with the exception of Amy, their expectations for future therapy were less consistent with respect to their historical experiences than any of the other interviewees.

One other note about termination in the context of a therapy history, is that Ida believed part of what she had achieved in moving through her therapies was an ability to recognize a dissatisfying therapy earlier, allowing her to leave it sooner. Early in her history, she says she exhibited a "pattern of sticking things out," describing it as "not knowing when to bail out." Amy, too, voiced a similar belief that it is important to know when to leave a therapy: not only did she wish she had ended her most recent therapy after three sessions rather than "letting it go on" for six, but also she made a point of emphasizing the general point that it is important for therapy clients to "not be afraid to stop if you don't feel that the way it's going is right."

It seems that clients erring on the side of staying too long in a dissatisfying therapy is not a common topic of discussion in the literature; instead, we usually concentrate on the "opposite" phenomenon of clients dropping out "prematurely." While there is something to be said for the importance of clients learning they can "drop out" and feeling free to leave in order to eventually feel safe in staying, we should not overlook the possibility that other individuals do not arrive at the therapy marketplace with the skittishness of "premature terminators," but rather with great, and sometimes too great, persistence.

Help-seeking in a Historical Perspective

As with termination, individuals' help-seeking patterns are not clear enough in the data gathered for an extensive exploration of particular hypotheses. There was evidence
contrary to the hypothesis that help-seeking necessarily becomes easier as an individual has more therapy experience. There seemed to be specific factors which may obscure such a global trend: for instance, Emily and Ida found it was easier to seek help when they felt they were suffering from a relatively concrete physical problem (panic attacks and teeth clenching, respectively). Karen suggested that being in a crisis made help-seeking easier no matter where she was on the time line, and the absence of a crisis made it more difficult for Karen to seek help even for her most recent therapy.

One other interviewee whose experience sheds light on help-seeking in the context of multiple therapies is Gerry. She reported that each time she sought therapy it was "very easy" for her; in addition, she believed that "it will always be easy." It may be informative to fit this into her broader picture: she had never stayed longer than six sessions in therapy, she described her therapies as "lightweight" and "not some eye-opening, gut-wrenching thing," she had always terminated the therapy herself feeling better temporarily only to find her problems reappear, and she expected a "long, intensive" therapy in her future. It is possible that for her, seeking help is extremely easy, but following through is extremely difficult (which would make sense if she believed some "eye-opening, gut-wrenching thing" is awaiting her).

**Reasons for Coming to the Research Interview**

Although not a focus of the project, it seems potentially useful to mention some possible motivations for interviewee participation, beyond curiosity and a desire to contribute to research. Perhaps this knowledge will allow a broader understanding of the individuals in the sample and the information they provided. As I only provided $5 to interviewees, money was an unlikely motivator.
I believe that the interview served a few purposes for Ida. After she had disclosed to me that she had been abused by one former therapist, she explained that she had experienced a great deal of anxiety about coming to the interview and talking about this incident. In the interview, however, I also got the sense that perhaps this was one reason she decided to do the research interview: it seemed important to her that she be able to face her experience (and it is possible she thought it would be therapeutic for her, and in keeping with her more "activist" current therapy). In addition, she may have felt the interview was another avenue for making her experience public (she has done this in other ways as well, and believes this has been important in allowing her to move on).

Amy provided the following information regarding her agreement to participate:

That's why I was really psyched when you called me up. I am like "Yeah, I am gonna really tell these people what they can do." Because I'm sure stuff has changed a lot in the past fifteen years, but I find that this profession can do a lot to help people, but because of this bad experience [in family therapy], I kind of feel in a way I might be scarred to where it can't do anything for me, that's all. And it's a real shame, because everyone's going "You need counseling, you need counseling, you need counseling." Fine, what's counseling got to offer? It didn't do anything the first time.

Although Ed did not comment on why he chose to accept the interview, I suspect from the negativity of his comments about psychotherapy and psychological training (i.e., "He was a very manipulative person, and that's why he became a psychologist"), he was at least partially there to make public his sentiments about therapy's uselessness to him.

There may also have been some desire on his part to find out more from the interview about what psychotherapy is all about, as he seemed conflicted about whether it could be helpful to him, and still in search of a way to make use of psychology.
Mark explained that part of the reason he participated in this study was to "share how central spirituality is in [his] 'psychotherapy' experience." In addition, he said that when I had called about the interview, he thought "Oh, that's interesting," and felt that "maybe the universe was asking [him] to do this."

As for Gerry's motivation for coming into the interview, it is possible that it was very much related to her current desire to seek help. She seemed to be looking for a therapist as soon as possible, and given her history of short therapies which ended with a temporary abatement of difficulties, she may have viewed the interview as an opportunity to have a short relief session of sorts.
CHAPTER 5
CONCLUSION

This project was designed to be an exploration into the area of longitudinal psychotherapy utilization which could inform subsequent research. Having described the data collected and some possible interpretations of their content, I turn now to an examination of the process of the research itself and directions for future study. There are four broad areas to address: how one might fill out the theoretical sample begun here, how the present research design could be modified, what other designs might be indicated, and lessons learned from this project which investigators are advised to keep in mind no matter what design they choose. Finally, I will conclude with a glance at the possible clinical utility of this area of research.

Sampling from a more diverse population while using the method from this project may be the first order of business for future study. The present sample was dominated by individuals who had lengthy therapy histories; it would be useful to interview more people who have more recently begun to use psychotherapy. This might yield a better understanding of how clients' retrospection changes as time, and more therapy, goes by. In addition, while the individuals interviewed here had virtually never returned to a prior therapist, this still seems an important type of therapy utilization to pursue in subsequent research.

Participants in the present project also had in common the fact that they had sought services at a graduate training clinic, a fairly unique service setting. Among other things, this probably means that all of these individuals at some point in the past have
desired affordable, relatively long-term therapy. It will be important to find participants who do not fit such a category.

The number of relatively negative therapy episodes reported in this study seems quite high. This could be the result of the characteristics of this sample noted above and/or other factors as yet unidentified. Perhaps people who have multiple therapy experiences are particularly difficult to treat, thus they are more likely to experience unsatisfactory treatments than are other populations. It would be interesting to compare the general attitude toward therapy of these participants with that of a group of individuals who had not had as much therapy experience; perhaps increased therapy experience gives an individual a different perspective from which to judge any single episode of therapy (i.e., maybe one gains a more accurate frame of reference, or uses more stringent criteria, or expects more and more). In any case, studying a larger and more diverse sample is called for before any conclusions are drawn with respect to the general level of dissatisfaction among multiple-episode therapy consumers.

Finally, further consideration should be given to the unknown effect of having interviewees with differing amounts of time between ending their last therapy and participating in the research interview. All of these individuals had ended therapy within eighteen months of the interview; some had ended much more recently than this. This sample lacked interviewees whose most recent therapy was in the distant past. It is likely that this variable could greatly influence an individual's presentation of their therapy history, both with regard to their global view of therapy as well as views of particular therapy episodes. For instance, would someone who has been out of therapy for three years, and who seems to return to therapy every three years, be more likely at the
interview to say they feel they still have not found a therapy that has really worked for them and plan to seek out therapy again soon? Is someone who has been out of therapy for only a month before the interview more inclined to say that they feel they have benefited greatly from therapy and do not see the need for more therapy anytime soon? By sampling individuals with a greater space between the research interview and their last therapy, there may be a greater possibility of finding people who seem more permanently "done" with therapy than those interviewed for this project.

The next topic to address is how the current methodology might be modified. There are particular questions I would emphasize in future interviews of this kind, for instance, questions which explore the time between therapies, particularly the lengthier gaps. I would specifically like to know more about my interviewees' subjective experience of this time: how they may have been thinking about the problems which had brought them into therapy in the past, and what thoughts they may have had about therapy and help-seeking in general. Linked to this would be a more intensive exploration of instances where help-seeking occurred but did not develop into a therapy. My sample reported a few instances of this, however it should be more systematically investigated.

Also, I would like to know more about clients' feelings regarding how medication use fit (or did not fit) into their psychotherapy histories. Sarah and Mark, for instance, seemed to view the suggestion of drug therapy as offensive and felt they really needed good psychotherapy rather than medication. Ed, however, felt that drug therapy was ideal for him; he viewed as "absurd" therapists' desires to frame his problem in psychological terms. The majority of interviewees had taken psychotropic medication at some point in
their histories, and often this was as an adjunct to a talking therapy. How the two treatments blended for interviewees is something which deserves further attention.

When I formulated this research I had expected to find some instances where individuals had returned to a previous therapist. However, only two interviewees had such an experience. This may be due to an unknown sampling bias, or perhaps it is a rarer phenomenon than I had anticipated. In any case, it would be advisable to add some questions pertaining to why (and why not) individuals returned to earlier therapists.

On a more general note, I would consider using a more structured interview for a subsequent project. This would likely mean sacrificing some of the narrative data collected, however the payoff would be more complete "factual" information on the details of individual psychotherapies. Such an approach might be a good transition step toward a design involving data collection from service providers and other non-client sources.

A variety of methodological approaches should also be considered in the future. As suggested in earlier pages, the "ideal" study of longitudinal therapy use would be an extensive prospective design which identifies individuals at the time of their first therapy and follows them through the service delivery system as they create a psychotherapy history. Such a study would have the advantage of providing a view of the progression of clients' subjective experiences regarding therapy; there would be less danger of the data being colored by an interviewee's mood and subjective experience at the time of a retrospective interview. Depending on the specific procedures used, such a study would be able to circumvent memory problems (for instance, it would catch brief psychotherapies which may be forgotten in retrospect), as well as reducing uncontrolled recency effects. The present project also suggests that such a prospective study should follow people for a
considerable length of time. For instance, Emily's experience with psychotherapy spanned nineteen years, and her therapy in that nineteenth year was one of the most significant (at least retrospectively) in her psychotherapy history.

A smaller study might focus on first therapies and their impact on subsequent therapy. This could be done by interviewing people at various distances from their first therapy (i.e., right before, during, and just after it; then while seeking another therapy, after another therapy, while seeking a third therapy, etc.). Another idea sparked by this study is to attempt to predict future therapy use based on a psychotherapy history like the ones reported here. For instance, I am quite sure that Ed's psychotherapy use will be very unpredictable; he seemed to have an unresolved conflict to battle with regard to seeking therapy and for this reason, I believe he will seek therapy on impulse in the future as he has in the past. For Gerry and Sarah, I lean toward predicting that they will continue seeking therapy on and off for an indefinite amount of time. On the other hand, Karen and Emily seem like examples of people who may never seek therapy again unless their life circumstances change greatly. A project allowing for follow-up to such predictions could provide feedback, enabling one to "calibrate" the prediction process.

No matter what design future investigators of this topic might employ, there are some experiences from the present research which could prove useful to them. First, there were many contacts which individuals reported that were not "strict" psychotherapy per se, but seemed important to them in reporting a full picture of their histories and opinions of psychotherapy. Some, like Amy, had experiences where friends or family attempted to be therapeutic, and this experience seemed to have influenced her later ideas regarding therapy. Others reported contacts with psychiatrists solely for medication; while they
viewed this as relevant for our discussion of their histories, most interviewees neglected to include these contacts in their rankings of importance at the end of the interview. I think this speaks to their ambivalence about how medication and psychotherapy are related, a topic which I suggested earlier might be a fruitful line of inquiry for future research. Finally, Mark and Gerry are examples of individuals who brought other types of "healing" experiences into the interview: Mark spoke of psychotherapy as part of a greater whole revolving around his spirituality, while Gerry made a point of bringing into the discussion her experiences with acupuncture, vegetarianism, meditation, and self-help. Researchers studying in the area of psychotherapy history-taking should be prepared for experiences like these to be brought into the arena, and have given some forethought to whether they want to include or exclude them.

Participants' reasons for and reactions to doing the research interview are also potentially useful data for planning further study of the topic. Earlier I noted that this sample does not appear to be a selective one from the population of former PSC clients who have used therapy multiple times; only one individual contacted chose to decline participation. As this sample had, on the whole, used a fair amount of psychotherapy, it would not be surprising if some of their motivation for coming to talk to me was derived from an expectation that it would be therapy-like. A number of interviewees did ask toward the beginning of the interview whether I was a therapist-in-training at the clinic where the interviews took place; it may be that this information was important in their determination of what they would disclose. Also, a few participants were in the process of seeking help at the time of their interviews, and to varying degrees may have looked to the interview as an opportunity to consult with an "expert" about seeking therapy.
Some respondents seemed to have a message that they came to convey. For instance, Mark said that part of why he came to the interview was to describe how psychotherapy for him is only part of a larger spiritual quest; he wanted to emphasize how important that spiritual component is. Ida reported feeling very anxious about coming to the interview because she anticipated talking about the therapist who had abused her, yet as I have said elsewhere, I believe she also felt it was important both for her and for the research that she talk about the experience. Amy and Ed, on the other hand, may have come in part to vent their frustration or anger with the profession as a whole.

The reactions of participants to the interview and time line are also potentially enlightening. On the whole, respondents reacted with surprise to the amount of therapy they were reporting. This surprise was often particularly in response to the time line. Ida commented: "I feel like I've been therapy shopping." Sarah said, "I never would have thought I would have filled [the time line] up." She also added:

It makes me feel weird looking at this time line. I guess I didn't realize how many times I've been . . . it makes me wonder how unstable I am. You know, I am not going to go and slash my wrists or anything, but I guess I really have had some up and down times.

It was not unusual that participants became upset recalling a particular part of their histories. Although none of the participants seemed distraught at the end of the interview, it is a potentially difficult topic and should be treated accordingly.

This leads also to the question of who is inappropriate for or unable to do such an interview. Ideally, individuals would have a fair amount of insight, as this would help in the process of stepping back from therapy and looking at the process of it all. Rita may be a good example of someone bordering on being unable to express herself in the way
demanded by this interview. However, to only interview individuals with "X" amount of insight would be to significantly misrepresent the population of psychotherapy consumers. There is no easy answer for how to adapt an instrument like the one used here for use with "lower functioning" individuals. While it may be tempting to simply obtain the "facts" of their psychotherapy histories from other sources, I believe such individuals likely have a perspective on their therapy histories which cannot be found in the accounts of their more articulate counterparts. Thus perhaps a mixture of data sources is particularly important for such participants.

Finally, I would like to briefly explore the possible clinical relevance of this line of research. Clinicians typically obtain a cursory account of a prospective client's therapeutic history, however there does not exist (to my knowledge) an assessment instrument specifically designed for this purpose. How might future therapy for these nine individuals be affected if the therapist were to begin the therapy by obtaining information such as that reported here?

First, it is possible that the content of the therapy would be affected. For instance, perhaps Amy's future therapist would fear a repeat of Amy's fourth therapy (in which she felt pushed to examine her childhood sexual abuse); thus, the therapist might avoid initiating discussion of the sexual abuse or wait until Amy presented it clearly and deliberately as a topic for the therapy. Another possibility is that the therapy process or structure might be affected. If a future therapist for Gerry felt it important that she remain beyond a few sessions, he or she might contract with Gerry for a certain number of sessions (in accordance with research suggesting that individuals at risk for "premature
termination" remain longer in a time-limited therapy than in an open-ended therapy [Sledge, Moras, Hartley, & Levine, 1990]).

Bringing this methodology, or even a portion of it, into a clinical setting would entail a number of changes. Prospective clients might respond to this procedure much differently than did the research participants for this study. Nevertheless, experimentation with therapy history-taking seems potentially valuable in clinical practice.
APPENDIX A

INITIAL INTERVIEW

Instructions:

I would like your help in discovering why and how people return to therapy during the course of their lives. I would like to find out about all the times you have seen a therapist (this could include a social worker, a psychologist, a psychiatrist), even if you only saw him or her for one session or as an initial meeting, or even an inquiring phone call that you decided not to follow up on. Please include individual, group, couple, or family therapy, in addition to any therapies that occurred during the same period of time or overlapped with each other. Please include both inpatient and outpatient therapy contacts.

It is essential that you be as accurate and complete as possible. If you have a faint memory for a therapy or therapist, please tell me as much as you remember. Please take time to respond to these questions -- memories for past events, especially those we don't think about every day, take time to surface.

[Before beginning, get a general sense of how many times the subject has been in therapy and very basic information regarding those episodes. Next introduce time line idea in order to help them pin down exactly when those episodes occurred and put them in the larger context of their lives. Create a time line with the subject in a manner relevant to the individual; include personally significant dates or periods of life and fit in the aforementioned therapies. With time line in hand, probe for other therapies they may have forgotten, using examples of unmentioned therapies such as referral from one therapist to another, counselor in high school or college, marriage counselor, participating in a family member's therapy, interviewing therapists before finding the right one, etc. Now ready to start interview, beginning with first therapy episode.]

Note: type of answer is enclosed in [ ]
content ideas for possible probes are enclosed in <>

Interview:

A.

1. When was the first time you contacted a therapist, or someone contacted a therapist on your behalf? [Month and Year; Age]

2. If it was not you who contacted the therapist, who did? [Relationship to Interviewee]

3. Can you tell me about the reasons that led you to seek therapy at that time? [text]
   <relationship problem, work problem, exploratory; long-term characterological or specific problem solving/symptom relief>
4. How long had that problem/those problems been bothering you? [time in ? units]

5. How long had you been thinking about seeking help? [time in ? units]

6. How did you feel about seeking help? [embarrassment, relief, fear, excitement, defeat] <secretive vs. open with social circle>

7. Did you try anything else to deal with your problem before seeking therapy? [Yes/No] If yes, what? [text] <self-reliance, others involved>

8. How difficult was the decision to go to a therapist? [Scale 1]

9. What was the therapists' name? [Name] (Or if they would rather not say the name: Do you remember the name of the person? [Yes/No]

10. What was his or her profession? [Social Worker/ Psychologist/ Psychiatrist/Trainee/ Other]

11. How did you choose that person? [text] <fee considerations, referral, location, interviewed and liked person, credentials, experience, gender>

12. How many times did you see that person? [Number or Range] {if 0, skip to B}

13. How far apart were those visits? [Time in ? units]

14. Was that for individual, group, couple, or family treatment? [I,G,C,F]

15. What was the goal or goals of the therapy? [text] <symptom reduction, exploration, insight, learning new coping strategies, behavioral change, emotional expression>

16. Why did the therapy end? [text] (Probe if needed: Was it you, your therapist, or both of you together who initiated the end of therapy? [self, therapist, both])

17. Here are a list of reasons some people leave therapy [Scale 2]: would you please tell me your main reason for leaving treatment? Was there another reason? <external reasons, therapist leaving area, problems subsided for external reasons, improved, dissatisfied, therapist felt therapy could help no more>

18. What were your plans regarding further treatment when you terminated? [text] <never again, maybe someday, wait a few months and see, immediately sought someone else, referred, didn't think about it>

19. How did you feel about leaving treatment? [text] <fear, happy to be less dependent or have more time, sad, indifferent, discouraged, bitter, proud>
20. How helpful was that therapy for you? [Scale 3]

21. Do you remember any particular sessions or conversations from that therapy? [Yes/No] If Yes, please describe one. [text] <content, affect, Th-CI relationship>

22. Please describe a typical session from that therapy. [text] <awkward/comfortable, lots/little affect, lots/little content, went by fast/slow, therapist active/passive, how began and ended>

23. How would you describe [name of therapist]? [text] <warm, quiet, judgmental, like someone you know?, parental, accepting>

24. Have you had any contact with that therapist since termination (either by phone or in person)? [Yes/No] If Yes, please describe. [text] <number of times, w.r.t. what (thanking therapist, fees, insurance, referral), therapy>

25. How often do you think about that therapy? [text]

26. What do you think of when you think about it? [text] <how room felt/looked, what therapist would say w.r.t. current problem, how felt with therapist, particularly meaningful exchange, technique learned, affect during memory>

27. How confident are you of the information you have given me regarding this therapy episode [Scale 4]? {Skip to C.}

B.
1. Can you explain what happened? [text]

C.
1. When was the next time you contacted a therapist? [Date or # of months from previous; Age]

1b. Were you in therapy with someone else at the time of contact? [Yes/No]

2. If it was not you who contacted the therapist, who did? [Relationship to Interviewee]

3. Can you tell me about the reasons that led you to seek therapy at that time? [text] <relationship problem, work problem, exploratory; long-term characterological or specific problem solving/symptom relief; relate to previous therapy: continuing where left off, unrelated>

4. How long had that problem/those problems been bothering you? [time in ? units]

5. How long had you been thinking about seeking help? [time in ? units]
6. How did you feel about seeking help? [embarrassment, relief, fear, excitement, defeat] <secretive vs. open with social circle>

7. Did you try anything else to deal with your problem before seeking therapy? [Yes/No] If yes, what? [text] <self-reliance, others involved>

8. How difficult was the decision to go to a therapist? [Scale 1]

9. What was the therapists' name? [Name] (Or if they would rather not say the name: Do you remember the name of the person? [Yes/No]

10. What was his or her profession? [Social Worker/ Psychologist/ Psychiatrist/ Trainee/ Other]

11. How did you choose that person? [text] <fee considerations, referral, location, interviewed and liked person, credentials, experience, gender>

11b. (If this is not the same therapist as earlier): What was your reason for not returning to [names of previous therapists]? [text] <dissatisfied, out of area, try someone new>

12. How many times did you see that person? [Number or Range] (if 0, skip to B)

13. How far apart were those visits? [Time in ? units]

14. Was that for individual, group, couple, or family treatment? [I,G,C,F]

15. What was the goal or goals of the therapy? [text] <symptom reduction, exploration, insight, learning new coping strategies, behavioral change, emotional expression>

16. Why did the therapy end? [text] (Probe if needed: Was it you, your therapist, or both of you together who initiated the end of therapy? [self, therapist, both])

17. Here are a list of reasons some people leave therapy [Scale 2]: would you please tell me your main reason for leaving treatment? Was there another reason? <external reasons, therapist leaving area, problems subsided for external reasons, improved, dissatisfied, therapist felt therapy could help no more>

18. What were your plans regarding further treatment when you terminated? [text] <never again, maybe someday, wait a few months and see, immediately sought someone else, referred, didn't think about it>

19. How did you feel about leaving treatment? [text] <fear, happy to be less dependent or have more time, sad, indifferent, discouraged, bitter, proud>

20. How helpful was that therapy for you? [Scale 3]
21. Do you remember any particular sessions or conversations from that therapy? [Yes/No] If Yes, please describe one. [text] <content, affect, Th-CI relationship>

22. Please describe a typical session from that therapy. [text] <awkward/comfortable, lots/little affect, lots/little content, went by fast/slow, therapist active/passive, how began and ended>

23. How would you describe [name of therapist]? [text] <warm, quiet, judgmental, like someone you know?, parental, accepting>

24. Have you had any contact with that therapist since termination (either by phone or in person)? [Yes/No] If Yes, please describe. [text] <number of times, w.r.t. what (thanking therapist, fees, insurance, referral), therapy>

25. How often do you think about that therapy? [text]

26. What do you think of when you think about it? [text] <how room felt/looked, what therapist would say w.r.t. current problem, how felt with therapist, particularly meaningful exchange, technique learned, affect during memory>

27. How confident are you of the information you have given me regarding this therapy episode [Scale 4]? (Skip back to beginning of C until all episodes have been covered)

D.
1. Please take a few minutes to look back at the time line and search your memory for any other times when you contacted a therapist, or someone contacted a therapist on your behalf. (if more go back to Section C)

2. Was there ever a time when you contacted a therapist when in therapy with someone else? (Make sure overlapping therapy information is recorded above, and length of overlap is noted)

3. Which therapy episodes were most important to you, from where you are today? [1st choice, 2nd, etc.]

4. Can you tell me why you chose that one as your first choice? [text] <think about it more often than others, most recent, first, longest, liked therapist the most, relationship best, did most work, still dealing with same problem>

5. Which was the least satisfactory therapy and why? [text]

6. How do you see all of these episodes fitting together? [text] <a progression, do a little work--stop--do a little more, if had found favorite therapist first wouldn't have need others, fairly unrelated--specific problems each time>
7. Are you currently seeing a therapist? [Yes/No/Other]

8. Do you have plans or thoughts about seeking therapy in the future? [Yes/No] Please describe. [text] <never again, maybe someday, wait a few months and see, immediately sought someone else, referred, didn't think about it>

9. Under what circumstances would you seek out therapy again? [text]

10. How confident are you that you've remembered all your previous contacts with therapists? [Scale 4]

**SCALE 1:**
- Extremely Easy
- Neither Easy nor Difficult
- Extremely Difficult

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**SCALE 2:**
1. Therapist moved out of the area
2. Therapist thought you did not need further therapy
3. Therapist referred you to someone else
4. You felt no more need for therapy
5. You were dissatisfied with the therapy
6. You moved, could no longer afford therapy, or had scheduling or transportation problems

**SCALE 3:**
- Extremely Unhelpful
- Neither Helpful nor Unhelpful
- Extremely Helpful

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**SCALE 4:**
- Not at all Confident
- Somewhat Confident
- Extremely Confident

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
APPENDIX B

FOLLOW-UP TELEPHONE INTERVIEW

Instructions:

Review the therapies which the participant reported in the first interview using identifiers such as name of therapist, length of treatment, age at time of treatment, etc.

Interview:

1. Did you think of any other therapies during the last week that we didn't discuss in the first interview? [Yes/No] If Yes, ask questions from Section A of initial interview.

2. Is there any information that you gave me last week that you would like to change? [Yes/No/Text]

3. Are there any additional thoughts you would like to share with me about your use of therapy over your lifetime? [text]

4. Do you have any advice to someone else seeking help? [text]

5. What type of treatment would you prefer in the future? [text]
REFERENCES CITED


