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THE ETHICAL IMAGINATION: A HERMENEUTICAL STUDY

A Dissertation

Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By

Jeb G. Jungwirth

May 2013

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Jeb G. Jungwirth

2013

THE ETHICAL IMAGINATION: A HERMENEUTICAL STUDY

By

Jeb G. Jungwirth

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ABSTRACT

THE ETHICAL IMAGINATION: A HERMENEUTICAL STUDY

By

Jeb G. Jungwirth

May 2013

Dissertation supervised by Professor Russell Walsh, Ph.D.

This research examines and describes the ways psychotherapists address ethical dilemmas through a hermeneutic analysis of how they responded to a portrayal of a therapy session represented in a television series. Interview transcripts were analyzed and assessed for both how therapists navigate difficult ethical terrain, and upon what, thematically, they tend to direct their thought and concern. Moreover, particular consideration is given to the role of imagination in the development of ethical meaning, intention, and understanding in the clinical context, which intersects with a critique of the American Psychological Association's ethics code and its underlying philosophical assumptions. Such theoretical underpinnings suggest a view of therapists as rational agents capable of applying ethical rules and codes to resolve dilemmas in a logical, formulaic manner, a view which is questioned for its failure to account for the empathetic, vitalizing, and hermeneutic value of imaginative thought, rehearsal, and reflection in practice. Finally, implications for therapy, pedagogy, and interpersonal understanding are explored.

DEDICATION

This dissertation is dedicated to my parents, Reg and Jeannine Jungwirth, my uncle, Dr. J. Michael Doyle, and my wife, Alissa.

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First and foremost, thank you to Dr. Russ Walsh for invaluable guidance and insight throughout this process, dating back several years to our initial conversations about imagination, film, and ethics. I have only been able to build this research by standing on a foundation of wisdom and talent as a hermeneutical researcher that Russ so crucially embodies, and generously provided. Also, thank you to my readers, Dr. Eva Simms and Dr. Will Adams for clear and thoughtful feedback on my writing and methodology that challenged me to go further into the work itself. I am indebted to my committee for providing exceptional mentoring and support. Thank you to the faculty of the Duquesne University psychology department for providing me with an unmatched education in human science psychology and phenomenology. Thank you as well to the research participants for providing excellent interviews, and all of whom must remain anonymous out of ethical necessity, but whose contributions are not taken for granted. This work would have been impossible without them.

Thank you to my parents for endless encouragement, support, and love, and to my Dad for teaching me how to write and always serving as my most trusted editor when needed. My Dad enabled me to pursue a doctorate through his readiness and enthusiasm to provide feedback on my thoughts, ideas, and writings.

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Finally, and tangentially yet historically relevant, thank you to E.B. White for writing *Charlotte's Web*, a book I was given by my parents for my sixth birthday, and a story of tender imagining whose ethical implications I have yet to fully grasp, but nevertheless greatly appreciate when considering from where my sensitivities have at least partly grown.

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“What is most human is not rationalism but the uncontrolled and uncontrollable continuous surge of creative radical imagination in and through the flux of representation, affects and desires.”

-Cornelius Castoriadis
(Castoriadis, 1987, Modell, 2003).

Introduction

This dissertation examines the role of the imagination in addressing ethical dilemmas in psychotherapy through a qualitative inquiry into psychotherapists’ respective reactions to a fictional portrayal of a clinically-relevant and value-laden ethical moment. Foucault’s distinction between formalized and informal knowledge provides a crucial basis for understanding how ethics is lived, narrated, and culturally constituted.

Moreover, this research builds, in part, from his post-structuralist critique of modern psychiatry, wherein Foucault demonstrates that psychiatric treatment shrouds itself in scientific jargon only to obscure its actual status as “a certain moral tactic...covered over by the myths of positivism” (Foucault, 1988, p.276; Gutting, 1989, p.95; Gutting, 2013). Consequently, our modern understanding of the psyche purports to free the mentally ill from madness while actually subjugating them to punitive moral systems, which in turn create further symptomatic responses, including those essentially arising from social marginalization and stigmatization. In effect, this research will investigate the convergence of values-based therapeutic practice, personal and cultural meanings, and the ethical imagination for the sake of identifying and describing a phenomenology of practical ethics. Such an inquiry holds heuristic, pedagogical,

liberatory, and psychotherapeutic relevance for those working both within and beyond the field of clinical psychology.

Beginning with the hypothesis that ethical practice requires *imagining otherwise*—a notion advanced by Ricoeur (2007)—this study investigates *how* psychotherapists rely on their imaginations to navigate difficult ethical terrain. Rather than following from the application of institutionalized codes to corresponding events, such imaginative activity draws from personal experience and cultural narratives, is informed by multiple sources, and includes the visual image. Furthermore, this study explores the polemical place of the imagination in Western thought as indicative of a broader tension between foundationalism and post-foundationalism, one in which ethical agency is frequently thrown into doubt. These concerns lead to an emerging view—inspired by the work of Ricoeur (2007) as well as philosopher Kearney (1988, 1998)—in which the imagination is seen as vital to the everyday practices of psychotherapists, who cultivate an ethical sensibility through culturally-situated narratives that provide both a script and screen for negotiating dilemmas. This is investigated through a hermeneutic inquiry into the sources of psychotherapists’ values, as reflected by participant interpretations of psychotherapy in film.

Applying the ideas of a wide range of thinkers, this study provides a counterpoint to the postmodern erosion of both imagination and ethical agency, an affirmative response to what Kearney calls “the wake of imagination.” This affirmation of the imagination is seen as indispensable to the process of engendering ethical agency and practical understanding insofar as formalized codes intentionally generalize, and thereby

fail to address ambiguous and marginalized ethical concerns. What is more, these ambiguous situations are often the foundation upon which agency might be affirmed, recognized, and advanced. Finally, these matters are considered in relation to courses of ethical action as narrated by specific therapists vis-à-vis images held in a wider cultural context; namely, through the use of a media clip from the television show *In Treatment*, which will initiate a semi-structured interview regarding the reactions of participants to ethical dilemmas.

Situating Contemporary Understandings of Ethical Practice

It is widely recognized that a working knowledge of ethics is indispensable to the practice of clinical psychology (e.g. APA, 2002; Barnett and Johnson, 2008; Tjeltveit, 1999). Moreover, the acceptance of psychologists in the broader community is grounded in a basic trust—or social contract—between the profession and the public, rooted in ongoing ethical practice of psychologists working in the field. This trust hinges on, among other things, decisions psychologists make about how they practice, as well as what sorts of institutional projects they explicitly or implicitly endorse (Tjeltveit, 1999). For example, the recent involvement of psychologists in interrogation procedures at the Guantanamo Bay Detention Camp and Abu Ghraib raised significant ethical concerns within medicine and psychology, but also among the general public (APA, 2005; Sharrock, 2009). Such matters impact the individual psychologist, the profession, society, and particular patients served (or denied service), as all are potentially affected by what comes to pass as either morally defensible or objectionable practice.

Across professions, ethical codes and standards are inextricably linked to a frequently implicit, yet nonetheless expected, social contract that exists between particular professions and the individuals or groups served by them. These contracts, both ancient and modern, date back at least to the roughly 2,000 year-old Hippocratic Oath (Amundsen, 1995), and are reflected in contemporary debates in science and medicine to clarify the ethics of biotechnology, end-of-life care, stem-cell research, and the like (Rifkin, 1998; Silver, 1998; Silver, 2006). Moreover, these agreements often highlight the basic expectations of conduct as well as desired ideals, thereby requiring respective professionals to take on special responsibilities in relation to those served, which embody a vision of “right,” just, or appropriate treatment (Haas and Malouf, 1995; Ozar, 1995).

Psychotherapy is among those professions wherein ethics is seen as critically important for practitioners, related legislative and administrative stakeholders, and the public who entrust mental health professionals to address delicate issues of psychological and social well being (APA, 1992/2002; Doverspike, 2003; Bersoff, 1994). Yet, its ethical nature is a profoundly unsettled topic, as disagreements flourish amid differing value systems and conflicting interpretations of how values impact clinical practice. These dilemmas are made increasingly complicated by the rich pluralism that is both characteristic of and celebrated within Western societies, thereby nourishing the dialogic basis of the psychotherapeutic relationship (Tjeltveit, 1999). As Gadamer argued in *Truth and Method* (1960/1989), relational understanding “occurs through a process of dialogical exchange of views during which good will (a serious honest attempt to

understand) is extended to different perspectives” (1960/1989). Ethical dilemmas test the strength of relationship insofar as the dialogism underlying interpersonal understanding is brought to the fore and possibly contested at a fundamental level.

While Gurman and Messer identify twelve of the “most important forms of psychotherapy being practiced today” (1995), alongside these core models are countless variations, all of which espouse some inherent differences—some subtle, others profound—in defining the basis of the good life, moral obligation, and values. Despite a profusion of approaches, ethics has been identified as a crucial component of psychotherapeutic practice because values, including ethical, psychological, and cultural ones, saturate client and therapist understandings, performance, and communication (Tjeltveit, 1999). Indeed, empirical research confirms that “nontechnical aspects of the therapist’s contributions are among the most influential in facilitating outcomes” (Beutler, et. al., 1986).

Complicating matters, though, are varying definitions of ideal, desired, or “good” therapy, based in deeper philosophical distinctions over how best to define human beings. For instance, differences between humanistic, psychoanalytic, cognitive-behavioral, and social constructivist understandings of psychotherapeutic treatment reflect significant disagreements over how human subjectivity is best defined. Rogers’ (1961) humanistic account of the good life, for example, privileges individual freedom and agency while Gergen’s (2009) social constructivist version subverts traditional notions of the autonomous subject, seeing value in movements toward greater relational notions of selfhood. What is more, traditional psychoanalytic accounts see subjectivity through

Freud's (1989) tripartite version of the embattled and divided-against-itself psyche, a view that gives rise to profound skepticism with regard to self-transparency and agency, ultimately seeing value in dismantling defenses for the sake of "changing the balance in favor of life [or Eros]" (Bass, 1998). Meanwhile, cognitive-behavioral models envision an individual whose symptoms arise as a direct result of the link between cognition and action, a relationship that is considered malleable through intentional and willed changes to maladaptive cognitive patterns (Wilson, 2008). These sorts of paradigmatic and intractable debates over subjectivity shape psychotherapy intervention, duration of treatment, and definitions of health. Perhaps the only unifying principle of the field, then, is that *effective practice is ethical*, and that the role of the therapist is significantly blurred with that of the ethicist (Tjeltveit, 1999). As a result, the complex question arises: what is *ethical practice*?

In an effort to define ethical practice, the American Psychological Association has established and promoted the Ethical Principles of Psychologists and Code of Conduct (APA, 1992/ 2002), otherwise known as the APA Ethics Code. Intended as a didactic document and not a legal one, the Ethics Code delineates two divisions: 1) General Principles—a set of five guidelines; and, 2) Ethical Standards. While the five general principles are considered unenforceable—"aspirational goals to guide psychologists toward the highest ideals of psychology"—the standards advance expectations that, when unmet, are subject to disciplinary consequences (APA, 2002). Practitioners are advised and required to consult the Ethics Code "in the process of making decisions regarding their professional behavior" (APA, 2002). However, other than this general statement,

the Ethics Code provides virtually no practical commentary or insight concerning the psychological qualities behind resolving, voicing, or negotiating ethical matters. Instead, intentionally broad rhetoric is employed, “in order to apply to psychologists in varied roles” (APA, 2002), while reserving the possibility that the standards are incomplete and may not cover the range of conduct that is, in fact, ethically ambiguous. Such a rhetorical strategy has been criticized as a means of protecting the profession over prioritizing any substantive moral development or foundation, ostensibly the sort of clear moral conviction that is in the interest of public welfare (Bersoff, 1994).

An attempt to provide practical commentary regarding *how* ethical dilemmas should be addressed may be found in a companion document, *Ethics Desk Reference for Psychologists*, which includes a subsection of the Ethical Standards, devoted to “Resolving Ethical Issues” (Barnett and Johnson, 2008). Styled much like the Ethics Code itself, this segment provides a generalized account of recommended, step-by-step procedures. For example, section 1.01 concerns the misrepresentation of one’s professional work by those within and outside of the discipline: “if attempts to resolve an issue informally are ineffective, consider a more formal action such as filing an ethics complaint” (2008, p. 25). The same is true of section 3.05 concerning multiple relationships, which instructs that one should “work to balance good boundaries with the unique therapeutic needs and cultural expectations of clients” (2008, p. 62). Such advice, while potentially informative and helpful, may explain courses of action to some degree; but fails to provide much in terms of understanding the complexity of how ethical dilemmas are enacted, narrated, negotiated, and meaningfully experienced.

Through its organizational and regulatory-like approach, the APA ethics code implies that dilemmas neatly map to categories outlined in the document. However, this approach—intended to represent ethical practice—provides no account of how decisions are made when matters do not correspond to established guidelines. In this dissertation, I propose that it is precisely the situations on the margins—those between clear categories—which typify many ethical concerns, requiring the use of a human and cultural faculty that lies beyond a technical or logical framework. Situations located at the margins of ethical knowledge require the use of imagination and reflection to practice ethics, as well as to further the ethical project itself, thus providing practitioners with the opportunity to engage ethics in the deepest, most vitalizing and life-affirming sense. Without the ability to *imagine otherwise*, as Ricoeur (2007) and Kearney (1998) argue, ethics becomes inherently non-participatory and, in effect, sterile, paralyzed, and a matter removed from history. Moreover, this understanding of ethics challenges oversimplified notions of thinking, thus extending the definition of thought to include the workings of imagination.

Ethics might be considered through “the productive power of language and that of imagination” (Kearney, 1998, p.148) which allows for consideration and generation of possible meanings, as well as the synthesis of dissimilar meanings. As a result, ethical practice might be seen to draw upon *both* language and the image, enabled by the productive and synthesizing modes of imagination. Such a view honors the phenomenological-hermeneutic model of imagination through its acknowledgement of its production of possible meanings, while also recognizing the Kantian model in which

imagination plays both a schematizing or ordering function, as well as a productive one (Kearney, 1998).

Kant's stance toward the imagination is worth elaborating upon by virtue of its stark contrast with previous versions. For Kant, the imagination was no longer seen through a Platonist frame as a "copy, or a copy of a copy," but instead assumed "the role of ultimate origin" (Kearney, 1998, p.158). Whereas Aristotle argued against Plato's *mimetic* version of the imagination by claiming that the imagination "was the passage between sense experience and reason," the two Greek philosophers agreed on the fundamental inferiority of imagination, concurring that "imagination is mostly false" (Gratton and Manoussakis, 2007). Moreover, the imagination's falsity and corruptive tendencies stemmed from its reproductive (or secondary) role in relation to sensation, a view that remained relatively unchanged until Kant unmoored the imagination from its complete servitude to sense perception.

Importantly, Kant's theory of knowledge heightened the significance of the imagination insofar as earlier accounts situated it within a mimetic model of representation, while Kantian and post-Kantian versions recognized its quintessentially productive, formative capacities, particularly its influence upon the cognitive structures which precede and organize experience. His assertion of the imagination's pivotal role in human understanding marked a turning point in the theoretical importance attributed to the imagination in other branches of philosophy as well, including aesthetics and ontology (Kearney, 1998, p.157).

Considering the influence of the imagination on ethical understanding, an ethics of everyday and historical relevance might be seen as active, engaged, reflective, and chiefly concerned with the *possible* influences and meanings of our actions on the actual lives of others. A participatory approach to ethics, then, acknowledges that ethical practice is less contingent upon one's application of formalized codes, and more dependent on thinking imaginatively about what is affectively, relationally, and morally at stake when dilemmas arise. Such an understanding of ethics aims to prevent the relinquishing of ethical agency and imagination to a higher authority, an unspeakably tragic act which characterized the behavior of Nazi doctors, as described during the Nuremberg trials (Sharrock, 2009), and presumably marks, to a large degree, countless instances of violence and brutality (see Milgram, 1965; Zimbardo, 1965).

Also serving as a painful reminder of the failure of ethical imagination are the Tuskegee experiments of the 1930s in which 400 healthy African-American men were used as test-subjects for syphilis. Dozens of the men eventually died from a lack of treatment and countless others suffered while the U.S. Public Health Service sought to collect data about the effects of the disease on the human body, and knowingly withheld penicillin even after it was discovered as an effective cure (Chadwick, 2002). These instances of inhumanity need not be limited to the realm of physical violence or mistreatment, as in the case of the Tuskegee experiments, but often occur in more subtle ways between those holding authority, power and expertise, on the one hand, and those being evaluated, served, or treated.

Avoiding unthinking deference to authority harkens back to the primary task of the Enlightenment, as understood by Kant and Foucault (MacIntyre, 1998, p.245). Importantly, we might pause to consider just what characteristics contribute to this fundamental task. Preventing potential atrocities inherent within the blind application of codes, both Kant and Foucault considered it a necessary project to achieve “a condition in which human beings think for themselves rather than in accordance with the prescriptions of some authority” (MacIntyre, 1998, p.245). From their respective yet kindred viewpoints, Kant’s and Foucault’s definitions of authority might be broadly conceived to encompass not only powerful figures and institutions, but also formal texts and codes, which threaten critical thought. As MacIntyre (1998) explains, “thinking for oneself is contrasted with thinking in accordance with the dictates of any authority [...] unenlightened thinking is characterized by the indiscriminate and unintelligent use of and appeal to rules and formulas” (1998, p.247).

Vital to the concerns of this study, the sort of enlightened thought which both Kant and Foucault had in mind is antithetical to a vision of the self-contained, autonomous individual characteristic of many Enlightenment philosophies. Against the notion of isolated subjectivity, enlightened thinking arises among communities of individuals who have arrived at, and continue to reproduce, certain agreed upon descriptive terms which strengthen and serve their value systems. Kant asserts that “thinking for oneself always does require thinking in cooperation with others,” according to MacIntyre (1999, p. 251). Indeed, thinking itself is best understood as “an essentially social activity” (ibid). Out of such a view of enlightened thinking, we might consider

how particular conversations about ethics serve as a foundation upon which the practice of ethics unfolds, and we might inquire into the features of those conversations, features which fundamentally transcend a limited understanding of public and individual reason. In other words, ethical understanding might be seen in a deeper and more communicative light, demanding of a more complex view than one that equates ethical thinking with reasoning per se.

From a human science viewpoint, the espoused “decision-making model” of the APA Code—intended as a “guide to understanding and applying the Ethics Code” (Barnett and Johnson, 2008)—demonstrates a common and misleading use of the term *understanding*. This misuse involves a blurring of the meaning between the terms *understanding* and *explanation*, a distinction found in the work of Continental philosophers Dilthey (1900/1989) and Ricoeur (1979). Dilthey noted this distinction in an effort to illuminate the primacy of interpretation in the process of understanding meaningful human phenomenon—such as ethics—particularly considering the inadequacy of *explanation*, which he equated to the technical and generalized language of the natural sciences (Burston & Frie, 2006). If ethics can be considered “first philosophy,” as Levinas (see Kearney, 1994/1998) argued, then it is necessarily a realm of knowledge and meaning beyond the scientific method per se. In other words, insofar as natural science—both methodologically and rhetorically—is a form of epistemology, it exists as a secondary branch of philosophy. Consequently, ethics and ethical practice cannot be understood when approached through a solely technical-explanatory lens, one lacking a vitalizing principle; such an insight is made especially apparent in the work of

thinkers such as Dilthey, Levinas, and Ricoeur. The APA Ethics Code and its accompanying desk reference serve as illustrations of how technical, list-like rhetoric is limited and insufficient with regard to ethics; the result being a rather vague, highly generalized document that neither addresses nor inspires moral conviction or informs practical ethical action. What is more, such documents do not provide a meaningful account of how ethical practice is lived, endured, debated, passionately performed, and creatively considered. These official documents provide little sense for the nuances of ethics in psychotherapy, leaving us with the question of how ethical decisions are made, including what the “sources”—from ontological to narrative ones—of ethical knowledge, discernment, and judgment might be.

Appealing to Foucault’s Archaeological Method and Ricoeur’s Notion of Imagination

A plethora of theories offer explanations regarding the sources or origins of ethical knowledge, including those favoring, in varying degree, religious or secular traditions, reason, the scientific method, human nature, extra-rational features, divine insight, relationship and community, and hermeneutics (Tjeltveit, 1999). Such foundations can be assessed according to their status in relation to formal or informal knowledge systems, a distinction derived from Foucault’s archaeological method. An amalgam of concepts, Foucault’s archaeology consists of the critical notions of *savoir* and *connaissance*. Defined as everyday social practices which merge with and embody a form of knowledge unique to a cultural and historical context, *savoir* is a special form of knowledge not so much written as enacted and performed (Scheurich and McKenzie, 2005, p.846). *Savoir* can be contrasted against the sort of formalized knowledge or

connaissance found in academic texts, official documents, philosophical treatises, and religious justifications (2005). Most importantly, *savoir* precedes and enables the construction of *connaissance*, allowing a given concept, principle, theory, rationale, or code to emerge.

One way of viewing Foucault's method is to understand its implicit subversion of the idea that formal disciplines work towards the accurate representation of phenomena, as though, for example, psychology's representation of the mind corresponds to how the mind exists "naturally" and "in essence." If *connaissance* came before *savoir*, one might believe, alongside Plato, that formal disciplines were involved in the discovery of correct representations of preexisting archetypal forms (or simply the discovery of reality as it "really" is), as opposed to the invention or construction of systems of meaning which provide a particular way of talking about problems, and certain frameworks for solving them. While the former position implies a sort of magical belief in the power of natural science to uncover truths about reality—through the use of objective, dispassionate, distanced reason; it is the latter position that appeals to Foucault and other Continental thinkers because of its outright rejection of the quest for universal foundations of knowledge. The latter position also seems congruent with the true spirit of the Enlightenment, which rejects any and all ideological or conceptual authority for the sake of tireless skepticism. In this sense, we might ponder whether an imaginatively-driven form of skeptical thought is more important to engaging the difficult questions of ethics and science than the authority of reason itself. What is more, an understanding of the proper sequence of *savoir* leading to the construction of *connaissance* recognizes the

ubiquity of pragmatic interests in the way we discuss and think about problems, which inherently reflects the particular interests of a specific time, people, and place; that is, of a locality taken in its disordered entirety.

The idea that *connaissance* can be removed or absolved of its connection to *savoir*—or the *everydayness* of historical and contextual practices—is typified in Western philosophy’s privileging of epistemology at the expense of ontology and ethics, something thinkers like Foucault and Rorty (1989) viewed as an obstacle to addressing the truly urgent problems of the day. This turn towards epistemology in philosophy symbolizes the priorities of psychology more generally, whose overarching interests have been with locating or “discovering” foundations and frameworks for the sake of reaching consummate conclusions about the human mind. This intersects with Foucault’s summary of his entire body of work as being “against the idea of universal necessities in human existence” (Martin and Gutman, 1988, p.11), which, as he aptly demonstrated through multiple works, may be countered by localized accounts that express the role of social practices and power inherent in the making of knowledge.

Foucault’s archaeology includes interpreting formal changes in a discipline [*connaissance*] as traces of more fundamental shifts in everyday life [*savoir*] (Scheurich and McKenzie, 2005, p.847). The genesis of a discipline, such as psychology in the late nineteenth-century, is indicative of much broader changes in “concepts, practices, procedures, institutions, and norms” (2005). This approach to research undermines the modernist notion that the human subject, operating as a master at the generative center of formal knowledge systems, is intentionally and coherently directing the development of

respective formal disciplines, as though *connaissance* exists apart from the cloudy influence of context, contingency, and circumstance (2005, p.848). At any rate, the point can be made, if we step back from methodology per se, that the entire modernist ideology—which still influences how psychology identifies and represents itself—of formal knowledge emerging through the rational efforts of respective human subjects at the center, is actually indicative of the way modernity imagines human beings to inherently exist. Specifically, such a human subject is conceived as an observer who can separate from phenomena for the purpose of objectifying assessment, as well as the source of an inwardness and privacy that is thought to occur naturally as a hallmark of individuality.

Our tendency to look primarily at *connaissance* when assessing the history and practice of psychology—and to consider *this* to be psychology—is overturned when one’s examination and inquiry extend beyond mere formal history, and subsequently investigates that which might be termed “the conditions of possibility.” Providing three axes or arenas for analyzing these conditions, Foucault’s method focuses on 1) the role of *savoir* in the making of formal knowledge; 2) power relations and accompanying tactics used to privilege certain discourses; and, 3) the development of the subject and parallel forms of subjugation (2005, p.849).

Perhaps more than anything, Foucault is drawing our attention to and insisting upon the innate incompleteness and, to a certain degree, arbitrariness of our explanatory and representational powers, rooted as they are in the interests of formalizing that which is more complicated than formalization allows. Additionally, such an acknowledgment enables reason to be put in its rightful place as only a portion of the broader creative and

generative capacities of the imagination, which Kant envisioned as the source from which human understanding arises.

Grasping the importance of imagination in the making of *connaissance* involves significantly altering our conception of the formalized account, as well as recognizing the intuitive and imaginative sources that inform everyday practices composing *savoir*. For psychology and psychotherapy, this might lead, perhaps, to a less hidden role of the fundamentally poetic and literary dimension of ethical codes, diagnosis, case reports, therapeutic intervention, and subjectivity, as opposed to insisting that psychology follow the model established by Western natural science which has, as Clifford (1986) explains, “excluded certain expressive modes from its legitimate repertoire: rhetoric (in the name of plain, transparent signification), fiction (in the name of fact), and subjectivity (in the name of objectivity)” (Clifford, 1986, p.5). These expressive styles were banished from legitimate formal knowledge structures by relegating them to the category of “literature.” By highlighting the paramount role of the imagination in the making of *savoir* and, subsequently, *connaissance*, we might begin to see why labeling any approach to psychology (or any formal discipline) as literary is radically misleading since formal knowledge is itself, to a certain degree, a literary pursuit. In other words, the distinction assigned to literary practices obscures the literary nature of all knowledge systems. This is not to dismiss the quality of one’s psychological inquiry, research, and interpretations—there is certainly a vital need for rigorous data collection, sophisticated description, diverse interpretation, skepticism, and critical scholarship in general. Foucault demonstrated such qualities throughout his work, but there is also the need to displace the

misleading, ultimately hubristic philosophical assumptions undergirding much of what we perceive to exist in formalized accounts.

Embracing Foucault's methodologies of *savoir* and *connaissance*, we might see their value as rooted in the perspective they provide on the distinction between "reasonable" and "legitimate" accounts, on the one hand, and those which fail to meet the criterion of formalization, on the other. By illustrating the way that *connaissance* is frequently appropriated apart from *savoir*—and through recognition that *savoir* precedes and exceeds the range of formalization—we can begin to see that any account which purports to be unambiguous is hiding a fundamental truth about knowledge, conceptualization, and writing; namely its partial and incomplete quality due to its location "in, and not above, historical and linguistic processes" (Clifford, 1986, p.2). Yet, it is just such a pursuit of "univocity" in ostensibly "objective" research and formalized codes that suggest there may be a different way of approaching how we account for and represent ourselves as bearers of knowledge.

A response to these problems of writing and signification might rely not only on Foucault's methodologies, but also on an understanding of the imagination which sees it as much more central to discursive processes than is often acknowledged. Frequently, we place the imagination into a functional category, defining it as that which creates images from the senses. This is limiting, though, in its denial of the equally indispensable faculty of the imagination as a creator of narratives and languages which allow for the unfolding of new lived worlds. Accompanying such unfolding would, of course, be the special knowledge or *savoir* that enables the emergence and reproduction of social practices. As

Ricoeur (1991) insists, “imagination [...] should be treated as a dimension of language” (p.304), by virtue of its connection to dialogue, meaning, and being. Ricoeur’s view, however, does not restrict imagination to a solely linguistic domain, but allows for imagination to be a mode of thought that exhibits visual and linguistic features.

In psychology, as well as Continental philosophy generally, there is a long history of questioning attempts at establishing a clear and firm boundary between rational speech and thought, on the one hand, and other forms of thought and communication, such as those seen which are primarily emotional, gestural, embodied, or imagined (Gratton and Manoussakis, 2007; Sampson, 2008; Gergen, 2009; Martin, Gutman, and Hutton, 1988; Bennett, 2001; Solomon and Sherman, 2003). Indeed, these latter features of thought and communication may be the very expressive avenues by which the *savoir* of daily life manifests, and it is often the “Other”—from non-Western peoples to the mentally ill to animals and nature—who carries the weight of this burden, linked to that which “civilized,” “rational” Westerners have desired distance (Corbey, 2005). Examining the role of imagination in the establishment of reliable knowledge marks, then, a departure from attempts to distance rationality from other forms of thought and communication, while suggesting a definition of thinking that exceeds the borders of reason per se (Murray, 1987).

For psychology, our treatment of the imagination and its role in the writing of psychological accounts is but one of many possible examples which typify the discipline’s struggles with its identity; among others is the role of *savoir* and its place in the genesis of *connaissance*. While *connaissance* can be seen as that which psychology

employs to symbolize and legitimate its value to the broader culture and its institutions, *savoir* is the messy but essential knowledge of context and practices which give rise to, but also might undermine established, reasoned accounts of phenomena. These dilemmas occur at the edges of the discipline, and highlight problems with the conventional classificatory frameworks through which psychology gains its identity, makes claim to possess legitimate knowledge about the human psyche, defends ethical practice, and communicates and symbolizes phenomena. Psychology's problems, then, might be redirected from focusing on obtaining universal information about the human mind to examining its own history and the difficulties of a value-laden psychological discourse vis-à-vis dilemmas of reason, alterity, social practices, and everyday knowledge (Sampson, 2008).

Some in psychology may rather ignore these ambiguous aspects of our work, as they pose threats to the traditional order of the field, at least from the perspective of social and philosophical precedent established by natural science (Kendler, 2005). However, if psychology is to acknowledge that its work is precisely on the margins—that is, with *what* has, and with *whom* have, been marginalized and neglected by the natural sciences, the medical model, and left out of formalized accounts—it might choose to embrace and celebrate its position and place as a discipline which is categorically ambiguous. As Foucault aptly explained with regard to his work,

I deal with figures and processes [on the margins of society] for two reasons: the political and social processes by which the Western European societies were put in order are not very apparent, have been forgotten, or have become habitual. They are part of our most

familiar landscape, and we don't perceive them anymore. But most of them scandalized people. (Foucault, 1988, p.11)

These remarks are appropriate for a psychology of the margins, one interested in its own history of acquiring, constructing, and formalizing knowledge; particularly surrounding the dilemmas and complexities of ethical practice. What is more, we might speak of the margins in a two-fold sense: both as a space in which people and ideas are positioned outside dominant discourse, as well as a space in which certain modes of human understanding—such as the imagination—are placed at the edges of formalized knowledge systems.

Addressing the Ethics-Practice Divide through the Cultural and Narrative Imagination

Coinciding with Foucault's distinction between formal and informal knowledge is the general consensus that a research-practice gap exists in psychotherapy (Walsh, 1995; Fourie, 1996; Talley, et. al., 1994). While this dualism is commonly seen as a problem caused by "the unscientific and vague nature of clinical theory and practice, [...] the solution [frequently] proposed entails transforming psychotherapeutic practices into experimental procedures," explains Walsh (2004). However, an alternative understanding of the problem is gained through a turn toward an ancient, tripartite distinction of Aristotelian epistemology between varying knowledge systems (Bernstein, 1983). For Aristotle, scientific knowledge (*episteme*), technical knowledge (*techne*), and practical knowledge (*phronesis*) distinguish our theoretical and practical ways of knowing. Furthermore, it has been suggested that psychotherapy practice necessarily and rightfully

occurs in the domain of moral or social action—known to Aristotle as *phronesis*—which explains the inevitability—indeed, necessity—of the notorious divide (Walsh, 2004).

With that said, just as different modes of knowing contribute to a research-practice gap, it is equally possible that epistemological distinctions give rise to an *ethics-practice divide*, particularly in consideration of the APA’s ethics canon, which sheds little light on the *phronesis* or *savoir* of psychotherapeutic ethics. In other words, this problem may not be restricted to psychotherapy research per se, primarily because the research-practice gap is a consequence of different modes of knowing, which produce a duality in the ethical domain as well. While empirical research is often ignored by practicing psychotherapists (e.g., Begley, 2009), ethical codes may be similarly deferred to a peripheral position insofar as they fall into the domain of formalized knowledge or *episteme*. This divide can be better understood by recognizing that ethical practice occurs within a domain of *phronesis* and *savoir*, as Aristotle and Foucault would respectively have it.

The notion of *phronesis* is an appropriate starting point for inquiries into ethical practice precisely because, categorically, ethics occurs in the realm of human action. This is markedly different from theoretical understanding in that theory “aims toward eternal and immutable being [whereas] practical wisdom takes the contingent and variable as its object” (Barash, 1998, p.33). In effect, *phronesis* “applies most directly to the domain of human affairs” (ibid). What is more, the practical wisdom inherent within moral judgment synthesizes with the core human faculty of narrative imagining. For Kearney (1998), “it is the task of narrative, in its ‘poetic’ forms, to provide us with

specific ways of *imagining* how the moral aspects of human behavior may be linked with [particular consequences]” (p.242).

Phronesis and narrative imagination are inseparably linked in the world of human action, joint features of how we relate to and enact contextually-bound values. Narrative itself is basically phronetic, according to Aristotle, insofar as it exhibits both *cathartic* and *poetic* functions. “As catharsis,” writes Kearney (1998), “narrative fosters wisdom by encouraging us to sympathize with the characters of imitated and plotted action while simultaneously provoking a critical attitude of withdrawal [...]” (p.243). This event of both cathartic release and poetic understanding leads to what Nussbaum (1990) sees as “special kinds of ethical attention” (Kearney, 1998, p.243). By way of humanizing and contextualizing abstract, theoretical ethical rules, Nussbaum (2001) views the literary narrative as especially crucial to the ethical project.

Nussbaum’s assertion could be taken even further by the claim that literary narratives—which might include fiction contained in film and media images—are not only complementary, but essential in the process of nourishing and maintaining a *vitalizing principle* in ethics. What is more, such a quality of aliveness is found waning in one-sidedly formalized accounts of ethics. As Kearney (1998) explains, “narrative considers ethics in terms of human desire rather than exclusively in terms of norms. It favors teleology over deontology and seeks to extend our understanding of ethical philosophy beyond formalist categories to include the ‘exemplary’ persuasiveness of literary and oral stories” (p.244). Moreover, we might add to such convincing accounts those derived from and contained within film, particularly in an age marked by the

ubiquity of untraditional “texts,” namely those transmitted through a hyper-technological popular culture. The kinds of narratives conveyed in these sources might be said to influence several aspects of moral and ethical life, from how individuals explore “the noncommensurability of valuable things” (Kearney, 1998, p.244) to contextually-sensitive judgments and the complex role of emotions in our value-laden actions.

Widely viewed, ethical sources might best be thought of in terms of affective and imagined phenomena that arise not in static isolation but through relationships of blurred boundaries in which webs of significance and meaning emerge. Such meanings are reflected in complex connections between communities, traditions, and the individual and social imaginings embedded in everyday practices. While moral and ethical codes reflect the formalization of values, ethical sources exist within the informal practices of everyday conversations, action, and performance. Such sources are inherently pluralistic and shaped by the ways particular agents make ethics their own, which requires the activity of the imagination to construct a meaning that has vitality with respect to the uniqueness of different situations. This might be thought of as a process of owning or crafting the plethora of ethical sources and meanings in the broader social imaginary, a process rooted less in the intellect and more in imagination. While the former attempts a clean break from affect and story, the latter is vitalized by emotion, narration, and aesthetically-rich visual imagery whose sources are elusive and multiple. In other words, what enables ethics to take on a *passionate* dimension is not contained by codes, but rather how particular subjects imagine the relationship between everyday practices or

savoir and the ideals expressed by codes, as well as in stories representing the lives of heroes, anti-heroes, and other characters with whom we can empathize (Tjeltveit, p.286).

Imagination and the Challenge of Inquiry

Considering these broad concerns, a critical challenge might be posed to an inquiry into ethical practice: is such practice the application of formalized knowledge or, because the variation in ethical scenarios is virtually infinite, is it a matter not of following procedure, but of practice rooted in the implicit knowledge of *savoir*? The presumption that ethics is driven by formalized knowledge problematically implies that unethical practices stem from a logical error in applying correct ethical knowledge. Yet, ethical dilemmas endlessly recur in new forms, extending ethics into an ambiguous realm beyond formalized, preconceived doctrines. One solution to this impasse would be to study and explore the *savoir* of ethics in psychotherapy, an inquiry that privileges practical knowledge by considering it as the ground upon which meaning and values arise.

In what ways does *savoir* require us to move into an alternate domain of inquiry? In engaged, lived practice, in order for someone to make a decision or acknowledge a dilemma, one has to imagine beyond the moment, which is fundamentally a non-technical act. While this act might be partly informed by formalized knowledge, it is by no means defined by, restricted to, or sourced in those systems. Rather, informal and implicit knowledge involves the critical act of imagining and telling it otherwise, which might best define the lived ethical moment. Indeed, Ricoeur (2007) and Kearney (1998) see

narratives as helpful in an ethical respect because it is always possible to create an alternate version or account; that is, to tell another way. This is elaborated by Foucault, who sees such acts not through individualized features, but as culturally and historically situated. Hence, while ethical practice is in some way informed by codified knowledge, it is more likely to take place in lived, dialogical, interpretive, and engaged ways (Sampson, 2008).

In effect, the everyday practice of ethics involves the activity of the imagination, which leads the actor to a place of not-knowing, reflection, and consideration of possibilities. Rather than deferring to moral rules from a quasi-administrative position (which is more bureaucratic than it is ethical), ethics is performed through imagining, wondering, and questioning. This process draws from a cultural imagination conveyed in popular and personal narratives (Gergen, 2009; Kearney, 1998; MacIntyre, 1981; Ricoeur, 1995; Valdes, 1991), suggesting entangled linguistic and visual dimensions. Moreover, the cultural imagination is informed by multiple sources, and in our technologically-based, media-saturated culture, these sources organize around the visual image, a defining feature of the cultural imagination (Kearney, 1998). We might consider, perhaps, a *multiattentional* approach—one that accounts for poetic qualities as much as technical and formalized ones—in understanding the mediatory forces and tools which assemble and shape both cultural and personal imaginings, as one media scholar has suggested (Boyer, 2007).

Ethical inquiry, then, begins with concern for how we go about imagining ourselves into particular relationships, which invariably reflect certain ethical dilemmas,

questions, and projects. Furthermore, ethical practice is less about resolving or quelling these ethical imaginings, and more contingent upon the *sustained practice of imagining*. This critically hinges upon how ceaseless changes in context, relationship, and interpretation re-orient us to our ethical narratives, calling for articulation of that which is implicitly enacted or performed. We are afforded the gift to name the otherwise nameless phenomena of the world around us, to paraphrase Rilke (2005). “Speak and make known,” he writes in the ninth elegy of his *Duino Elegies*, “more and more the things we could experience are lost to us, banished by our failure to imagine them” (Rilke, 2005, p. 58).

If mass media might be interpreted as a form of dreaming or imagining, as Romanyshyn (1992) has proposed, the sustained practice of ethical imagining might be seen to occur through narratives conveyed in and through media. This view of imagination leads to the cultivation of a poetic and aesthetic (values held in language as well as visual images and forms), rather than a technical orientation to ethics. In particular, Kearney’s notion of the narrative imagination allows for a sense of ongoing engagement with the ethical possibilities inherent within the flux of relationship with both actual and imagined others.

An oftentimes vaguely held concept, imagination might be viewed as a form of questioning and contemplating, even as a state of reverie in which emotional and thoughtful consideration might be given to matters usually held at the margins of the intellect. We might consider such a state as exemplary of a certain aptitude or *imaginative sensibility* that animates affective, intellectual, narrative, and aesthetic and

visual domains, thus allowing for greater sensitivity and empathy towards others.

Providing the imagination a critical place in discourse on ethics allows for the return of a vitalizing principle to ethics, something that is sorely lacking in many overly bureaucratic and formalized accounts of ethics which leave few inspired.

While philosophers have emphasized the vital role of imagination in human understanding—including Kant, Heidegger, Ricouer and Kearney—researchers have yet to apply these concerns to the specific ethical matters at play in the relationship between psychotherapy practice and cultural imaginings. In the interest of focusing on the narrative aspects of the ethical imagination, this inquiry will concern itself with Continental philosophy and contemporary cognitive science, and related theories that provide a central place for imagination both in terms of visual and linguistic capacities.

Thus, an adequate exploration of the ethical-cultural imagination must include an examination of some of the visual tropes that may provide both a script and screen for ethical narratives. This calls for a structural *and* post-structural sensibility, allied with a method that negotiates the difficulties and subtleties of concrete practice, often riddled with the weight of clashing priorities. The implications for seeing the imagination as culturally embedded requires a research methodology which extends beyond the subject per se, and into broader representations of ethical practice. For instance, popular representations of psychotherapy shape our understanding of ethics, including what might constitute an ethical dilemma and response. An example in this regard is the television show *In Treatment*, with a narrative and dramatic structure revolving around ethical dilemmas. This cultural artifact highlights the ways in which film and media narratives

might inform and inspire ethical deliberation and action, as well as how viewers or “readers” of the cultural text might re-appropriate and reshape ethical understandings that were previously implicit. Indeed, de Certeau (1984) has insisted that we have little understanding of the ways viewers use the images conveyed to them. As he notes, “once the images broadcast by television and the time spent in front of the TV set have been analyzed, it remains to be asked what the consumer *makes* of these images and during these hours” (p.31). De Certeau’s observations parallel a broader trend in the field of media psychology, in which there exists a paucity of research concerning the particular “*meanings* that media hold for audiences, rather than assuming (as with much media [...] research) that their effects are homogeneous” (Giles, 2003, p.82).

McLuhan also provides valuable insight with regard to the relationship between media and meaning, particularly through his distinction between hot and cold media (1964/1994). As he explains, hot and cold media can be distinguished by the degree to which they respectively allow for greater or less participation from the viewer, reader, or user (McLuhan, 1964/1994). McLuhan sees a hot medium like the printed word or ballet as definitively less participatory than a cool medium like television, which offers the viewer the possibility to be included because it does not require any special training or set of skills or expertise with which to engage its content or imagery. The greater the degree of specialization or formal training required to use or engage it, the less participatory potential the medium contains, according to McLuhan. “Any hot medium allows of less participation than a cool one,” he writes, “as a lecture makes for less participation than a seminar, and a book for less than dialogue” (McLuhan, 1964/1994, p.23).

If anything, the only training one needs to understand the content of a television show is to be a member of the particular culture in which the medium is intended to be viewed (and, lacking even that, one could argue that much of what is contained within television shows is at least partly understandable to nearly any given audience). Alternatively put, one only needs to understand the implicit knowledge or *savoir* of a given community in order to grasp and engage with a television show. We might, then, observe the workings of imagination, *savoir*; and the everyday practices of the non-specialist in a cool medium such as a television. In turn, it seems appropriate, that the study of practical ethics might ideally involve studying the effects of a participatory, inclusionary medium on the viewer, particularly when that medium involves the portrayal of a difficult, yet intuitively realistic, emotive, and believable scenario, one which calls the viewer to respond without excessive formality, abstraction, or ostentation.

Consequently, this inquiry into the everyday practice of ethics involved researching the ethical imagination by showing psychotherapists a segment of the TV program *In Treatment*, and then asking them to imagine the ethical implications and potential options of unresolved dilemmas faced by the characters in the story. Participant responses were then analyzed hermeneutically in order to articulate implicit values and practical ethics. Findings were compared across participants for the purpose of delineating individual and cultural features of the ethical imagination. Finally, the results were discussed within a broader historical and philosophical examination of ethics and the imagination with particular attention to integrating pragmatic clinical concerns with ideas stemming from philosophy and cognitive science.

Method

As referred to above, the methodological approach of this study is qualitative in general and phenomenological-hermeneutic in particular, consisting of an approach in which an understanding of the explanations, justifications, and meanings of individuals was sought in relation to the unique social, cultural, and personal worlds in which they live (see Packer & Addison, 1989; Murray, 2008). This method concerned first and foremost the dynamics at play in the convergence between social and historical factors in the making of personal meanings, including concern for the ways individuals make sense of, interpret, and imagine these forces through the stories they tell about their experiences and challenges (Murray, 2008).

Specifically, my method is phenomenological insofar as it seeks to attend to contextually-dependent descriptions of experience, meaning, and ethics. The starting point for this encounter begins with the phenomenological assertion that such matters are constituted through the daily and seemingly ordinary re-production of certain interests, purposes and activities. In this sense, my method aimed to illuminate what is typically overlooked in relation to the significance of everyday practices, which marks the intersection of its phenomenological and hermeneutic sensibilities. In other words, since hermeneutics provides an interpretive pathway to understanding an action through bringing “to light the world outlook of which it is a response” (Greco-Brooks, 2003); the methodological focus on uncovering the meanings and narratives embedded in the everyday workings of personal and cultural variations of the imagination signifies mutually phenomenological and hermeneutic interests, concerns, and priorities.

Since this research project investigated the influence of both the cultural imagination and personal variations of imagination vis-à-vis storied responses to socially and historically-based meanings, it employed the broad and interdisciplinary vision celebrated in the human sciences; namely, an appreciation of *integrative scholarship*. As van Manen (1990) explains, “a human science researcher is [...] a sensitive observer of the subtleties of everyday life, and an avid reader of relevant texts in the human science tradition of the humanities, history, philosophy, anthropology, and the social sciences as they pertain to his or her domain of interest [...]” (p. 29). Such a description resembles both Freud’s and Jung’s respective opinions regarding the ideal training for a psychotherapist: as broad, global, and multi-disciplinary as possible (McWilliams, 2004).

With this in mind, my comprehension of imagination and its complex influence upon ethical practice is heavily steeped in the literature I have studied in the Continental tradition of philosophy (as described throughout the above sections), as well as my exposure to such media sources as *In Treatment*, which have engendered curiosity about the ways popular imagery and narration are impacting, inspiring, and/or complicating the ethical domain of psychotherapy practice. Keeping these tendencies in mind, the method applied here is grounded not only in the hermeneutic-phenomenological human science tradition, but also—indeed, necessarily—in my personal experiences as a member of contemporary culture. What is more, there has been little if any research done into the ways such cultural artifacts shape the life of ethics in psychotherapy, thus having presented the opportunity to investigate the narrative dynamics with which clinicians

engaged an imagined ethical dilemma, as represented by a popular media source. In this sense, my approach makes an original contribution to the current literature in the field.

Additional contributions that this research intended to make include validating the method to the goal of exploring the role of imagination in ethics. Methodologically, I have outlined an alternate way of looking at how people solve dilemmas, a way that is intended to honor the practical foundation of ethics. Clinically, this study informs how ethics is understood professionally in relation to formalized codes, and with regard to trainees and the educational aspects of ethics.

Research Participants

This dissertation involved recruiting six active psychotherapists from regional doctoral programs in clinical psychology and master's degree counseling programs, namely Duquesne University, University of West Virginia, Chatham University and Carlow University. In an effort to diversify the theoretical orientations of the participants, I sought to gain at least one participant from each program, which provided sufficient theoretical pluralism, highlighted by the distinctions between the psychology departments of each of these universities. Though initially challenging (mostly because the first two therapists to respond to recruiting were male, presenting worry that a gender imbalance may develop), I succeed in recruiting and interviewing an equal balance of male and female therapists. Through the use of email, I informed clinicians of the study by contacting department chairs and requesting that they forward the research description and call for students of respective doctoral and master's level programs.

After the first two participants responded from Duquesne, there was a complete absence of response from potential participants for nearly four weeks. Consequently, I met with my director, Dr. Walsh, and discussed the possibility of providing an incentive for participating. We decided to give \$25.00 in return for participating in the roughly hour-long interview. Although not immediately resulting in a sea change of interest, eventually four more participants were recruited, and a seventh expressed intrigue, all occurring within several weeks of sending email notification of the financial incentive. The seventh was declined since Dr. Walsh and I had agreed to limit the participants to six, mostly out of an intent to keep the scope of the project reasonable, particularly since it involved extensive interview transcribing and close hermeneutical analysis of data.

My interest in recruiting graduate students rested in my desire to attain rich and detailed narrative accounts in response to the research inquiry (a short film clip followed by questions and conversation about the piece). While other populations might have sufficed, it seemed important that the participants had recently received ample formalized training so that an inquiry might be made into the influences of everyday sources on ethics, while also encouraging imaginative activity between formal and informal knowledge structures. If the participants had been out of training for a lengthy period of time, it is possible that the accessibility of their formalized training may have waned. In other words, I was interested in interviewing therapists who were recently exposed to ethics courses and clinical training materials, hoping that they may recall formalized codes if necessary.

Typically, television programs are not considered formalized sources of knowledge, which allowed for the juxtaposition of knowledge sources. This called for encouraging participants who had received a high degree of formalized training to navigate informal sources of meaning. As noted previously, this meaning was taken to be both visual and linguistic, which challenged participants to articulate and narrate a responses that appealed to a sensibility that was far from strictly intellectual, conceptual, or academic. This task indirectly suggested to them the need to rely on analytic tools that are typically underrepresented in conversations about ethics, such as imagined and affective-laden responses to the characters and story, as were featured in the media clip. Such inquiry was made easier for participants since they were talking about fictional characters in a story, and thus provided insight into a task that is not unlike a *projective* psychological assessment.

The recruitment email described the study in the following terms:

“Psychotherapists are sought for participation in a study about the HBO television program *In Treatment* and the unique meanings it holds for practitioners. Interviews will be conducted at the Duquesne University Psychology Clinic.” There was no explicit mention of the short film clip or the role of imaginative thinking. Rather, the involvement of these factors was only explained to the participants at the outset of the interview. Specifically, participants were asked to imagine their responses in relation to a particular television segment which was invariably shown to all of them (in separate interviews).

The interviews were approximately 60 minutes in length and were audio recorded for subsequent transcription and hermeneutic analysis. By “fixing” the narratives by way of audio-tape, the content became “a text-analogue [that could] be interpreted,” as Greco-Brooks (2003) writes. At the beginning of the interview, participants were informed of the purpose of the research (to explore psychotherapy values vis-à-vis a popular representation of a psychotherapy dilemma), the duration of their participation, their rights that confidentiality would be maintained, full disclosure that their involvement was voluntary and subject to termination at their discretion or choice, and that such a decision would lead to no penalty whatsoever. Furthermore, they were given the financial incentive at the outset, preventing any pressure to complete the interview under any discomfort. All of this was conveyed verbally as well as in a written form; participants were asked to sign the consent form delineating these conditions, which included assuring them that the study should pose no risk to their well-being in any way.

Following the initial process involving consent and a description of the purpose of the study, participants were shown an episode from the television series *In Treatment*, which lasted approximately 30 minutes (Season 1, Episode 37). They were informed that they would be asked to respond to the piece during a semi-structured interview following the piece. Specifically, the episode was taken from the first season of the miniseries.

Featuring a dramatic portrait of a highly confident and intellectually challenging Navy fighter pilot named Alex, the episode culminates with Alex terminating therapy, thereby putting his psychotherapist Paul in a difficult position. In the portrayal, Alex copes with the weight of a haunting combat experience in which 16 Iraqi children were

killed after he and his comrades carried out a bombing attack on a mistaken target. While the Navy acknowledged faulty intelligence and placed the blame elsewhere, Alex is tormented by his involvement in such a tragedy. Moreover, he passionately resists displaying his vulnerability and distress, as he strives to hide the depths of his suffering from his therapist, Paul. Toward the end of the session, it becomes clear that he is determined to return to active duty, including combat missions. His successful return depends crucially on Paul's summary of Alex's treatment. As the façade Alex struggles to maintain begins to crumble, his animosity and verbal aggression toward Paul intensifies, leaving Paul perplexed. Paul must decide whether to alert the military authorities to Alex's psychological instability, or whether to abide by Alex's request to keep such information between them. This particular segment was chosen because of its complexity and ambiguity, as well as the abrupt completion of the episode, which leaves the viewer quite uncertain as to what will transpire among and between characters.

Immediately after the segment was completed, participants were given the following prompt: "Imagine that you are the therapist in the story. What is his ethical dilemma, how would you respond, and can you imagine other possible responses?" The prompt was intended to allow participants to engage in a process of thinking which invited the emergence of imaginative activity insofar as the film segment portrays an ambiguous situation, one that will be left unresolved by the character(s) in the story. Furthermore, because imagination is, according to Murray (1987), taken to be an indispensable part of thought, language, and action; imaginative moments unfolded due to the ambiguity of the portrayed scene. This particular aspect of the method followed

Barrows' (1999) research into the role of imaginative thinking in borderline personality. Since the interview was semi-structured, many of the questions during the subsequent conversation were those seeking clarification.

Specifically, the semi-structured interview involved the initial prompt noted above, followed by questions seeking clarification about participant responses to the situation, including what they thought was occurring between the characters in the scene, what risks were involved for the patient and therapist, and what sources and experiences they relied upon to resolve some of the particular questions the portrayal sparked for them. Instead of using a written scenario to convey the ethical dilemma, an evocative media source was arguably more appropriate for the purposes of this study since a dramatic representation has the potential to evoke stronger feelings and imaginings from the participants. The familiar experience of television and film provided a starting point from which participants were able to immerse themselves in ethical moments. Consequently, what I looked for was not an intellectualized response, but one closer to emotional and imaginative sources, which shape our initial, practical reactions to events both within and outside a clinical context. In this sense, I searched for the subtle and idiosyncratic ways in which imagination converged with and helped ground the construction of a (partly) coherent and meaningful account.

Participants were also asked to reflect on what alternate responses they considered in the process of narrating the particular course of action that they eventually chose, as well as to explain in detail how they made their decisions. Attention was given to uncovering the relationship between their imagined reactions and formalized ethical

codes, which I anticipated they would, eventually, refer to in narrating their envisioned courses of action. However, it turned out there was a significant absence of participants' referencing of such relationships, necessitating the need for me to inquire into their sense of conflict (e.g. the sort of conflicting ideas, emotions or interpretations they experienced). I also asked how they might respond communicatively and socially with regard to the dilemma (i.e. whom they might contact and how they might articulate their position).

Interviews were determined to be complete when the complexities of narrating possible and chosen ethical responses had been voiced, as well as when both myself and respective participants felt they had adequately explored the rich material evoked by the film clip. In particular, this process was assessed through three thematic categories within the narratives of participants: 1) reference to the sources of ethical action; 2) justification for decision, including how conflict was deliberated, resolved or assuaged; and, 3) concrete description of ethical response. Essentially, this template sought to illuminate the broad, yet underrepresented, categories of deliberation, choice, and action in the creation of ethical coherence. After the participant had provided content for these three categories, the interview was considered complete for the purposes of this study.

Interpretation of Data

Fundamentally, my approach to interpreting the data began with a movement away from reaching any sort of fixed conclusion about the way individuals resolve ethical dilemmas, thus moving toward a greater openness in considering the more subtle and elusive aspects—often unrecognized and arguably rooted in imagination—involved when ethical complexities were negotiated. This method aimed to cultivate appreciation for a vitalizing principle in ethics that is frequently eroded by heavily formalized, codified and conceptual approaches to ethical practice. Interpreting the data, then, focused less on fixing a grand design than upon ethical action, and more on encountering *lived ethics*. It thereby sought to strengthen a sense for the richness of everyday ethical practice, and preserved a quality of incompleteness valued by a phenomenological-hermeneutic perspective. It is the very quality of incompleteness that enables critical and innovative conversations about ethics to continue. This understanding necessitates the use of the hermeneutic circle in making sense of and producing meaning from the data, as described by Packer and Addison (1989), among others.

Acknowledging the hermeneutic circle in the process of interpreting the data is to recognize the inherent circularity of all understanding (ibid). As Packer and Addison (1989) write with regard to impact of Heidegger's contributions to the process of studying new phenomenon:

“...we are always thrown forward into it. Unless it is totally alien we will have some preliminary understanding of what kind of phenomenon it is, and what

possible things might happen to it. This means that we both understand it and at the same time misunderstand it; we inevitably shape the phenomenon to fit a ‘fore-structure’ that has been shaped by expectations and preconceptions, and by our lifestyle, culture and tradition.” (Packer & Addison, 1989).

Keeping such a process in mind, as a hermeneutic researcher, my understanding of the phenomenon of ethics arose through my own projected horizon or framework, which did not misinform my interpretation approach, but rather enabled and structured a meaningful encounter with the data. Concretely, this meant that I studied the transcripts and formulated initial interpretations of respective participant discourse, and looked for thematic continuity, as well discontinuity, where moments of imaginative activity may be heightened. Moreover, I reviewed the transcripts after themes and interpretations coalesced, and intended to uncover places where my emerging understanding was contradicted by the data. After an account was obtained from a participant, I distinguished among certain phrases to highlight thematic content. This procedure converged with the previously mentioned interview categories, which involved highlighting words and phrases in those three domains.

Among the patterns I was looking for is *how* the imaginative moment emerged and unfolded in relation to the evolving ethical perspectives and positions of participants. This included concern for where the imagination took the narrative; did the narrative lead to divergence, convergence, or idiosyncratic combinations of both? The concern was with investigating how the narratives of participants established (or perhaps avoided establishing) a foundation for moral and ethical meaning and action, and, in effect, how

that foundation served to resolve a crisis of meaning stemming from the desire for ethical coherence.

Such desire—stemming from the ability to imagine the world otherwise—has been reduced in modern analyses, but was highly prized in ancient discourse, and may be seen as crucial to re-enchanting and re-vitalizing our sense of ethical engagement with the world around us (see Garrison, 1997). Furthermore, this analysis sought to follow the imagination through the fog of conflict and ambiguity, and into the clearing of situational, contextualized understanding and knowledge, which I hypothesized would be critical in allowing a response to be formulated, spoken, and enacted. In particular, I attended to where ambiguity was (dis)placed as the narrative developed, including examining how ambiguity was dissolved, integrated or denied, and to what degree it remained present in the discourse of participants.

Ambiguity was considered to be particularly important because the *practice* of ethics occurs in a realm beyond the order and structure of formalized knowledge, thereby involving *a necessary tension between the lack of a framework and the need for one*. We might understand the human tendency to seek a frame as reflective of a basic desire for ambiguity to be curtailed, which rests in what the Greeks envisioned in the relationship between *eros*—or the desire to do good—and practical wisdom, which involves the application of imagination in the service of that desire (Garrison, 1997).

Following an investigation into and formulation of participant themes, I comparatively used the summaries of respective narratives for the purpose of contrasting

differences and similarities. This process enabled me to identify final themes which explored the varying sources of imaginative activity, from narrative to ontological ones. What is more, this process of engaging themes across participants ultimately intersected with theoretical interpretations based in a historical assessment of various philosophical treatments of the imagination, as well as current ideas from cognitive science.

In sum, this study explored ethical action in a clinical scenario prompted by a fictional portrayal of psychotherapy practice. This involved investigating the role of imagination in ethical decision-making in ways that exceeded the formalized codes, which attempt to dictate specific ethical behaviors, procedures, and meanings. In other words, rather than presuming that formal knowledge grounds particular action and understanding, this study attended to the actions, rationale, and supporting sources evident within individualized accounts, which unfolded within the broader realm of practical knowledge and understanding.

The method of analysis for this study began with a close reading of the interview transcripts followed by a process of distilling central themes, ultimately resulting in both situated and general structures of analysis. Initially, central themes—distinct for each participant—were identified that corresponded to my research question concerning ethical decision making. Such central themes then led to the emergence of additional groupings or clusters which reflected my initial concern for *how* therapists address ethical dilemmas in therapy. Practically, that initial concern—namely, the research question—was pursued through a process of highlighting interview content that was relevant to the

participants' discussion of an ethical dilemma, including any material related to client background story, case formulation, diagnosis, ambiguity, etc.

The initial categories that emerged from my review of the transcripts concerned several thematic areas of participants' ethical decision making: 1) identification of an ethical dilemma; 2) evidence or indication of ambiguity, doubt, or uncertainty; and, 3) justification for a course of action. Subsequently, interview content was highlighted to identify any evidence of ethical decision-making that applied to one or more of these thematic categories.

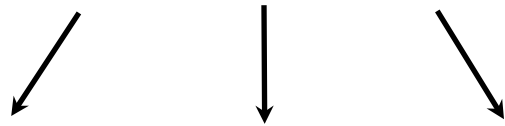
In the process of thematic highlighting, a set of interpretive marginal notes was created and ultimately organized into clusters, providing a second set of data, one rooted in my interpretation of the participants' statements. In other words, following the first step of highlighting content relevant to the research question, I summarized particular statements into simple thematic phrases. For instance, if a participant stated that she would "keep in mind the goals of treatment," my translation would result in a category summarized as "goals of treatment." The marginal summaries were then organized into preliminary groupings, which led to the emergence of a second set of central themes. The material clustered into four groups: 1) ambiguity; 2) metaphors; 3) intended action; and, 4) ethical dilemma. Following the identification of these four groups, I further categorized the themes into additional unique groupings, with the intent to identify central ideals derived from my marginal summaries.

Data was subsequently assessed to capture the subcategories of respective major ideals, in effect illuminating the frequency with which subcategories occurred for each participant, as well as instances of repeated thematic comparison. These two dimensions-- frequency of subcategorization and instances of repeated thematic comparison-- were organized into tables to best illustrate when such instances occurred and which participant cited particular ideals (see Tables 1 and 2). The ideals were also assessed in terms of frequency by which individuals discussed each ideal, listed parenthetically next to the ideal, thereby indicating the individual participant. The same was then done for subcategories (see data section). These tables can be found under the results section entitled "Comparisons Across Participants."

In summary, the method for this study involved both a structural analysis and a content analysis, as discussed above. For the sake of clarification, a flow chart is provided below to outline the two major divisions of the method, and specific aspects of each. The structural analysis was preceded by a careful reading of the interviews to gain an overall sense for the content and concerns of participants' responses. It should be noted that each step of the analysis is documented in the Appendix.

Structural analysis

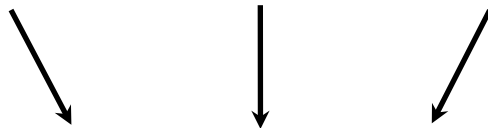
Thematic categories identified
within transcripts



Identification of an
ethical dilemma

Indication of ambiguity,
doubt, or uncertainty

Justification for a
course of action

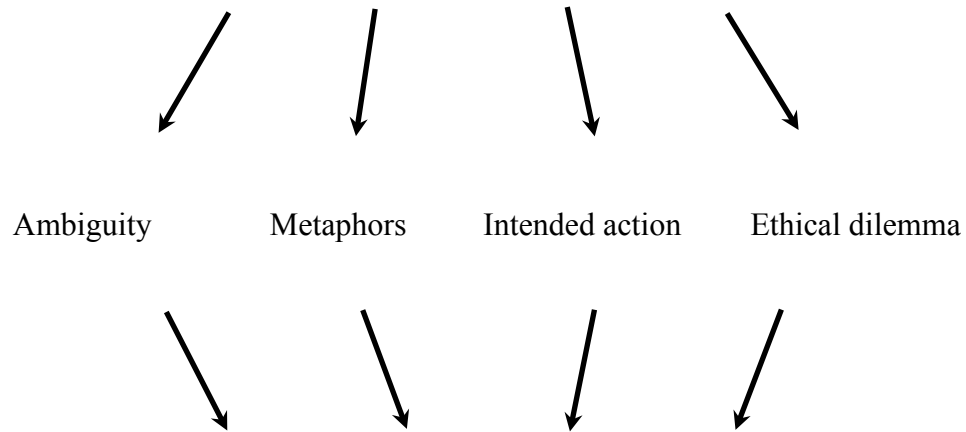


Interpretive Marginal Summaries

(leading to Content Analysis)

Content Analysis

Marginal summaries
(leading to second set of themes)



Central ideals

-identification of six major ideals across each participant

(see tables 1 & 2 below for analysis of subcategorization
and instances of repeated thematic comparison)

Results

Individual Participant Summaries

Greg

Participant 1, referred to by the pseudonym Greg, is a 33 year-old Caucasian male who was in his fourth year of doctoral training in clinical psychology at Duquesne University at the time the interview took place. He had practiced psychotherapy and psychological assessment for nearly four years, and underwent a one-year training in neuropsychological assessment at a regional hospital. Furthermore, he identified his clinical orientation as predominantly informed by psychodynamic theory.

Greg approached the task thoughtfully and intensely, taking notes about the clinical vignette, and extending his rumination over various ethical dilemmas and possibilities well beyond the length of any other participant. He returned to each of his major ethical concerns multiple times and, at several key moments, accepted and acknowledged contradictions inherent to the complexity of the clinical portrayal. Overall, his approach was characterized by confident pondering and careful consideration of the clinical encounter, notably shaped by his self-identified proclivity toward psychoanalytic thought and an attempt to understand unconscious and hidden motives.

In terms of specific content, Greg's responses seemed to run the gamut, acting as a veritable flagship for subsequent participants; his was the only interview that comprehensively spanned categories, including concern for and content from each of the six major themes, namely, those of clarity, patient's past, patient's safety, boundaries, therapeutic relationship, and clinical understanding. Greg also provided numerous

responses derived from these major categories, expressing concern for nuance and subtleties within the ethical dilemmas with which he was preoccupied.

More than any other participant, Greg identified themes that were diverse and descriptive enough that subcategories needed to be noted in order to account for his extensive responses. Such a trend is visible insofar as his responses, in the form of interpreted ideals, appear with greater frequency under the six major ideals than any other interviewee. In order to account for this diversity, 46 instances of subcategory responses were noted across the six major ideals (see Table I, Ideals from Analysis of Marginal Summaries section).

Greg's responses also involved a numerous instances of what might be termed "repeated consideration," suggesting increased rumination and heightened awareness of and concern for specific dilemmas and difficulties. While not as great a disparity from other participants as with the aforementioned instances of subcategory differentiation, he expressed the greatest number of any participant, with repeated consideration of particular themes in 15 instances (see Table II, Ideals from Analysis of Marginal Summaries section).

In addition to high amounts of subcategory differentiation and repeated consideration of ideals, Greg also explicitly attested to a concern for preserving ambiguity, noted in bold under the general section entitled "Boundaries." His concern for ambiguity appears thematically tied to his valuing of maintaining a treatment space and respecting the patient's values, on the one hand, and confronting the patient and avoiding collusion, on the other. Such an observation about Greg's thinking is reflected in the way

that his consideration of boundaries involved all four of those potentially conflicting subcategory concerns. These themes are illustrated at various points, including the following rumination:

“Because what is it that he [the patient] wants? And I think I would, um make that very clear. And I think in the session I would have been a bit more, just for my own sake, be a little more clear about what it is that he wants [...] you know, because it seems like there is this, um, in the session where it becomes, um, the boundaries are beginning to cross because the client is asking you to lie in a way.”

In light of these observations, Greg demonstrated an ability to simultaneously hold contradictory ideals while wrestling with his values; that is, he expressed a desire to maintain a somewhat inactive stance that he felt would preserve ambiguity while also indicating the importance of direct confrontation and the avoidance of collusion. What is more, at some point during a practical clinical encounter, these values would eventually lead to a conflict in which Greg would need to assess how much inactivity or ambiguity to preserve in the face of the growing pressure to confront when necessary. Furthermore, any confrontation inevitably conveys values, and Greg would be communicating his values when applying a confrontational interpretation or response-- grounded in his theoretical orientation-- to the patient. Despite the vagueness with which Greg leaves both the interviewer and himself (in that he does not explicate which path he would

actually choose), it is expressive of an underlying and perhaps more vital value system about psychotherapy that he, in fact, holds; one that is accepting of contradiction and paradox in the realm of conflicting values. This is demonstrated through statements such as the following:

“Is [...] being in the air a safe place for him [the patient]? When these kinds of issues of identity and responsibility and guilt are set aside? Can I be certain about that? And I don’t know [...] I can see it going either way.”

Another instance in Greg’s interview where this became evident is with regard to his repeated concern for clarity, for example clarity of communication, language, and ordering of clinical material. Such values, through his use of the clarity metaphor, may conflict with his concern for remaining inactive and ambiguous. If we assume that the process of clarifying involves ordering and negotiating what is otherwise opaque or cloudy, then we can conclude that Greg is concerned with both helping the patient toward organized thought while also ensuring there is *adequate ambiguity* to leave the ultimate agency with patient, and cultivating possibilities; as possibilities thrive on ambiguity and open-ended questioning. However, taken from a different viewpoint, we could see his concern for clarity as compatible with remaining inactive in that through inactivity, Greg would be forcing the patient to clarify the meaning of his statements and language while also engendering agency and responsibility. In multiple places, Greg makes comments along the lines of “[intending on] being a little more clear with the client about what I’m

willing to say or what I'm thinking," as well as "I think I would have been a little more clear, I mean, a little more direct [...] in the session."

Greg's responses indicate a noteworthy balance and tension between direct and practical concerns of patient safety, boundaries, and ethical pragmatism, which tend to cluster together, as well as a more subtle concern for the importance of depth, interpretation, and intuition. At various points, he cites interest in each of these themes, while avoiding a dependency on or deferral to codified rules and abstract ethical codes, exemplified by the fact that he makes no explicit reference to particular rules, instead relying on his idealization of a rather unspecified "moral foundation" amid a stream of steady and speculative questions, which is a more lengthy and complicated task than justifying action based on an abstract code. If anything, his interview suggests that Greg's moral foundation is built upon values of openness, basic safety, confrontation, psychodynamic interpretation, and the preservation of ambiguity, even when these values at times conflict and contradict one another. As will become evident, Greg's values and concerns differ from other participants, some of whom demonstrated perhaps a stronger desire to maintain greater pragmatic coherence and avoid explicating ambiguous material. These values can be summarized in one of Greg's quotes in which he describes his view that difficult material calls for the use of both clinical intuition and imagination. With regard to making hard choices, he states:

"It's more of a feeling, you can feel it and it's imaginative. You have a certain ideal of what is possible that is kind of guiding, um, what you're saying. But like

he [the therapist, Paul] says: ‘we have a lot of work to do.’ He has a certain image of what therapy is, what is possible, based on his experience but also on what he has been taught.”

Finally, toward the very end of his interview, Todd, beautifully summarizes his outlook, saying that, as a therapist,

“You see certain outcomes, you see certain things, but what really guides you a lot are the cases you read, the things that you hear, about what is possible, what goes on in your own therapy, what you’ve experienced kind of thing, you know, as a therapist. There is this kind of thing, um, this ideal, this kind of thing that guides you, an ideal, that I’m going to look at this situation and, you know, not just ‘what am I obligated to do’ but ‘what is possible for this client’ and that’s guided by experience and theory and your worldview.”

Todd

Participant 2, referred to as Todd, is a 30 year-old Caucasian male who was, alongside Greg, in his fourth year of doctoral training in clinical psychology at Duquesne University. At the time of the interview, his training was similar, although he lacked the former participant’s training in neuropsychology, substituting in its place training at a counseling center at a small liberal arts college in Pittsburgh. He identified his clinical approach as humanistic and post-structuralist.

Todd's approach to the task was visibly more relaxed and, at times, even more playfully contrarian than that of the other participants, but by no means less sincere. He seemed to relish moments when he could depart from the immediate, and perhaps, expected script; one that seemed to equate ethical dilemmas with problems confined to the therapy room.

Moreover, Todd was quick to bring lingering political and meta-theoretical questions to the fore. Such transgression and defiance of thematic confinement was most pronounced when Todd questioned the whole notion of treating a client's symptoms for the sake of allowing him to return to military duty as a Navy pilot, a duty in which the client would, presumably, be directly engaged in activities intended to kill other human beings. Todd suggested that the client's complaints and presenting symptoms might, perhaps, be best left untreated or, at a minimum, interpreted with a pacifist leaning, lest the client return to a wider unethical lifeworld of military violence and destruction. Additionally, Todd questioned whether it would be ethical for a clinician to clean the wounds of war, so to speak, knowing the client would likely return to a situation where he would be further wounded, possibly both emotionally and physically. This is typified through the following remarks:

“My initial sense was that I thought [...] that the question or phrasing of someone being ready for war was already flawed in a sense [...] the whole ‘are you ready for this or not’ doesn’t really make sense to me [...] if the guy was traumatized by killing innocent people [...] Are you really going to go back and kill innocent

people? Because it's a nonsensical question to me. It's like if, as for me, coming from the place of a psychologist because that's psychopathic, you know?"

Ostensibly, Todd would have departed from the more conventional approach of the fictional therapist, instead pushing the client to (further) question the purposes and consequences of military work and war. It is indeed fitting that Todd's interview involved pondering questions on the borders of professional psychology's ethical canon, such as the ultimate ends of a professed ethical psychotherapy that in effect causes wider ethical problems; exemplified through his humanistic and post-structuralist theoretical orientation, which conveys a set of values, concerns, and interests that extends well beyond the discipline of psychology per se, intersecting with sociology, philosophy, and linguistics, just to name a few. At one point, during a moment of reflecting on making mistakes in therapy, Todd states:

“you can look at it [therapy] somewhat analytically and say, well, ‘I [messed] up and that would have allowed therapy to change or that would have allowed them to have some realization that they should have or whatever [...] and the opposite is true as well, like, I just tend to assume that things are going really well, I take a class in post-structural psychology and begin to think, well, what is really going on in here?”

While not as broad-ranging or lengthy as Greg's, the specific content of Todd's overall interview touched upon every major category, and he ruminated on all six of the themes, demonstrated through repeated concern for and questioning of issues surrounding clarity, patient's past, patient's safety, boundaries, therapeutic relationship, and clinical understanding. Todd also provided numerous comments which qualified for subcategorization, leading to consideration of several critical themes, as well as idiosyncratic and meta-clinical concerns.

The diversity of Todd's responses is demonstrated through 21 instances of subcategory responses across six ideals. While below the participant average, his repeated and numerous subcategory responses visibly hover around the rest of the group, making the statistical average of 25.5 misleading, due to the disproportionate number provided by the first participant, Greg (see Table I, Ideals from Analysis of Marginal Summaries section).

Todd's interview also involved multiple moments of repeated consideration, illustrated through 12 instances in which he returned to the same theme or dilemma three or more times. This suggests ongoing concern for and valuing of particular themes and their complexity, implying that an unambiguous application of a rule or code will not suffice for making sense of the dilemmas at hand (see Table II, Ideals from Analysis of Marginal Summaries section). Todd's 12 responses of repeated thematic consideration are virtually precisely at the average (12.2), and occur with a frequency quite similar to that of the other participants, especially since there were no extreme scores in this area, with the highest number of instances being 15 and the low 9.

Alongside frequent occurrences of subcategory differentiation and repeated consideration of ideals, Todd also expressed concern for a number of particular dilemmas, reflected in the interpreted ideals highlighted in bold, and present in five of the six major thematic categories. Among these, concerning clarity (Theme 1, Interpreted Ideals), Todd ruminated on several thematic subcategories, including “clear, precise language,” “clear communication,” and “order and clarity.” Paralleling these themes, Todd added concern for “coherent history” under patient’s past (Theme 2, Interpreted Ideals), which is seemingly compatible with his valuing of organization and clear communication as a means to ethical practice. However, his responses become more complicated and conflicting when several of his other key concerns are taken into consideration. Such conflict revolves, in particular, around his valuing of ambiguity, inaction, and mystery, themes which he struggles with and returns to repeatedly throughout the interview, epitomized when he says “I leave a little bit of mystery and ambiguity in what the right thing to was or is.” He also states that [the clinical situation] “pushes me to the limits of not-knowing what is going on. I mean, yeah, I think it is important for me to say that I don’t look at this as some kind of, some riddle, some riddle that has a right answer.”

Given the convergence of these interests, it seems Todd, not unlike Greg, wants to respect and hold a sort of tension, so to speak, between pursuing ethical structure while also leaving room for the unexpected, and the ethics that exists, perhaps only as a potentiality, beyond convention; in other words, he is holding a tension for what might be learned not through continuously placing rules, structure, answers, and formalized

knowledge upon a given interaction or dilemma, but rather holding a tension between structure and ambiguity for what might be understood-- by clinician and client alike-- only through a loosening of cognitive restraint, which appears to be contingent upon letting go of the pressure to over-structure.

Ann

Participant 3, known in this study as Ann, is an international graduate student from China in her mid-twenties who was in her third year of doctoral training in the counseling psychology program at West Virginia University. She had extensive training experience in the college counseling center on the campus of WVU. Additionally, she identified her clinical approach as cognitive-behavioral and psychodynamic.

Ann approached the task patiently and sincerely, taking ample time before responding and mulling over her descriptions of ethical dilemmas. She indicated a more pronounced concern for the ethical code than other participants, and was the only interviewee to reference a particular section of the ethics code, though (understandably) she did not seem confident that it was the correct section. With regard to boundaries, Ann stated:

“the codes and standards...one standard, I think maybe the eighth. Let’s see. I don’t remember which one, but [...] one is human relations [...] about boundary issues.”

While this marked a turn to formalized knowledge unmatched by others, Ann remained more similar to her counterparts than not, demonstrated in the overall pattern of her rumination, including multiple instances of repeated thematic reflection and subcategorization of ideals.

Specifically, Ann's responses came across as highly focused on the concrete aspects of ethical practice, such as safety, crisis prevention, and ethical guidelines; which perhaps reflected her theoretical orientation based in cognitive behavioral thought, or shaped by challenges associated with cultural and linguistic differences. This latter factor may have inhibited more sustained speculation or thematic risk-taking, mostly since such activity requires more detailed, nuanced, and thick description that is representative of linguistic and cultural subtleties. Nevertheless, Ann's strong proficiency in recognizing and attending to the important ethical matters of the portrayed clinical encounter were not lacking in terms of astute recognition of safety concerns, boundaries, treatment planning, effective communication, and sensitivity to context.

Ann's concern for these issues, and her methodical deliberation of their complexity, is at least partly illustrated by the frequency with which her responses required subcategorization. Of all the participants, Ann provided the second highest amount of ideals expressed in subcategories at 29 instances (see Table I), above the average of 25.5. The next closest in this regard was 22 instances. Additionally, Ann's responses spanned all six major categories, suggesting she was engaged with a variety of clinical concerns and thematic interests. Her responses also included 14 moments of repeated thematic consideration, above the average of 12.2.

Among Ann's more unique and idiosyncratic comments are those highlighted in bold, themes she returned to several times or more. These included establishing clear communication, maintaining patient safety and preventing suicidal tendencies, respecting boundaries and preserving the treatment space; and, lastly, providing timely, insightful, and context-sensitive interpretations. Essentially, these themes indicate a prevailing interest in practical values and concrete concerns related to ethics in therapy.

Further strengthening this conclusion are Ann's responses that qualified as unique themes unmentioned by any other participant. In this case, she provided 7 instances of unique, unshared thematic concern, second only to Greg (see Table III). Of these 7 instances, three concerned the major category of patient safety; namely, addressing the patient's aggression and anger, safely transitioning the patient out of the session, and ensuring social support for the patient. Three other instances concerned the therapeutic relationship; specifically, avoiding multiple relationships, awareness of cathartic role of therapy in relation to the client's difficult emotions, and confrontation of aggression. Finally, the seventh unique theme concerned gaining a clear and accurate sense of diagnosis. At one point she stated:

“it sounds like some sort of PTSD, but I'm not sure or clear enough to diagnose. It is some sort of PTSD related [disorder], and I really think to have a plan to not do it again [return to military combat].”

Ann also expressed concern about the therapist's competence and the question of diagnosis, as indicated in the following remark:

“One question is the competence. I'm not so sure about the psychologist's competence. Of course, it is not addressed, but we're not sure he's competent to treat a certain population. It kind of sounds to me like the client might have PTSD problems and it is not clear to me whether the therapist is competent or got training in that.”

As these themes suggest, Ann's ethical concerns translate into a treatment approach that values the practical and concrete. Interestingly, unlike the former two participants, she did not wrestle with themes of ambiguity or inactivity, but instead valued a proactive approach, at one point mentioning frustration with the fictional therapist's *absence* of direct and decisive action. In one instance, Ann criticized the therapist, Paul, for being too inactive, passive and unclear, particularly toward safety issues. She expressed the following concern:

“[I'm not sure] how just listening is benefitting the client. And there are some exceptions of just breaching confidentiality and I think it fits into that category because he does, um, have the potential to hurt other people, and he [the therapist] didn't go into that and ask [...] what would your plan and usually what

would trigger that, and his potential for doing something that would hurt himself or others.”

In summary, Ann suggested several times that she would “apply the ethical code” and “apply ethical knowledge.” She remarked that the therapist “might have to breach confidentiality at some point, but I don’t remember where that ethical code is [...]”. Despite wanting to recall a specific code, it remained unclear how she meant to apply the code, if located; consequently, she left a sense of ambiguity to her responses without actually acknowledging the role ambiguity might play in her ethical understanding. Perhaps this is indicative of a valuable skill set of cognitive flexibility and an ability to think creatively within the moment without getting distracted by the apparent absence of a clearly recollected ethical framework. Overall, Ann’s such qualities conveyed thoughtfulness, patient deliberation, and sincere care for the client’s wellbeing and safety.

Kelly

Participant 4, referred to as Kelly, is an African American female and mother of three who returned to graduate school after nearly two decades in another career. At the time of the interview, she was attending Carlow University and studying clinical psychology in its doctoral program, where she was in her second year. She identified her approach as cognitive-behavioral and humanistic.

Kelly’s approach was distinguished by an overt and repeated concern for the social basis of ethical knowledge and authority. Without any prompting, she made

frequent reference to consulting supervisors, peers, and “imagining ‘what *others* would do in this situation,’” all of which converged with her intuitive and practical concerns of patient safety and clear communication. When presented with the general instruction at the beginning of the interview (i.e. “Imagine what you would do in this situation...”), Kelly mentioned turning to *what others might do*; that is to say, imagining the possible responses of others as a bedrock for her own course of action. This is most evident in the following quote from her interview:

“In going through the training I’m going through, they teach us our ethical dilemma-decision making models. And, I think that at the core of the ethical decision-making models is the decision you make if another person were to evaluate it; if it were evaluated by a peer. Would they say that was an ethical and reasonable decision or would they say this goes against every professional standard and ethical model and ethical practice? That would guide me.”

Such a statement illuminates an approach to ethical thinking based in imaginative activity and mental rehearsal that corresponds to Kelly’s understanding of a broader social value system, in this case professional psychology.

Compared against the responses of other participants, Kelly’s were the second most brief, lacking the thematic repetition of her counterparts. Only the sixth participant, Arnold, provided a more concise set of responses. Despite comparative brevity and perhaps decisiveness, Kelly still engaged the task with a significant degree of nuanced

description, including subcategory differentiation, instances of repeated thematic consideration, and several instances of unique, unshared thematic concern; all of which suggests the use of imaginative thinking.

In particular, Kelly's responses qualified for 15 instances of subcategorization insofar as she provided descriptions of varying complexity for each of the six major categories. Such descriptive breadth across all six categories indicates a concern for multiple value-based frameworks at play in the clinical encounter. While her 15 subcategory responses were well below the group average of 25.5, Kelly managed to pinpoint the important and overarching concerns shared by the others, thereby fulfilling her intention of maintaining continuity of understanding with "what others would do," even though she was never actually informed or aware of what other participants said. In effect, it seems that her approach of visualizing and speculating about the likely responses of others contributed to her construction of a socially-astute ethical understanding, affirmed by subcategory responses in every major category shared by her peers in the study.

Kelly engaged in nine instances of repeated thematic consideration, which was below the group average of 12.2. She demonstrated special concern for a number of familiar themes, including establishing clear communication, thematic order, and a sense of the patient's history, while also preventing crisis, destabilization, and violation of boundaries. These safety concerns are illustrated within statements such as "[I'm] also thinking about if this guy has PTSD [...] because what is going on? And then I go back to [...] do you really think it is a good idea to put yourself in active duty?" Additionally,

Kelly indicated that she valued preserving the treatment space, providing insight, and open communication with supervisors and peers, as previously noted. This characteristic of her approach is also exemplified through the following remarks:

“Another peer- if they were looking at my decision in this scenario. Would they look at my decision and think, objectively and uninvolved, that [it] was reasonable, or would they say it was unreasonable? And, how would I then, if I was questioned about it [...] from a legal standpoint or another standpoint [...] could I justify the decision I made on ethical standards, model of care standards, [...] really that’s what would guide me. Because at the end of the day, your professional integrity has to win out. And I think that would be the key thing for me.”

Finally, Kelly provided two instances of unique, unshared thematic concern, namely, the desire to establish a clear understanding of the effects of treatment, and to consider unresolved issues from the patient’s past. These two instances were below the average of 5.1 unique responses, suggesting that Kelly was intuitively aware of the social consensus in that her responses stayed within a familiar, shared, and common ethical frame that mirrored her counterparts. In this sense, Kelly’s interview-- more so than any of the others because of its overt and implicit valuing of the social-- demonstrates an ethical reasoning that is strongly connected to, informed by, and seen through what might be termed the social imaginary.

Lori

Participant 5, identified as Lori, is a Caucasian female in her mid-twenties who was enrolled in her second year of the counseling psychology program at Chatham University. Her training included various clinical experiences through practicum placements around the Pittsburgh area. Her clinical approach was described as humanistic.

Lori's approach was marked by a socially active, relational contemplation of the task from the moment the research question was posed, distinguished by her idiosyncratic and reciprocal questioning in response to the initial directive. From the onset, she challenged the researcher, which came across somewhat surprisingly, particularly in contrast to previous participants who took up the research question and went with it. This feature of her approach is marked by questions such as:

“What has happened to him that he wasn't allowed to fly? Or, um, was he allowed?” [and] “So the bombing thing, he, was it accidental that he ended up taking out all of the civilians? [...] Was that part of his job and then, consequently because of having done that he was struggling?”

Both of these questions were directed at the researcher, which differed from others who posed questions, but only in a rhetorical manner.

In effect, Lori was slower to start into her own independent inquiry, reversing the expected script through direct and firm requests toward the researcher to clarify a number

of the more ambiguous elements from the clinical vignette. Her interaction was an enriching respite from the more predictable and contained reactions of the others, as she colorfully engaged the researcher in a *conversational*, dialogical approach to ethical practice. To this effect, she displayed similar qualities to those of Kelly; specifically, in the way she relied upon and valued an overtly, socially-mediated ethical query. Yet, in contrast to Kelly, Lori blurred, at least momentarily, the lines between researcher and participant, giving herself permission to question the researcher in return. In light of such a dynamic, she demonstrated an ability to subvert the social roles to which the others had, perhaps unknowingly, conformed. This signified a noteworthy departure from the way others navigated difficult ethical terrain.

In terms of the structural patterns of Lori's interview, she displayed similar qualities to the other participants, roughly striking the average range for the three primary matrices of analysis. Lori demonstrated 22 complex responses requiring subcategorization, scoring not far from the average of 25.5, again suggesting the production of detailed scaffolding to account for the nuances of the six major ethical themes. She also arrived nearly precisely at the average for instances of repeated thematic consideration with twelve, and not far from the average of 5.1 for instances of unique, unshared thematic concern with three. These trends illustrate that Lori was both engaged with similar patterns of reflective analysis as her counterparts and capable of creative deviation from the values and conclusions of the others.

Among Lori's foremost ethical concerns was a focus on questions surrounding clarity of communication, coherently understanding the patient's history, assessing safety

concerns and preventing crisis, and maintaining stability. In several instances, she utilized clarity as a metaphor, reflected in remarks such as “[...] understanding where he’s coming from and how he’d do things. That would *paint a clearer picture for the therapist.*” Regarding boundaries and the therapeutic relationship, Lori was focused on respecting the patient’s agency, avoiding collusion, integrating and unifying psychological issues, preserving the therapeutic alliance, and understanding the larger view. It seems that this latter aspect involved a profound concern for cultural difference and diversity unmatched by other participants. Such cultural concerns are highlighted by the following comments:

“I would probably consult with a military psychologist because [...] I have a lot of friends in the military, and their frame of mind is very much [...] they kind of have a different world view of what is and is not important, and where they should be, and what their responsibilities are, so, I think, given that, he would get a better picture of what this guy is thinking and grappling with if he had insight into the military. So, I really think he would benefit from consulting because that would have painted a more clear picture.”

Finally, similar to Kelly, she emphasized and valued the social and supervisory sources of ethical direction, action, and understanding, noting that she would rely on consultation amid ambiguous ethical matters, as evidenced in the quote above and in multiple other places.

Arnold

Participant 6, known as Arnold in this study, is a Caucasian male in his mid-twenties who was attending a graduate program in counseling psychology at Chatham University at the time the interview took place. He described his clinical approach as combination of rational-emotive, cognitive-behavioral, and humanistic.

Arnold approached the research question with focused intensity, and did not mull over questions as extensively as the others. In terms of length, his was the shortest interview. Notwithstanding, even within a limited amount of time, he demonstrated numerous noteworthy instances of continuity and discontinuity when contrasted against the responses of the other participants.

Despite overall brevity, Arnold's responses included 20 instances of ideals requiring subcategorization to account for their complexity. This was not far from the group mean of 25.5 subcategories per participant, an average that was statistically inflated due to the first participant's unusual number of responses. Moreover, Arnold touched upon five of the six major thematic categories, his only exception being category II, "patient's past." In other words, he did not express concern for the role of the patient's history with regard to ethical issues or clinical concerns. In terms of instances of repeated thematic consideration, Arnold provided 11 responses, which demonstrated a focused, sustained concern for resolving ambiguous subject matter. This was relatively close to the group average of 12.

The shortness of Arnold's interview began to impact the complexity and diversity of his responses when seen through the third axis of analysis, namely Table III, instances

of unique, unshared thematic concern. He did not provide any responses that were unshared, suggesting, in part, an astute awareness of group consensus. To his credit, Arnold touched upon nearly all of the major thematic concerns expressed by the others, while avoiding tangential rumination. However, he did, in fact, demonstrate less overall rumination, at least in terms of trends found in this study, in particular the kind which fell within close range of the others' concerns.

Among Arnold's specific thematic focal points was expressed concern for clear communication, language, and case conceptualization, a resounding theme with his peers. At one point, he expressed interest in establishing clarity and shared understanding, as well firm boundaries, stating:

"I think he [the therapist] could have been a bit more direct with him [the patient] and told him, you know, I cannot be biased in [giving you a favorable] assessment and it's basically coming back on my professionalism; I need to be as unbiased as possible and really [...] give an accurate assessment, so I guess he could be a little more direct and com back to that [issue]."

Further themes included patient safety, and associated concerns of preventing crisis [both in and outside of therapy], assessing and ensuring the patient's ability to perform his military job safely, and preventing violence. Indicative of these trends, Arnold stated the following:

“I think [...] the pilot sounds like he’s not so much in the session, but he’s aggressive in a lot of situations outside the session, too. So, I think that [...] maybe the therapist didn’t want to get off on a bad foot that early in the session and tell him directly that, you know, this is what I need to do and what I’m going to say. I’m going to be neutral and not going to, you know, [necessarily endorse] the opinion of you going in for training and going on as a pilot.”

Arnold also wanted to retain boundaries through an avoidance of collusion, maintaining the therapy space, and allowing ambiguity to play a role in the patient’s therapeutic work (e.g., his references to “being neutral”). Regarding the relationship in treatment, Arnold displayed significant interest in responding with sensitivity to context, cultivating insight, and preserving the alliance. Finally, similar to Lori, Arnold expressed concern for cultural sensitivity and understanding the role of subculture and race in the making of the client’s identity. This latter theme seemed directly tied to Arnold’s repeated concern for working toward an understanding of context. These therapeutic characteristics are illuminated in the following remarks, which concern working with a patient who has had traumatic experiences and is from another culture or subculture:

“You have to [...] you cant’s just come out and say ‘what was your experience in Iraq and Afghanistan?’ You have to be, you have to build a relationship with them before you can get into any of the details because they’re just going to see you

as a civilian. There's a huge thing between talking to each other and talking to a civilian.”

Later, Arnold added to these cultural, identity, and communication concerns by questioning the therapist's readiness to understand military culture, as Arnold stated:

“He [the therapist] couldn't be detailed about anything in the military. All the acronyms and everything else. And, um, but I think that's good because I think that he struggles with-- the pilot struggles with-- the relationship with his dad [...] And, even his wife, he had mentioned [...] I think a lot that probably has to do with, um, he's in the military life for nine months out of the year, and on a full-time basis. And when he's deployed, he's completely wrapped in that, and it's two different worlds.”

Overall, Arnold demonstrated cultural sensitivity and skepticism about the therapist's ability to bridge the divide between two separate cultural worlds, while also speculating about the possible benefits of that divide. In effect, Arnold displayed an ability to simultaneously hold two possibly contradictory ideas, and thereby engage the ethical ambiguity at the core of the therapeutic encounter.

Comparisons Across Participants

The general findings and analysis of participants as a group stems from the review of marginal summaries for respective participants found in the Data section, including Tables I and II. The general analysis was conducted with several key concerns in mind, namely to identify commonalities across all participants, assess for subgroups, and delineate idiosyncratic themes.

As evident in the previous data section, there are numerous participant commonalities deserving of attention, particularly those illustrated through participants' repeated interest in and concern for specific ethical themes, values, and dilemmas. One of the most clear commonalities is illustrated by a convergence of ideas when considering the six major categories of ethical themes. All six participants expressed a concern for five of the six major categories, which include clarity, patient safety, boundaries, the therapeutic relationship, and clinical understanding. Following this convergence, five out of six participants shared concern and expressed value for all six major categories; in particular, the five mentioned above along with patient history, which only the last interview participant omitted from his major concerns. This suggests that the six major thematic categories of clarity, patient safety, boundaries, the therapeutic relationship, clinical understanding, and patient's past firmly rest in the shared, collective ethical value system of the participants.

Among other strong commonalities, every participant expressed interest in a number of subcategories. These included a concern for clear communication (under the broader category of clarity), patient safety to perform a high-risk job (under patient

safety), and confronting the patient about safety concerns (under the therapeutic relationship). Furthermore, when assessed for commonality by considering subcategories endorsed by five of the six participants, several significant patterns emerged. These included five of six participants expressing concern for the respective subcategories of assessing safety and preventing crisis, suicide, and violence (both under patient safety), maintaining a treatment space (under boundaries), and relying on social/supervisor understanding (under clinical understanding).

When framed by and assessed through the commonalities shared by three participants, a plethora of shared values and interests emerges. These include concern for clear and precise language (under clarity), coherent history (under patient's past), maintaining patient's stability (under patient safety), avoiding lying to please the patient (under boundaries), refraining from action in therapy and preserving ambiguity through inaction (under boundaries), and leaving responsibility and agency with the patient (under boundaries). Additionally, three participants held in common an interest in the following subcategories from the major theme "therapeutic relationship": help the patient to integrate and unify, communicate directly, provide context-sensitive response, cultivate awareness and insight, and preserve the alliance. Finally, three participants valued two subcategories from the general category of clinical understanding, namely, understand context and understand what is latent or concealed.

Among additional common themes, every participant engaged in multiple instances of repeated thematic consideration, as evidenced in Table II. The mean was 12.1 instances. This suggests a significant level of reflection, rumination, and implicit

awareness of ambiguity at work within participants' consideration of particular dilemmas.

The assessment of subgroups stems, primarily, from the frequency of ideals expressed in subcategories (Table I), of which all six participants engaged in ethical deliberation to the extent that a degree of subcategorization was necessary to organize their responses. Participants ranged in frequency of ideals expressed in subgroups from 15 instances to 46 instances (participants 4 and 1, respectively). The mean for subcategorization was 25.5.

Idiosyncrasies among participants are indicated by singular subcategory responses, or, alternately stated, any instances in which a theme was identified by only one participant and did not resemble or share commonality with any others. Specifically, these included clear understanding, knowing clearly, clear and coherent motivation, clear thinking, clear diagnosis, ethical clarity, clear effect of treatment, and narrative clarity, all under the general theme of clarity. While these instance occurred singularly, and thus as idiosyncrasies, they are indicative of the broader and more general common interest in clarity, as shared by all participants.

A second subset of idiosyncrasies can be seen under the general category of patient past, and includes the unique themes of comprehensive history, treatment history, unresolved issues from the past, and absence of history as a viewer of the clinical encounter; the latter being what I have come to see as a meta-theme, or one concerning a reflective, perhaps critical, stance toward the actual research interview in which the participant questions what it means to witness only one session among a series of

therapeutic encounters. There were several distinct meta-thematic moments during various interviews, and this represents the first among them. All of the meta-thematic moments were idiosyncratic and unshared, but nevertheless noteworthy insofar as they mark a divergence from common ethical thinking.

The next subset of idiosyncratic themes is found under the category “patient safety,” and includes patient’s aggression and anger, transitioning the patient out of session, cultivating social support, and patient’s understanding of social issues. Under “boundaries,” several more idiosyncrasies were cited, including leaving responsibility with the military, responding to the patient following the session, ending the session, and understanding the therapist’s role. Subsequent idiosyncrasies under “therapeutic relationship” concerned ordering (clinical) material, provide meaningful interpretation, maintain a singular relationship, provide a catharsis, and confront the client’s aggressiveness in the session. Finally, under “clinical understanding” multiple thematic idiosyncrasies were present, in particular to reveal underlying, understand the military’s intentions, understand family dynamics, understand patient’s expectations, understand defenses, and rely on moral foundation.

Amid such idiosyncrasies, it is important to note they all unfolded within the domain of broader, shared common themes, namely the six general categories. This seems to indicate that there was a collective ethical framework at work, encapsulating the possibilities in which unique ethical dilemmas and values emerged. Such an observation does not preclude imagination from working its way into the ethical concerns of participants, but instead illuminates that a significant portion of ethics may be held less in

the individual subjective psyche in and of itself, and more in the social or collective psyche of the group as a whole. Put succinctly, the range of concerns and values was obviously not infinite or divergent beyond common ground, but rather imaginative within six generously wide yet specific shared categories.

Table I, Frequency of ideals expressed in subcategories:

Interpreted Ideal	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6
Seeking clarity	11	6	5	2	2	3
Patient's past	3	2	1	1	1	0
Patient's safety	3	1	7	5	6	3
Boundaries	11	4	1	1	5	4
Therapeutic Relationship	7	5	11	5	5	7
Clinical understanding	11	4	5	1	3	3
Total	46	21	29	15	22	20
Mean: 25.5 Median: 21.5						

Table II, Instances of repeated thematic consideration (frequency of returning to item at least three times during interview):

Participant 1: 15
 Participant 2: 12
 Participant 3: 14
 Participant 4: 9
 Participant 5: 12
 Participant 6: 11
 Mean: 12.1
 Median: 12

Discussion

The findings from this study suggest a variety of implications pertaining to ethics and the significance of imagination to clinical practice, including insight into *how* therapists construct variations of intention and *what* alternate paths of action they tend to consider. Participants' unique and shared responses reflect imaginative thinking that draws upon both interior or subjective meanings, as well as socially and institutionally-sourced ones, resulting in a blurry line between personal and cultural values and ethical ideals. The purpose of this discussion section is to address the relevance of these findings for practical ethics, while also considering broader questions concerning the use of imagination in interpersonal communication, clinical understanding, and the making of therapeutic meaning.

Seeking clarity

The general ideal category of *seeking clarity* provides a subset of particular minor ideals, which are among a plethora of preoccupations described by participants spanning the six major ideals (beginning with the first, clarity). Achieving clarity, gaining clarity, and establishing clarity are all intention-laden phrases that occurred frequently during interviews, and clarity as a concept may be among the prevailing metaphors used by psychologists and scientists, regardless of whether they identify with the respective human, social, or natural sciences.

Clarity also relies on a metaphoric turn hinging on the epistemological role of vision in our processes of building shared understanding (e.g., “seeing the same thing

politically”), as well as the privileging of empirical knowledge of the natural world as it may actually exist (e.g., “seeing an object accurately and as it really is”). Both ways of seeing-- of the social consensus sort and the correspondence-to-nature kind-- have been part of what it means to see clearly for centuries in Western thought. Clarity as an everyday ideal is also found in common speech, and we can basically count on hearing the concept in the workplace or home whenever effective communication is sought after and demanded.

Another dimension underlying the focus on seeking clarity is an intention to establish clear thinking about a particular dilemma, and effectively commit to a position, stance, narrative, or organized and directed view. To gain clarity is to gain a sense of teleology (not a firm unwavering *teleos* per se, but at least a sense for a sought after end). Use of the word itself implies awareness of varying perspectives, as well as the need to move toward interpersonal and/or subjective position that essentially makes both meaning and sense based on information and insights gathered from a given phenomenon. In other words, clarity is fundamentally about establishing a contextually-rich, historically-informed perspective that can be shared and verified by another observer or participant narrator. This does not necessarily require a complete relinquishing of uncertainty or ambiguity, but rather seeks to construct intelligible, reasoned reflection on what is possible. Seeking clarity overlaps with the notion of *savoir* as a way of knowing that arises out of the contextually-embedded, situationally-grounded struggle for clarity; in the movement toward making what is implicit explicit, a widening ethical understanding is constructed and developed. The data indicates that the

movement of trying to become clear leads to engagement and diversification, which then leads to a different picture of ethics and restructures ambiguity.

Of the ideals expressed in subcategories, several concern gaining clarity regarding the patient's history and past, demonstrating a tendency among therapists to approach ethical practice not only through clear, ordered, and structured understanding, but also through an ordering of the patient's past. Such tendencies appeal to underlying psychodynamic theory, even among therapists who do not explicitly identify with psychoanalysis or its kindred theories; primarily because psychodynamic thought, more than any other theoretical foundation, awards a privileged place to the historic, genealogies of self, and the search for symptomatic origin.

Participants also expressed strong concern for gaining clarity of communication and language, linking linguistic precision, accuracy, and directness to ethical action. This tendency overlapped with establishing narrative clarity and clear intentionality, implying that ethics converges with an ability to order the patient's story, self-direction, expectations, and desires. Furthermore, participants frequently noted the importance of establishing clarity in treatment planning, direction and effect of treatment, case conceptualization, and diagnosis. These themes suggest a vision of ethical action that sees clarity by way of shared planning, intent, direction, and coherence of clinical understanding. Through such subcategories, it becomes apparent that participants assign meaning and value to a process of therapeutic communication that seeks and ideally creates clear and unambiguous planning, direction, motivation, and treatment expectations.

While the theme of clarity is important to understanding *how* therapists engage in ethical thinking and *what* content is involved, it by no means offers a comprehensive account of such content, particularly since later themes cited by and valued by therapists contradict and belie easy and clear ethical ideals that rest easily together. For instance, under the general ideal of clinical understanding, participants expressed the importance of the “big picture,” using intuition, and understanding culture and identity differences. Additionally, under “boundaries” participants sought to “preserve ambiguity.” None of these themes is open to singular interpretation, and consequently they subvert and complicate therapists’ intentions to work toward clarity.

Among the divergent and idiosyncratic responses concerning clarity, eight subcategories were endorsed by only one participant, indicating divergent thinking in contrast to group and shared trends. These subcategories included “knowing clearly,” “clear understanding,” “clear and coherent motivation,” “clear thinking,” “ethical clarity,” “clear diagnosis,” “clear effect of treatment,” and “narrative clarity.” Their importance seems to revolve around divergent thought that remained within the bounds of the expected range of concerns, and did not deviate in extreme ways from other subcategories that were shared by multiple participants. The eight idiosyncratic themes speak to the participants’ desire to establish organized, structured, and unambiguous thinking in regard to clinical thought, ethics, narration, effects of therapy, and understanding the patient. By way of such desire, they embody the search for more firm, certain, and solid foundations of understanding, and imply that obtaining greater certainty through a processes of clarifying converges with ethical practice.

Patient's past

The second major thematic category, *patient's past*, includes a number of subcategories which stand independent from the previous themes concerning gaining clarity about the patient's history, although there is some overlap. This merger occurs through therapists' use of the descriptive terms "comprehensive" and "coherent," which parallel their search for "clarity" from the first thematic category.

Research participants endorsed ethical action that addressed the patient's past in terms of developmental history, treatment history, and "unresolved issues." Their focus on the individual's past echoes earlier thematic emphasis on values found most explicitly in psychodynamic theory, suggesting that ethical action relies, to some degree, on gaining perspective of the patient's early development, including "issues" or traumas, conflicts, and unmet desires. These inclinations resonate with what the late psychiatrist-analyst Ethel Person conveyed in *Feeling Strong* (2002), that "no one can really know us unless they know where we come from, what bumps and wounds we experienced in early life" (quoted in Burt, 2012).

What is more, the emphasis on the past also suggests therapists' concern with the influence of biology and the potential organicity of patient complaints, symptoms, and distress. To understand the historic basis of a symptom-- whether seen as biological or psychogenic-- requires an attentiveness to the value of the patient's past as conveyed in their narration and sequencing of life events, including how they order difficulties in

terms of cause, effect, and origin. Therapists participating in the study appear to equate ethical practice with an awareness of such a perspective.

An exception to these trends occurs in the final subcategory of the *patient's past* category, namely “absence of history as viewer of clinical encounter,” a concern of only one participant, but noteworthy nonetheless. Given the context in which the participant expressed this, it seems he was referencing the situation of the research interview and limitations imposed by viewing a video portrayal of psychotherapy. Moreover, he was emphasizing the importance of having a direct, first-hand experience of the patient's progress through therapy, and not simply a snapshot provided by a limited and finite portrayal of a session. Nevertheless, his concerns are indicative of a more general frustration and dilemma therapists may experience at any given time; for, what clinical relationship is not bound by a beginning and an end, a trajectory unfolding over a period of time which is relatively short in comparison to the breadth of any given patient's lifespan and development? While the limitations imposed by the video clip are to some degree artificial insofar as actual therapy, of course, involves a first session followed by subsequent sessions and, eventually, a final session; a therapist's vantage point is always limited by the “snapshots” she receives of a particular patient regardless of whether the patient is seen for one session or fifty. Inevitably, therapists must resolve to piece together a coherent and workable version of past events on limited information. In other words, therapists occupy and attend to a realm of meaning that, by definition, will create a multitude of gaps in understanding, necessitating that clinical work occur between the bookends, so to speak.

Further complicating this concern is the issue of empathy and social proximity, an ethical problem raised by several prominent liberal social theorists, including two leading contemporary philosophers, Jeremy Rifkin and Peter Singer, whose respective writings have reached a mass audience over the past several decades (Asma, 2013). Both Rifkin and Singer have argued for widening the ethical circle and expanding our moral obligations to include the welfare of all of humanity, regardless of race, ethnicity, or nationality.¹

In a recent article in *The Stone*, philosopher Stephen Asma (2013) polemicizes Singer's empathy project, arguing that our ability to empathize with and understand the moral relevance of another's situation, whether human or nonhuman, depends on our ability to experience an emotional connection to them. He also argues that these moral connections are only realistically available to those whose lives we directly associate with, exemplified in Cicero's outlook that "society and human fellowship will be best served if we confer the most kindness on those whom we are most closely associated" (Asma, 2013). While certainly not as idealistic as the vast, boarder-transgressing, and inclusionary hopes of Western liberalism, Cicero's stance may, in reality, be the more accurate reflection of the way human behavior has and continues to operate.

¹ Singer has also argued in favor of extending the ethical circle to include our closest genetic kin, the four nonhuman Great Ape species of the Hominidae family (made up of chimpanzees, bonobos, gorillas, orangutans, and homo sapiens). Singer has made some strides toward such goals, particularly through his role in promoting the international Great Ape Project, which has illustrated that at least some human beings are capable of engaging their empathetic imaginations to traverse divisive ideological barriers.

Applying Asma's position to the research situation, it is likely more difficult for participants to feel a strong affective bond with a patient who is portrayed in a filmed therapy scenario. Even more importantly, If Asma is correct, it is quite possible that direct social contact with a patient is a critically important factor in evoking strong affection and, consequently, ethical care for patients. In effect, the recent emergence of online psychotherapy could become a deeply problematical topic of current ethical relevance, particularly as philosophers like Asma alert us to the important role that social proximity likely plays in awakening us to "the true wellsprings of ethical care, namely the emotions" (Asma, 2013).

There were a number of idiosyncratic responses, each cited by only one participant under the patient's past category. Specifically, these include "comprehensive history," "treatment history," "unresolved issues from the past," and "absence of history as viewer of clinical encounter." The first three subcategories clearly overlap with one another and share concerns with "coherent history," a subcategory shared by three participants. The last one listed is unique and original in its speaker's attempt to discuss the research study itself. It also demonstrates the generative, problem-creating potential of imaginative thinking, mostly as it raises a question that leads to further, essentially unresolvable questions. It is a dilemma that engenders further dilemmas concerning the nature of an authentic encounter, the relationship between ethics and social proximity, and the value of first-person experience, all of which were discussed above. Finally, these themes all concern ethics and were generated through the divergent thinking of only one participant, which demonstrates that importance of imaginative thought. Through a

hypothetical dialogue among participants, it is possible that this concern could be raised by one and discussed by all of them, effectively deepening the ethical discourse, and expanding notions of what sorts of dilemmas we include within the ethical domain.

Patient's safety

The third category, *patient's safety*, encompasses a number of related values and ideals which are perhaps more defined by practicality and concreteness than those from other general categories. Through a clinical vignette that was weighted with potentially catastrophic, tragic, and momentous implications, participants were quick to attend to the urgency of preventing irreparable harm to the patient or others. Furthermore, they felt these clinical concerns were ethical in nature.

The subset of values encased within the *patient safety* category range from stabilizing the patient's high emotionality and securing his safety (and consequently safety of others), on the one hand; to creating a web of supportive relationships and establishing an appropriate treatment frame, on the other. While these themes were mentioned by all of the research participants, they are relevant insofar as the threat of suicide, aggression, and violence toward others is never explicitly communicated by the patient. The presence of such themes is inferred through participants' speculation regarding the patient's state of mind, vis-a-vis observation of the patient's affect, communication, and comportment converging with cultural images of mental instability. Moreover, these cultural images of mental illness appeal to broader societal portrayals of

madness and insanity, especially our fears and anxieties of patients, in the worst of scenarios, “losing it.”

In the fictional portrayal, the participants’ fears turn out to be correct, though those who did not view future episodes would be unknowing (assuming they were not told by someone else who watched the series). At any rate, therapists’ worries of the patient destabilizing and inflicting harm turned out to be justified; as the client eventually dies while performing his job flying a military jet, and his death appears to be deliberate and self-inflicted. However, in evaluating this scenario, we must consider the entertainment dimension of allowing these fears to materialize. It is certainly more sensational to introduce the death of a character to a dramatic production than to only allow mortal consequences to merely hover in the backdrop, as a threat and nothing else. Such a script would fail to illustrate that tragedy is, indeed, a very real part of life.

Fortunately, most patients, including those suffering from repeated episodes of suicidal ideation, do not end up committing suicide. According to the National Institutes of Health website, “about 10% of people who threaten or try to commit suicide will eventually kill themselves” (see NIH.gov, 2013). Although it is difficult to discern and measure how many people experience suicidal ideation because many do so in isolation and beyond the reach of documentation, and many clinicians can attest to working with countless patients who endure suicidal ideation but never develop a plan or act on those thoughts.

The ethical practitioner will, ideally, take suicidal thoughts and threats with the greatest seriousness and diligence, and the participating therapists in this study appear to be well aware of the necessity of keeping these safety risks-- from suicide, aggression, violence, and isolation without support-- always in the backdrop, ready to take center stage should the indicators arise. Additionally, these indicators may rely on the ever-present fears therapists have of losing a patient or having a patient engage in violence, as well as on the sensationalized images of the mentally ill in movies, the news, and popular culture; nevertheless, with the issue of grave risks, we are better off being hyper-vigilant than asleep at the helm. It appears that the research participants invariably share such a conclusion.

Among the unique and singular responses provided by participants in the third category, four subcategories arise as relevant and, ultimately, overlapping the shared concerns of participants. That is to say, unlike the second category in which a participant provided a truly unique and divergent response, subcategories in the third category hovered closely to the primary concerns of participants as discussed above. Given the highly practical nature of the category itself-- safety-- all of the responses, from shared to singular ones, focused on how to ensure the patient is adequately cared for, intensified by his variable mood and overall instability. Participants' concerns for this theme were far from surprising and relied on crisis prevention thinking and the well-known value of social support for mentally unstable individuals.

Boundaries

The fourth category, *boundaries*, involved participants constructing a frame around the agency and responsibility of relevant parties involved in the patient's life and care, primarily for the sake of ordering an otherwise potentially disordered social encounter. Participants' concerns tended to equate ethical practice with preserving the patient's power and freedom to determine his future, make important decisions, and thereby take responsibility for his actions. Such a view reflects the heart of Western values, namely the privileged position and weight bestowed upon the individual's presumably self-contained agency.

Among the subcategories composing the *boundaries* section, numerous participants were troubled with the possibility of becoming involved in an ethical quandary in which their honesty and integrity was compromised to please the patient. These converge with overarching themes of leaving responsibility, and the patient's vocational fate, with external actors; that is to say, the patient himself and the military doctors in the video portrayal.

Participants also wrestled with the extent to which the patient should be confronted and pushed by the therapist, and what role, if any, the therapist should play in making decisions about the patient's desire to return to work, reactivate in the military, and maintain values that engender anger, hatred, and further divisiveness. At least two therapists felt that the patient's values should be respected, even if they contradict the prevailing liberal-humanist value system characterizing our era, espoused by most

contemporary institutions, and embodied in professional ethics codes in medicine and psychology. Meanwhile, the other participants felt either anger or ambivalence toward such matters, while some refrained from voicing their uncertainty, or they refrained from considering its importance, illustrated through the absence of their outward consideration of this dilemma.

The unique and unshared subcategories for the boundaries section were contained in four themes, each noted by just one participant. These include “leaving responsibility with the military,” “responding to the patient after session,” how to “end the session,” and “understanding the therapist’s role.” Participants respectively mentioned these concerns and left them unresolved during the interview, citing them as dilemmas of notable difficulty and significance. While the first and last themes (“leaving responsibility with the military” and “understanding the therapist’s role”) at least partly appear to be a way of distancing from the patient and avoiding the potentially unanswerable question of job preparedness; the other two (responding to the patient after session” and “ending session”) concern transitioning between therapy and the outside world, and ensuring proper care.

Although these four themes were idiosyncratic, they exhibit a strong commonality with the other themes under the boundaries category, which rests in questions of space, orientation, and positioning toward the patient; questions such as: How close is too close? What decisions must the patient face alone? What am I, as the therapist, qualified to address here? How should the patient’s lack of sensitivity to cultural diversity be handled? How is a tense, tumultuous session best ended? And, what communication, if

any, should occur beyond the frame of the session? Such questions, demonstratively important to all those interviewed, do not have clear, easy answers, nor is there a code or set of guidelines which neatly corresponds, applies, and resolves. Rather, what is evidenced in the participants' responses and the questions they raise is that therapists, at least among those interviewed, seem to address ethical dilemmas not by referring to answers, but rather by *attending to questions*, without any haste to side-step or reduce the subtleties accompanying an encounter with a values-based dilemma.

In some sense, the question of “how do therapists resolve ethical dilemmas?” is not easily amenable to a formulaic explanation because the *how* of their responses is less an answer than a practice; one predicated on the healing, therapeutic value of attending to, being open, and holding a mental, emotional, and imaginative space in which patient and therapist alike, and perhaps together, can come to answers and insights about things carrying the greatest of meaning; and, often, consequence as well. Such features come to the fore most clearly in the boundaries section, where it becomes apparent that the therapists are not necessarily trying to solve a problem like a mathematician would, but instead are playing by entirely different rules, much like walking carefully in a delicate emotional and psychological landscape, and being ever diligent not to damage the growth already occurring around them.

Therapeutic relationship

Subcategories in the fifth category, *therapeutic relationship*, revolved around themes found in several of the other six categories, but bonded through a common interest in how such shared material could be applied directly to the actual patient--therapist relationship. These themes concerned integrating, ordering, and unifying the patient's story; providing effective, meaningful, and timely interpretations while communicating them directly; utilizing intuition, empathy, and contextual sensitivity; and, confronting the client while refraining from "advice giving." Additionally, imitating successful treatment approaches and maintaining a singular patient--therapist relationship were seen as important ethical issues.

Undoubtedly, these themes cover a wide spectrum of clinical values and ideals, beginning with the privileged place given to psychological integration and unity, as well as awareness of context. While the former seem to resonate with both psychoanalytic and humanistic visions of psychological wholeness, the latter echoes post-structural values emphasizing the necessity of contextual sensibilities. The two value-systems are not necessarily contradictory, but they certainly do not relate without conflict and, to some degree, contradictory.

Uniquely, the therapeutic relationship category marked the first time that participants explicitly mentioned the ethics code and preconceived ethical knowledge. Two subcategories involved participants' concern with how to "apply ethical knowledge" and "the ethical code." Interestingly, the participants were not able to clearly or

definitively identify or locate the particular aspects of the code or specific sources of their ethical knowledge. At most, the only references to the code were characterized by vagueness (see Interview III in the Appendix).

Nevertheless, in the case of one of the participants, ethical knowledge, the ethics code, and contextual sensitivity were all mentioned as important considerations. Given such concerns, contradictory themes inevitably arise, particularly as the ethics code, if specified, would likely and eventually (as detailed knowledge of an individual patient grew) conflict with certain sensitivities bound by the uniqueness of person and context. Consequently, the therapist would be forced into an intensifying dilemma, to be resolved either by allowing one to win out-- the generalized precepts of the code, on the one hand, or the unique phenomenon revealed within the context, on the other-- or, alternatively, responded to with a tolerance for uncertainty. In other words, practitioners with an interest in applying both the code and honoring the context will most likely face situations in which the direction of the clinical relationship is guided by an attempt to amalgamate the two, but also challenged by moments when there is no clear or memorable guideline to apply, exemplified by these research participants' absence of detailed recollection of the code. Amid such moments, therapists will likely, and indeed hopefully, defer to the vividness and emotionality of the context, while abandoning the abstractness and distance of the code because the context and life-world provide a much richer reservoir of information that can feed the moral intuition and ethical imagination, and thereby lay the groundwork for flashes of empathy and compassionate wisdom.

Clinical understanding

The sixth category, *clinical understanding*, is composed of a number of subcategories concerning dilemmas of clinical knowledge and particular interpersonal dynamics that interview participants deemed essential to therapeutic work. Describing these considerations, interviewees either directly referred to their desire to obtain greater understanding of X, or they deferred to well-known knowledge structures, such as “rely on moral foundation,” “rely on diagnostic frame,” and “rely on supervisor.” The other subcategories illustrated a pressing interest in focusing clinical thinking on resolving ambiguity in terms of context, latent motives of the patient, military and institutional intentions, family dynamics, patient defenses, and differences stemming from cultural and identity issues.

A tangential subcategory within the sixth category referred to participants’ desire to “understand intuitively,” a topic gaining increasing attention within academic psychology and beyond. In *The Righteous Mind: Why Good People Are Divided by Politics and Religion*, Haidt (2013) contends, and argues quite convincingly, that difficult human matters are fundamentally decided using moral intuition, as opposed to rationality or reason. A recent paper in the A.P.A.’s journal (Rogerson et. al., 2011) argues much the same, positioning intuitive and emotional processes at the front and center of moral decision making, and our understanding of value-based dilemmas.

Yet, perhaps both Haidt and others are missing something crucial; specifically, a response to the question of what, thematically and phenomenologically, connects the

intuitive processes of moral sentiment and decision-making with the logical, rational, and reasoned justifications we provide for those very moral sensitivities and propensities? In response, and in line with this study, the human imagination provides a bridge between unreflective intuition and reasoned justification. Imagination serves this role insofar as it involves contemplation of various possible scenarios, many of which blend with and emerge from personal experience, emotion, subtle imagery, and the attempt to *language and narrate* what is otherwise vague and unthematic. Consequently, when participants refer to “understanding [clinical material] intuitively,” they are referring to the importance of a “gut feeling” and unreflective knowing, but are also omitting, in my view, imagination’s role in making clinical experience meaningfully thematic and intelligible.

Additional themes within the “clinical understanding” category touch upon the multiplicity of participants’ philosophical viewpoints, including overt psychodynamic themes (“understand defenses”, “understand what is latent or concealed”), family systems theory (“understand family dynamics”), post-structuralism (“understand context, “understand cultural/identity differences”), foundationalism and humanism (“rely on moral foundation”), and social constructionism (“rely on social and supervisory understandings”). Furthermore, they also value (for lack of a better term) practical reasoning, demonstrated in somewhat unspecified intentions to “understand big picture,” “understand patient’s expectations,” and “rely on diagnostic frame.” All of this appears to suggest that clinicians rely on a variety of sources to inform their imaginings of how they would respond to a possible clinical scenario, and in effect, most likely utilize

multiple sources to explain, justify, and lend meaning to their understanding of both self and other in therapy. Stated alternately, clinical understanding, in the eyes of the research participants, depends on the integration of different sources to assemble a plausible, reasonable, and practical response to a complex encounter.

Another theme that is visible in the subcategories is a quality of vagueness and ambiguity in the participants' responses, which could be immediately seen as a weakness in their explanations. However, such ambiguity can instead be taken as a respect for the role of speculation within the clinical encounter itself, as well appreciation for the dimension of lived experience within the clinical relationship. Given that participants were responding to a clinical portrayal, their responses, at most, qualify as *simulations* of what they *intend* to do. This need not diminish the value of their reflections, but rather it points to the participants' tendency to leave a lot to be determined by an actual encounter, indicating that over-planning and predetermining the detailed specifics might be detrimental to an authentic response. It also suggests that the work of the therapist is unavoidably vague and ambiguous to the degree that every participant offered distinct perspectives as to what ethical dilemmas were present, and how they should be addressed.

While there was clear social consensus in that thematic similarities emerged and were organizable into relatable categories; such a task was by no means streamlined or perfectly continuous, visible in the thematic overlap between categories, and repetition of similar themes across participants and categories. Such is the consequence of filtering

participants' completely unique choices of language and narration into generalizable, organized ethical dilemmas.

Evidently, what is at work is a process of *combinatory* understanding wherein participants loosely utilize socially-held values and ethical frameworks, and then combine those concepts with their respective and idiosyncratic leanings. This integration of objective and subjective ethical systems is what lends each clinical encounter its meaningfulness, and perhaps, its efficacy. Importantly, by objective, I refer not to objective morality in a universal sense, but, alternatively, seen as a correspondence to socially, culturally, and communally shared values, which are then treated generally, and used to construct formal guidelines and codes. Subjective, then, implies idiosyncratic, unique, and contextually-sensitive values that are created from *lived* encounters, which demand practical applications of imaginative variations of generalized moral codes.

Conclusion

Among the findings provided through this research is the recognition of the role that imagination might play in a viable, lived, and generative ethics, one that is critically revitalized amid our all-too-frequent encounters with stale and institutionally-bound formalized ethical codes. Too often, formalized codes mask the ambiguity at the core of human relationships, glazing over complex questions with a ready-made rule and procedural structure, or a near magical belief in the power of a universal or timeless authority, one external and oblivious to the particulars of a given context. Yet, it is precisely the complex, values-based ethical questions that do not yield easily to moral formulae, and need not be put to rest by codified rules, especially since so many problems of human relationships and suffering remain intractable and call for our continued concern.

The relationship between Foucault's distinction between *savoir* and *connaissance* allows us to gain a deeper and more accurate understanding of the interaction between formal and informal knowledge systems, particularly with regard to ethical codes and values in the clinical encounter. Moreover, when combined with Ricoeur and Kearney's understanding of ethics as the ability to *imagine otherwise*, we may begin to appreciate the essential vitality of alterity, contradiction, and ambiguity within many ethically-layered situations. The results of the data in this study illustrate the large degree to which these ideas-- from Foucault's post-structuralism to Ricoeur and Kearney's hermeneutics-- are present in the struggles of clinicians attempting to engage in ethical *practice*.

With respect to the discipline of clinical psychology, the results of this study suggest that rethinking standard texts and decision-making models for ethics courses might be improved to better reflect the phenomenology of ethics if they were to include a discussion of the ethical imagination and experiential themes addressing how dilemmas are understood and dealt with in practice.

While formalized codes and ethical standards occupy an important and necessary place in society and clinical practice, they need not be viewed as the source of ethical action and understanding; the idea that to be ethical requires only awareness of what is right or wrong according to rules is gravely misleading. Indeed, Kitcher (2011) maintains that ethics appropriately be seen as an ever-evolving human project, one that is forever incomplete, but nonetheless deserving of our utmost attention.

Converse to the notion of ethics-as-the-rational- application-of-corresponding-codes, the imaginative thinking that takes place amidst ethical dilemmas is a better representation of the foundation (or anti-foundation) of ethics; for, it is through the generative capacities of our thought that new and unexpected ethical horizons arise, which in turn, allow for empathy and understanding of another's suffering, and the ability to envision, simulate, and model alternative courses of action. Furthermore, it is through imaginative consideration of alterity that variations of language and description emerge, bringing forth varying interpretations of meaning, affecting greater ethical nuance, and engendering a deeper appreciation for ambiguity in moral dilemmas. To respect ambiguity is to remain open, both emotionally and cognitively, which might be the single greatest aspect of developing a meaningful understanding of another person. What is

more, *meaningful understanding alone is an effective psychotherapeutic approach*, and perhaps the vitalizing quality that ethics needs in our society's quickly retreating conversation concerning ethical frontiers.

To appeal for a moment to the creative wisdom of the arts, the American painter Chuck Close (Popova, 2013) contends that our society is entirely too focused on problem-solving, which may be seen to include a broad oversimplification of ethics and moral understanding in favor of coming to quick, pragmatic, and results-driven solutions. The proper response, for the artist and creative thinker, urges Close, is to focus on approaching one's craft- whether painting or otherwise-- with a keen sense for problem-creation. Such an embrace of problem-generativeness requires an aptitude for holding contradictory and opposing value systems in mind simultaneously, and being open to the uncertainty these systems produce when juxtaposed.

Much like humanity itself, the origins of ethics are elusive, fluid, and not easily amenable to our desire to establish firm lines between right and wrong, virtue and vice. While some dilemmas may ultimately be resolved with clear and firm judgement, many more are not. They remain ambiguous and fraught with porous boundaries between what is ethical and, in the clinical context effective, on the one hand, and what is damaging and harmful, on the other.

Based on the data collected in this study, and in light of ambiguity in ethics, we might consider a number of features of imaginative thinking used by research participants and evidenced in their responses. Although there may be others, a number of important qualities of the ethical imagination come to mind, including flexibility of thought, active

interpretation of possibilities, envisioning multiple intentional and emotional scenarios affecting self and other, consideration of alterity; and, the use of various metaphors to describe moral dilemmas and potential solutions.

The authors of a recent article in the *American Psychologist* (Rogerson et. al. 2011) would seem to agree with the importance of these qualities. Rogerson et. al. (2011) contend that ethical decision-making depends much less on rationality than on “nonrational factors,” namely, “automatic intuitive and affective processes” (Rogerson, 2011, p.621). They call for going “beyond existing rational models” to “utilize deliberation, intuition, and emotion most effectively.” Furthermore, they prescribe a three-fold approach to resolving ethical dilemmas that closely parallels the characteristics evidenced by the research participants in this study. When faced with an ethical dilemma, Rogerson et. al. recommend seeking additional information, patient consideration of alternatives, and re-examining initial assumptions. The third step is aimed at limiting the damage of preconscious and intuitive reactions from dictating one’s ethical understanding and position. Nonetheless, Rogerson et. al. do not seek abandoning or obscuring the potential contributions of nonrational aspects of decision-making, especially concerning generativity and the emergence of creative solutions to initial assumptions about what a rule or ethical code means *practically*; that is, they think ethics-in-practice too often involves the application of a black and white choice between abiding by or breaking a rule (2011, p.621). More often, there exist alternatives that perhaps avoid an either/or dichotomy and can appeal to nuances without the blind and rote application of rules in practice.

Interestingly, Rogerson et. al. fail to acknowledge the vitalizing role that imagination might provide in such a discussion. Despite their commendable efforts to redress the imbalance favoring rational deliberation as a model for decision making; Rogerson et. al. ultimately align with the very philosophical tradition, and its accompanying assumptions, which they ostensibly have set out to critique. Insofar as the authors omit a place for imagination, both conceptually and practically, they avoid attending to a critical distinction between Analytic and Continental traditions regarding how reason should be defined. As Gutting (2012) writes, Continental philosophers since the 1960s, including Foucault, Derrida, and Deleuze, “regard the essential activity of reason not as the logical regimentation of thought but as the creative exercise of intellectual *imagination*” (Gutting, 2012, p.3).

Gutting describes two contrasting priorities accorded philosophy within the Continental tradition, one being focused on philosophies of experience and the other on philosophies of imagination. Both variations are apt to the discussion here, but the second is particularly relevant to highlighting the problem with the aforementioned research of Rogerson et al. Gutting explains:

“Continental philosophies of experience try to probe *beneath* the concepts of everyday experience to discover the meanings that underlie them, to think the conditions for the possibility of our concepts. By contrast, continental philosophies of imagination try to think *beyond* those concepts, to, in some sense, think what is impossible.” (Gutting, 2012, p.3).

By omitting the imagination as a concept, Rogerson et. al. limit the chances of reaching a better phenomenological understanding of ethics, and align psychology and decision-making models with an Enlightenment era language and frame, which diminishes what Continental versions of the imagination, and its potential for liberation, may offer. In thinking beyond current ethical structures, we are liberated into using imagination not only for the sake of creatively problem-solving ethical dilemmas, but also for perceiving ethical concerns that have yet to be thought. The latter forces us to confront the strange typecasting that ethics gets in our professional culture, and begs the question: why do we so frequently think of ethics as rules and what is proper, as opposed to an incomplete project toward envisioning what is possible?

It is not only Continental thinkers who find imagination valuable to thought generally and ethics in particular. Among the latest developments in cognitive science is an emerging discussion about the central role of imaginative capacities in making us uniquely human, as well as forming the basis for humane ethics, in both theory and practice. As cognitive scientist Benjamin Bergen (2012) illustrates in *Louder Than Words: The New Science of How the Mind Makes Meaning*, all human communication leaves gaps of meaning and understanding; mental representations enhanced by narrative are always, to varying degrees, incomplete. However, this incompleteness provides the opportunity for imagination to craft links in the narrative gaps, breaks, and ambiguous patches. As Bergen writes, “human language, in contrast to all other animal communication systems, is open-ended” (Bergen, 2012, p.4), which leaves room for

linguistic pliability wherein imaginative activity becomes essential for interpreting and inferring meaning.

Bergen extends the conversation about language and imagination further, describing the emergence of the *embodied simulation hypothesis* within cognitive scientific circles in the mid-1990s (Bergen, 2012). Basically, the idea stipulates:

“Maybe we understand language by simulating in our minds what it would be like to experience the things that the language describes.” (Bergen, 2012, p.13).

Bergen contends that the mental imagery of “simulation creates echoes in our brains of previous experiences,” allowing us to “simulate percepts and actions without actually perceiving or acting” (Bergen, 2012, p.15). Such simulations, though, are not limited to structures corresponding to previous experiences, but can transcend them through acts of imaginative, mental rehearsal to create new patterns of visualized, imagined movement, thought, and linguistic variation. Mental rehearsal, according to Bergen, is useful for visualizing and improving motor skills, such as with choreographed dance or shooting free throws, which has been known by performance artists and athletes for years (e.g., I can still, quite vividly, recall my Uncle Mike, who played college football at Marquette University in the 1950s, reminiscing to me that he used to visualize performing specific defensive tackles as a middle linebacker, and reaped great successes on game day from strenuous *mental rehearsal* off the field). What is more, simulation also enables us to make sense of and story from the ultimately arbitrary symbols of a given language

system. As Bergen writes, “meaning, according to the embodied simulation hypothesis, isn’t just abstract mental symbols; it’s a creative process, in which people construct virtual experiences -- embodied simulations-- in their mind’s eye” (Bergen, 2012, p. 16).

Even evolutionary evidence seems to point to the primacy of our capacities to imagine, and thus mental simulations to form a foundation upon which language may have emerged. Simon Garfield (2013), author of *On the Map: A Mind-Expanding Exploration of the Way the World Looks*, has explained that early mapping, and the visualization and subsequent pictorial representation of landscapes, may have preceded the development of complex language, an idea advanced by the evolutionary biologist Richard Dawkins (Garfield, 2013). Early cave paintings, sketches of imagined landscapes, and attempts at representative mapping may have enabled the evolution of an interior landscapes that, in turn, allowed for extraordinary variation in mental rehearsal. In effect, the vital need arose to apply verbal description to a rapidly expanding world of mental imagery, leading to an eternal and inextricable bond between the visual imagination and the linguistic imagination.

All of these important theoretical digressions relate to the phenomena observed in this study. When participants were asked to “imagine how they would respond to the ethical dilemmas portrayed...”, they responded not by applying rules or ethical codes, which have their place; but instead by speculating about questions of narrative meaning. And, they achieved this by mentally simulating countless scenarios in an attempt to fill in the spaces within the patient’s history, context, and interiority, the latter including speculation about intentionality, affect, and desire.

Interestingly, these ideas from cognitive science intersect with those espoused by Steve Almond, an American writer and essayist. He laments the “erosion of narrative authority in our civil discourse,” as well as in the arts (Almond, 2012). Almond describes the irreplaceable virtues of the traditional and modern narrator, and sees the narrator as being systematically fragmented in an increasingly technological and visual media-saturated culture in which “the audience’s role [has become] increasingly passive-- to absorb and react, not to imagine” (Almond, 2012). Amid these trends, many of the very concerns of the psychologically-minded clinician have come under duress, namely those shared by Almond in particular, and the writer generally, who are interested in telling a coherent and unified story. These include, the ability to “establish setting, supply vital background and push the plot ahead,” as well as describe “subjective modes so the reader can experience the interior lives of characters” (Almond, 2012). These qualities closely mirror those illuminated by the research participant-therapists, whose focus was on imagining what descriptions might best apply to the setting and context, history and past, and interior life of the patient. In this sense, the ethical decision-making processes of therapists more closely resembles the attentiveness of the writer than virtually anyone else.

It is puzzling, then, why the A.P.A. model for ethics is based on the rational and logical model of the natural scientist when, in practice, therapists rely on much different sources of understanding, including those stemming from imaginative capacities assessed, utilized, and praised by creative writers. Clearly, the A.P.A.’s ethical canon is neither concerned with attending to how clinicians *experience* thinking about ethical

dilemmas, nor with *how* they use vital qualities inherent to imaginative thought to resolve dilemmas; instead the A.P.A.'s canon conveys the institutional hope to design and further a set of guidelines that pleases the dominant cultural values of our time, one favoring clear and distinct ethical codes, and corresponding guidelines to be applied rationally.

The linguist and cognitive philosopher Mark Johnson raises similar concerns with regard to ethics, literature, and the sources of our moral sentiments. Johnson asserts that widespread views of morality, particularly those within mainstream religious, legal and institutional circles, are characterized by the notion “that living morally is principally a matter of moral insight into the ultimate moral rules, combined with strength of will to do the right thing that is required by those views.” This moral absolutism fails to account for the crucial and “fundamental role of imagination in our moral reasoning” (Johnson, 1993, p. iv). Johnson calls us to recognize morality as a process of discerning “what is morally relevant in situations” and understanding “empathically how others experience things, and to envision the full range of possibilities open to us in a particular case” (Johnson, 1993, p.x) Such a process, as demonstrated by the data described in this study, requires the use of imaginative thinking. As a result, we are faced with the challenging task to avoid strict adherence to abstract, standardized moral codes, as well as the equally important need to avert total disregard for the grounding which moral principles can provide; indeed, we may find a middle path between the two extremes through the recognition that “it may be harmful to think that there *is* one right thing to do” (Johnson, 1993, p.xi). Johnson’s advice is that, in order to engender moral

sensitivity, “we are going to have to take as our principle task, not the formulation of moral laws, but the cultivation of moral imagination” (Johnson, 1993, p. xii).

Johnson sees a vitalizing relationship between ethics, imagination, and narrative, explaining that literature and story foster emotional and imaginative depth. He writes that “it is never enough to have moral principles, unless you have a sense of the tragic in life, the fragility of human well-being, and the importance of moral imagination in everything you do” (Johnson, 1993, p. xiii). Furthermore, the sources of these capacities are accessed, says Johnson, through a deepening engagement with literature and narrative.

One conclusion we might make from Johnson’s work, then, is that ethical practice requires the ongoing enrichment of the imagination through immersion in works of literature, art, theatre, film, and any performance which conveys narrative. Instructing clinicians how to practice ethics by informing them of codes and guidelines has its place, but is not nearly as important as promoting a larger and wider engagement with developing one’s mind through exposure to the more difficult, essential, and meaningful ethical matters portrayed within stories, an idea promoted by the psychiatrist-writer Robert Coles in *The Call of Stories: Teaching and the Moral Imagination* (Coles, 1990).

Ethical training needs to include a component of narrative enrichment stemming from interdisciplinary sources and multiple mediums-- textual, visual, tactile, performative, auditory, etc.-- in order to teach and strengthen the ability to *think deeply and imaginatively about ethics, out of which unforeseen ethical queries may arise*. The study of creativity and creative individuals across walks of life and throughout history,

has demonstrated that “creativity is combinatorial,” as writer and blogger Maria Popova explains in *Brainpickings*, a website which is, as she calls it, “a human-powered discovery engine for interestingness” (Popova, 2013). Popova, a self-described “interestingness hunter-gatherer and curious mind at large,” embodies the sort of imaginativeness that can lead to new insights, including ethical ones. Her project has revolutionized what a website and e-newsletter for book lovers might look like.

Discussing innovative thinking, Popova notes that “the most profound and valuable insights appeal to the cross pollination of disciplines” (Popova, 2013). Her ideas resonate with the ideas of both Freud and Jung, who thought that the best preparation for becoming a psychoanalyst was to immerse oneself in a broad and sustained study of anthropology, literature, history, mythology, philosophy, the arts, and the like. Without such intellectual depth, the imagination is starved, and any psychological language or ethical codes one might entertain will amount to being little more than a facade, and perhaps a dangerous and harmful one insofar as the recitation and unthinking application of psychological facts, ideas, codes, and rules lacks humanity.

The project of the ethical imagination is rooted in the idea that ethics is, indeed, an ongoing *project*, one that is never complete, yet vitalized by the ambiguity at the core of human relationships. Without outward recognition of this fact, human beings have a tendency to forget that codes and rules are human created, and can be dangerously used to irresponsibly hide behind, obscure identities, limit experience, hinder empathy and understanding, and further injustice. Notwithstanding that, rote memory of an ethical rule or code is valuable, but only to the degree that its application to an actual event is

wrestled with, and that thinking, pondering, and reflecting on the various dimensions at play does not wither amid the temptation for a quick resolution to a given problem, which moral rules may seem to promise (at least from the perspective of the frequently impatient human mind).

Another proponent of the role of imagination in ethics, psychiatrist and philosopher Arnold Modell, draws a critical distinction between the construction of meaning and the cognitive acquisition of information, explaining that making meaning “is not the same as the processing of information; meaning cannot be ‘represented’ by a formal symbolic code” (Modell, 2006, p. xii). Modell argues that “the construction of meaning requires the use of emotions and feelings as markers of value,” and that what makes us most uniquely human and separates us from the rest of the animal kingdom is “not only our possession of language, but also our capacity for generative imagination, which in turn relies on the use of metaphor as a cognitive tool” (Modell, 2006, p. xiii). Furthermore, metaphor enables affect to be “imaginatively interpreted, displaced, and transformed,” which, in effect, allows human beings to sublimate instincts and reflectively choose alternatives to otherwise unconscious proclivities and desires (Modell, 2006).

The philosopher Hilary Putnam affirms kindred views, espousing that meaning is not created through the translation of a cryptographer’s code but rather through *social interaction*, and dependent on “what is in our heads [...] and in our environment,” writes Modell (ibid). Consequently, meaning is best seen as embodied, social, and imaginative,

making the sources of ethical and moral values ecologically rooted in the human community, so to speak (Modell, 2006, p.4).

Yet, despite a cacophony of voices praising the vitality of imagination in both making meaning and morality -- ranging from contemporary ones like Johnson, Modell, and Bergen to much older ones like John Dewey, Frederich Nietzsche, and the 17th century Italian philosopher Giambattista Vico-- there has been an even larger movement in the sciences away from such a view. As Modell laments, “the flight away from a meaningful mind is widespread,” possibly representing “an aspect of American culture that is relatively intolerant of conflict and the disorder that is part of one’s inner world, and that welcomes the orderliness of ‘objective’ and presumably scientific explanations of how the mind works” (Modell, 2006, p.5).

From this we might infer that our culture, in both popular and scientific sentiment, has difficulty accepting and working creatively with the ambiguity at the heart of the human mind, and the related ethical thought, meaning, and language that such a mind generates. We seem to individually and collectively resist the effort, humility, patience, and uncertainty which accompanies the admission that much of what we know, in terms of meaning and ethics, is quite pliable and can be seen alternatively. It is significantly easier to see the mind through mechanistic and computational metaphors than through the murkiness of human relationships, culture, language, history, and subjective imaginings. Indeed, we seem to specialize in the accumulation of information and ‘facts’ at the expense of developing an understanding not only of how imagination works, but also

how it can be cultivated and experienced. Such tendencies severely restrict ethical understanding and empathetic sentiment.

Postscript

Phenomenologically, the workings of the imagination can be, at times, defined by an essential quality of slowness. Much like the slow drip of a sugar maple in January, the pace of imaginative thought unfolds along the long span of geologic time over the short one of industry, bureaucracy, and the contemporary institution; the latter being especially vulnerable to the ideological, ethical, and conceptual short-sightedness imposed by a particular cultural-historical context.

If we are to ponder the relationship of imagination to ethics, we might consider Martin Luther King, Jr.'s affirmation that "the arc of the moral universe is long, but it bends toward justice" (Howe, 2009) to be a sagacious contention that the pace of ethics, humanity, fairness, and human wellness develops over centuries, even millennia, and crucially depends on the ardent evolution of our sympathies, understandings, and imaginings of one another's circumstances.

As equally as imagination is marked by slowness, it can, after long periods of incubation, strike at lightening speeds when the conditions are right, sparking epiphanies that may impress us as somehow being eternal truths, and so electrically clear that they inspire unwavering conviction (much like Plato felt that all true knowledge was always in us, but forgotten until uncovered through self-examination and dialogue). In this sense, imaginative activity is paradoxically dependent on slow, patient, resolute thoughtfulness, while correspondingly characterized by swift, seemingly-spontaneous insight.

Needless to say, human imagination is not unconditionally, necessarily, or definitively employed for the sake of ethics or justice. Plenty of examples to the contrary

abound in literature, philosophy, and the daily headlines. The most evil and maligned among us have often been the most brilliantly imaginative, in some cases offering a veritable starburst of *inhuman* imaginings, with subsequent murderous, destructive acts springing forth.

In their introduction to *Imagination and Its Pathologies*, editors James Phillips and James Morley make an abundantly clear case for imagination's insane, mad leanings. Through their own research and a selection of insightful essays from various psychiatrists, clinical psychologists, and philosophers, Morley and Phillips express both affection for and alarm at the workings of imagination, illustrating how imagination came to be associated with the irrational, particularly through the application of Enlightenment philosophy and values to medicine and psychiatry.

The darkness of imagination is also disturbingly portrayed in Franz Kafka's short story *In the Penal Colony* (2007), in which the main character devises the penultimate torture machine, one so ingenious that the reader is left wondering what is more evil: the man/technician operating the machine or the one who imagined and then created it in the first place. In short, the machine works by manipulating the anticipatory cognition and rumination of its victim insofar as it slowly, and intermittently, provokes the victim and drives him mad while killing him. What is more, Kafka's upsetting tale leaves the reader perplexed, for, the very imagination that can contemplate why such a particularly evil machine is so effective is the same imagination that can unlock and contemplate the victim's suffering.

Despite the potential for evil rooted in imagination, we are left with no choice but to face its complicated and frequently contradictory nature, mostly since the same force and capacity in us for developing, planning, and conceiving acts and methods of harm and atrocity is inextricably linked to our ability to understand precisely why such acts are wrong; that is, because they are harmful to individuals whose interior life and circumstances we can both imagine and, in effect, empathize with and comprehend.

In light of this dual and paradoxical nature, the interest of this research project has been to examine the creative, generative, and ethical workings of imagination in the interest of gaining a deeper understanding of how people respond to ethical dilemmas. In other words, questions of how imagination is employed for the use of destructive, harmful, and immoral action and ideation has been, at least for the moment, put on hold for the sake of engaging in a research endeavor that is reasonable in scale. Furthermore, since the project set its gaze specifically on the work in which psychotherapists engage, and the difficult clinical problems they encounter, it has limited the exploratory terrain and inquiry to instances in which the agent of imagination-- the psychotherapist-- intends to direct the imagination at interventions and interactions that will assist, guide, and, ideally, help heal the other. In doing so, it is hoped that our understanding of ethics continues to be both deepened and expanded in ways unexpected and unforeseen.

Finally, in consideration of the sort of reflective struggles with which participants engaged the research question, I would like to take the liberty to honor such contributions and conclude with words that are not my own, but those of Wendell Berry, who is among the greatest writers and poets of our time, and whose imagination, wisdom, and

descriptive gifts far exceed my own. The excerpt below is from his essay *It All Turns on Affection* (2012), and, while written with a specific focus on our ever-pressing environmental crisis, which is really also a crisis of economic philosophy; its applications are essentially limitless, and converge nearly perfectly with the ideas discussed heretofore. It also applies to the idea of place, and creating a space for affection to flourish, something that will likely concern any clinician interested in creating an environment of hospitality, warmth, and care in the therapy room. Berry offers a beautiful, revitalizing vision of imagination, a passage worth ending on, and a message ethicists would benefit to heed:

“The term ‘imagination’ in what I take to be its truest sense refers to a mental faculty that some people have used and thought about with the utmost seriousness. The sense of the verb ‘to imagine’ contains the full richness of the verb ‘to see.’ To imagine is to see most clearly, familiarly, and understandingly with the eyes, but also inwardly, with the ‘mind’s eye.’ It is to see, not passively, but with a force of vision and even visionary force. To take it seriously, we must give up at once any notion that imagination is disconnected from reality or truth or knowledge. It has nothing to do with clever imitation of appearances or ‘dreaming up.’

For humans to have a responsible relationship to the world, they must imagine their places in it. To have a place, to live and belong in a place, to live from a place without destroying it, we must imagine it. By imagination, we see it

illuminated by its own unique character and by our love for it. By imagination, we recognize with sympathy the fellow members, human and nonhuman, with whom we share our place. By that local experience, we see the need to grant a sort of preemptive sympathy to all the fellow members, the neighbors, with whom we share the world. As imagination enables sympathy, sympathy enables affection. And in affection we find the possibility of a neighborly, kind, and conserving economy.” (Berry, 2012, p.3)

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Appendix

Analysis of Marginal Summaries, Interviews 1-6 (Int.1-Int.6)

Categorical Key

IA: Intended action

AM: Ambiguity

ED: Ethical dilemma

ME: Metaphor

General Key

Tx: Treatment/therapy

PT: Patient/Client

MH: Mental Health

Hx: History

Rx: Prescription/medication

SI: Suicidal ideation/intention

HI: Homicidal ideation/intention

Category

AM- what are the ethical challenges?

AM- back story, past, PT's Hx.

ED- PT's safety to function in professional role.

AM- regarding PT's background and past work in Tx.

AM- regarding back story, PT's Hx.

AM-regarding who PT blames for primary tragedy in his
personal and professional life.

AM- regarding presenting problem.

AM- presenting problem, PT safety, responsibility,

PT's agency, and PT's guilt.

ME: chaos, disorder regarding PT's narrative.

“Intertwined and entangled”

AM: presenting problem.

AM: PT's identity and relationships, as well as meaning.

AM: PT's motives.

ED: is PT fit to fly and safe to perform professional role?

AM: PT's motives and concern for what military's intentions are.

ED: whether to collude with PT when he asks clinician to lie about MH.

AM: PT's intentions and what PT is seeking or expecting from Tx.

IA: need for clinician to be more clear and direct with PT.

AM: how should clinician respond or what action should be taken?

ED: how to best communicate with PT?

IA: be clear about expectations and communication with PT and
other professionals.

AM: PT's symptoms in life context.

AM: PT's Tx Hx.

ED: best communication, PT safety to perform job.

IA: request, pursue more information. Engage PT in deeper inquiry.

IA: interpret that PT is projecting. Inform PT of his defensive
patterns.

AM: PT's relationship with family, namely those only know through

PT's second-hand accounts.

IA: communicate to PT that he has more work to do in Tx.

IA: acknowledge that PT cannot be forced to work on a particular issue;
preserve PT's agency and responsibility.

IA: confront PT about potential impact of his actions on family members.

AM: PT's safety in professional role.

IA: confront PT about his sense of urgency to return to work and
impatience with Tx process.

ED: should clinician endorse PT's return to dangerous,
high-risk work?

AM: safety of PT in professional role.

ED: basic safety of PT and others around him. Risk of SI/HI.

ME: mapping, marking, and ordering an otherwise chaotic landscape.
"fencing in the territory."

IA: avoid addressing material or assessment questions beyond one's
clinical expertise.

IA: allow military doctors to decide PT's return to work and completion
of Tx.

IA: refrain from crossing the boundary of favoring Tx over PT's career.

AM: PT's military status and appropriate time for return
to high-risk role.

ED: how far should PT be pushed to stay in Tx?

ED: whether or not clinician should take the decision out
of PT's hands.

IA: preserve PT's autonomy and responsibility.

AM: what do PTs actually want from therapy?

IA: assess PT's mental status out of concern for basic safety.

ED: avoid collusion with the PT; important to avoid
negating responsibility and choice.

ED: PT's safety. How to address problematic symptoms and
erratic behavior?

AM: lack of background information to assess for safety.

IA: be more direct with PT.

IA: be clear with PT.

AM: how to interpret PT's situation?

IA: avoid forcing PT to stay in Tx.

IA: "hold on," maintain boundaries, maintain a "Tx space."

ED: how to interpret emotional dynamics in Tx room?

ED: how far to take Tx and interpretations?

AM: regarding ethical action.

AM: regarding PT Hx.

AM: what kind of chance to take with interpretation and
confrontation.

AM: decision making; go with intuition.

AM: regarding inaction as response.

ED: should more direct interpretation of PT's situation occur
in session or to outside psychologist?

IA: go with my intuition ("go with my gut")

IA: consult supervisor.

ME: must get clear, gain clarity.

AM: response after session.

ED: how to restore and preserve PT's agency?

ED: how to address PT's desire to have clinician decide?

AM: PT's motives.

ED: how to leave the session? How to end it?

AM: PT's Hx.

AM: directness, confrontation, assertiveness and interpretation.
what role do they play?

ED: not sure how far to push PT.

AM: regarding relationship dynamics and transference in Tx.

ED: how to handle transference?

how to address repetition compulsion?

AM: regarding fictional therapist's decisions.

IA: follow instinct and hope luck and chance are on
side of enacted intervention.

IA: take a chance with considered interventions.

IA: follow instinct.

AM: best course of ethical action?

AM: ethical action.

IA: remain largely inactive and maintain boundaries.

ED: how to handle one's own anger toward PT.

AM: regarding inaction or "sitting back."

AM: regarding multiplicity of Tx paths.

ED: what are my responsibilities and obligations?

IA: follow intuition.

AM: regarding if Tx works or is effective only
in the way we perceive an outcome.

IA: determined by safety, but cannot be assured
PT will be safe.

ED: will be solved by basic guideposts.

ME: "basic guideposts"

AM: what kind of Tx and ethical action is possible?

AM: how to erase what fictional therapist did
and what to do with PT's behaviors?

IA: agree with fictional therapist's confrontation;
mimic it.

AM/ED: questioning whether someone is qualified or capable
of killing others in war—should an ethical stand be taken?

IA: pressure and question regarding PT's perceptions of

Self-Other. Gain PT's perspective.

AM: regarding PT's motives and what he is actually

communicating in Tx.

AM: fictional therapist's statements in session.

IA: mimic some of therapist's behaviors and intervention.

IA: avoid depth of most difficult ethical issues and remain

clear in responses to PT.

IA: answer "yes" or "no" to PT's questions. Be as clear as

possible.

IA: make black and white statements.

IA: access other ethical dilemmas vis-à-vis issue of PT's

assessment request; conflict over assessment

can crystallize clinical issues.

ED: how to deal with another psychologist, namely

military psychologist, and how to respond.

AM: what to do with one's own anxiety about PT's

request?

IA: spend more time on assessment, PT's request, and

PT's expectations.

IA: spend more time on PT's request itself.

AM: regarding how to best respond about keeping

PT in Tx.

AM: unsure of situation as a whole; never been in one quite like this.

AM: what actions to take in/during session?

AM: regarding directness of communication. Should PT take particular actions to resolve problem?

ED: contextualize problem and locate answer or action within context.

ED: how to treat the last session, particularly since PT announced he was leaving unexpectedly.

AM: regarding PT's abrupt announcement of last session; what does such a statement mean?

AM: Which of the ethical dilemmas is more important or urgent?

IA: do not leave PT with false impression of what can be done with psychological assessment.

AM: regarding how fictional therapist left things with PT and what therapist's intentions were.

IA: rely on intuition in session and luck.

ME: the situation of the assessment request is a "roll of the dice."

IA: leave decisions for PT to make—preserve ambiguity

of therapist's own position and opinion.

IA: leave situation at termination ambiguous as to whether
it is best for client to leave. Extend invitation to return.

AM: regarding if fictional therapist's actions were correct.

IA: "go along for the ride" with PT.

ME: "going along for the ride" enables a real decision and
intervention to arise.

AM: need for more information about PT's situation to make
therapeutic and Tx decision.

IA: resolve dilemma out of experience in session.

AM: what is difference between being a viewer of session
and living or experiencing session?

IA: therapist cannot speak it, but implies thought.

ME: a certain "barrier" exists.

AM: because there is no Hx with that portrayed PT,
situation is unclear.

ME: all the work here is done "under the gun" because
PT states he's leaving and the "clock is ticking."

ED: no single correct response is possible. There is no riddle, so
how to leave some degree of mystery and ambiguity?

IA: through consultation with others, value of different approaches
emerges.

AM: regarding boundaries with PT.

ED: how to maintain professional boundaries.

IA: begin with presenting problem and identify whether

PT is ready to return to active military duty.

AM: regarding multiple relationships with PT.

AM: regarding PT's readiness to return to work/duty.

AM: what is presenting problem?

AM: regarding what fictional therapist is actually endorsing.

What is his action?

AM: regarding PT's readiness.

IA: assess whether PT is ready for duty.

ED: what to do about PT's aggressiveness, anger.

IA: need to address PT's safety and SI/HI.

IA: clarify why PT feels aggressive.

IA/ME: find an "outlet" for PT's emotions.

IA: confront PT regarding aggressiveness.

IA: validate PT's anger.

IA: validate challenges PT is facing.

IA: encourage outlets for PT's anger.

ED: Will PT hurt others?

IA: determine PT's diagnosis.

IA: do not give PT cell phone number as fictional therapist does;

give him crisis hotline number instead.

AM: what is PT's diagnosis?

ED: Is clinician competent to Tx PT's diagnosis?

ED: how to address PT's aggressiveness?

IA: do more than listen, as fictional therapist does.

IA- clarify PT's intentions with PT.

AM: is PT intent on hurting others?

ED: how to handle homicidal potential?

AM: unsure if simply listening to PT is an adequate intervention.

IA: carry out standards as outlined in ethical code, section on
human relations.

ED: boundaries between PT's needs and clinician's abilities.

IA: justify intervention based on ethical code.

AM: exact meaning of ethical code.

AM: how should code be applied?

AM: is clinician competent?

AM: what is code? How should it influence decision?

IA: need for clear, unambiguous statement about PT's
preparedness for work.

ED: how to overcome lack of directness by fictional clinician?

IA: assess PT for SI.

ED: what action should be taken if PT cannot work?

ED: how might PT respond to upsetting news?

AM: unsure about PT's situation and actual circumstances.

AM: what is context PT is dealing with? What disparity exists
between PT's presentation and reality?

AM: actions rest on contingency, namely what PT's actions are.

IA: better assessment during session regarding SI and S potential.

ED: how to address SI?

AM: diagnosis?

IA: gain more detail about SI.

IA: take more action than fictional therapist.

IA: make SI/HI concerns clear and concrete.

IA: recommend higher level of care.

AM: how serious is SI?

AM: regarding questions that are not addressed in video clip.

IA: use CBT techniques to help PT deal with trauma and guilt.

IA: do more than listen.

IA explore anger issues more deeply.

AM: how to handle PT's trauma?

IA: ease PT's anger.

IA: create more awareness.

AM: PT's motives. How to address PT's conflicting motives?

AM: not sure of presenting problem.

IA: refer PT to someone else.

IA: clarify continuity of care.

ED: how to leave PT in safe position? How to handle transition?

AM: how to extend Tx?

IA: develop better communication among family members.

IA: encourage development of social supports and crisis plan.

ED: PT's preparedness to deal with intense emotion.

AM: regarding high stress military position.

ED: how ready is PT to return to duty?

ED: how to handle PT's request to return to duty?

AM: regarding unresolved issues from past that could
effect PT's safety.

ED: PT's stability and what to do about it?

ED: client's lack of self-insight and awareness.

IA: clarify with PT beyond clinician's intervention.

IA: be more direct with PT regarding his
complicated request.

ED: choices regarding risks to therapeutic relationship and
what PT is requesting.

AM: how should the ED be handled?

AM: how to respond to PT's request?

IA: base action on decision making models.

IA: base action on imagining how others in profession

would evaluate and respond to PT.

IA: base action on model of care and ethical standards.

IA: imagine a peer in this situation and enact/mimic how
that peer would respond.

AM: how would others respond?

IA: address PT's request more directly.

ED: how to address PT's difficult request for assessment
and return to work?

IA: be more confrontational than clinician.

IA: therapist should have pressed PT more than clinician.

AM: how will therapist actually respond to this request?

AM: could PT have handled more insight from clinician?

IA: attempt to add greater depth to therapeutic encounter.

AM: could more psychological processing be done?

AM: does clinician have empathy?

AM: was there an opportunity for processing?

AM: is PT fit for active duty?

IA: discuss safety issues surrounding military role more actively.

AM: how to provide confirmation that PT is stable.

IA: confront PT about over confidence in being ready for duty.

IA: seek supervision.

IA: maintain boundaries and frame relationship.

IA: refer to others and rely on other professionals.

IA: use honesty and directness.

ED: dilemma of continuing care and Tx.

IA: use more direct confrontation regarding PT's request.

IA: request that PT return for one more session.

ED: PT's fitness for active duty?

AM: influence of all this intervention on PT?

AM: not sure of intervention.

AM: what is PT's Hx?

AM: what is PT's situation?

ED: asking therapist to lie.

IA: Consult professional peers about request to lie.

IA: inform PT that assessment might disappoint him.

AM: did therapist agree to make statement assessment or

are they meeting again?

IA: Give an honest evaluation and avoid lying to please PT.

IA: clarify with PT that assessment will be honest, not necessarily

pleasing to him.

ED: how to do least harm to therapeutic relationship.

IA: consult because overall situation is unclear.

AM: not sure what I'm missing about this case.

IA: clarify for PT.

AM: what is therapist's role here?

ED: lying about PT's status to please PT.

ED: PT's power and control issues and how to address them?

ED: HI and safety of others around PT.

ED: PT and his abuse and violence toward others.

ED: let him fly? Safety concerns, PT's impaired judgment.

IA: advise PT to remain in Tx.

IA: refrain from advice giving.

AM: does PT think about safety issues?

ED: therapist should have stayed with PT longer?

ED: role of cell phone in session?

ED: contact with PT outside of Tx?

ED: boundaries with PT and how to address?

IA: consult with military psychologist.

ED: dilemma of cultural differences between therapist
and PT; civilian and soldier.

AM: PT's identity and influence of military culture.

AM: understanding the PT's identity.

IA: confront PT about responsibilities to his family.

AM: not sure therapist was engaging with cultural and identity
issues enough.

AM: how to respond to overall situation.

ED: should decisions be made about PT's fate in military?

ED: how to handle PT's identity as a military man?

AM: how to handle PT's military identity.

ED: identity dynamics of PT and how to address.

AM: many missing aspects of story that remain unclear.

ED: how to best handle delicate issues of PT of him flying and his
military career.

IA: process PT's reaction to the upsetting news that assessment might
lead to him not flying again.

ED: request for assessment that will allow him to fly.

ED: boundary issues surrounding session (use of cash, giving PT cell
phone number).

IA: do not allow phone calls to therapist so readily.

ED: asking therapist to lie and PT's request for a direct answer.

AM: follow up to PT's request for a response.

IA: respond like therapist did in terms of trying to get PT
to expand his thoughts about issues.

ED: unresolved issues. Therapist left things unresolved. Is that okay?

AM: not sure of overall context, situation of session.

AM: does PT have PTSD?

IA: would act as fictional therapist did.

AM: not sure if exact path of fictional therapist would be repeated.

IA: would be more direct in assessment.

ED: how to handle request for assessment?

IA: agree with fictional therapist's indirectness, and mimic.

AM: violence, safety, HI issues.

ED: how to handle PT's potential aggression?

IA: build relationship before addressing difficult material.

ED: dilemma of cultural issues and PT's identity.

ED: how to address cultural differences?

AM: case formulation.

ED: how to handle HI?

IA: address personal issues that therapist left out.

AM: unsure about what action would be best.

ED: how to confront family dynamics.

IA: confront PT's avoidance of core issues, namely those with family.

IA: avoid indirectness.

Ideals from Analysis of Marginal Summaries, Interviews 1-6.

- Respective participants' interviews (e.g. 1, 3, 4) are listed parenthetically.
- Items highlighted in bold indicate an ideal that was repeatedly cited by multiple participants (a minimum of three times by each participant listed in bold for that particular item). Additional items in bold are highlighted to indicate that more than three participants expressed concern for or valued that item, theme, or dilemma.

I. Clarity (1-6)

- A. Clarity of patient history (1, 2)
- B. Clear understanding (1)
- C. Knowing clearly (1)
- D. Clear intent (1, 3)
- E. Clear, precise language (1, 2, 6)**
- F. Clear communication (1, 2, 3, 4, 5, 6)**
- G. Clear treatment plan (1, 3)
- H. Order and clarity (1, 2)**
- I. Clear and coherent motivation (1)
- J. Clear thinking (1)
- K. Clear intentionality (1, 2)
- L. Ethical clarity (2)
- M. Clear diagnosis (3)
- N. Clear case conceptualization (3, 6)
- O. Clear effect of treatment (4)
- P. Narrative clarity (5)

II. Patient's past (1, 2, 3, 4, 5)

- A. Comprehensive history (1)
- B. Coherent history (1, 2, 5)**
- C. Treatment history (1)
- D. Unresolved issues from past (4)
- E. Absence of history as viewer of clinical encounter (2)

III. Patient's safety (1, 2, 3, 4, 5, 6)

- A. Safety to perform job (1, 2, 3, 4, 5, 6)**
- B. Assessing safety (1, 3, 4, 5, 6)**
- C. Preventing crisis, suicide, violence (1, 3, 4, 5, 6)**
- D. Patient's aggression and anger (3)**
- E. Maintaining patient's stability (3, 4, 5)**
- F. Transitioning patient out of session (3)
- G. Cultivating social support (3)
- H. Keeping patient in treatment (4, 5)

I. Patient's understanding of safety issues (5)

IV. Boundaries (1, 2, 3, 4, 5, 6)

A. Avoiding collusion with patient (1, 5)

B. **Avoiding lying to please patient (1, 5, 6)**

C. **Leave responsibility, agency with patient (1, 2, 5)**

D. Leave responsibility with military (1)

E. Respect patient's values (1, 2)

F. **Maintain treatment space (1, 3, 4, 5, 6)**

G. **Refrain from action in therapy; be inactive/preserve ambiguity (1, 2, 6)**

H. Responding to patient after session (1)

I. Ending session (1)

J. Pushing, confronting client (1, 6)

K. Containing anger toward patient (1, 2)

L. Understanding therapist's role (5)

V. Therapeutic relationship (1, 2, 3, 4, 5, 6)

A. **Help integrate and unify (1, 2, 5)**

B. **Confront patient about safety (1, 2, 3, 4, 5, 6)**

C. Order material (1)

D. **Provide effective, timely interpretations (1, 3)**

E. Communicate directly (1, 3, 6)

F. Use intuition (1, 4)

G. Apply ethical knowledge (1, 3)

H. Apply ethical code (3, 4)

I. Attain empathy (2, 4)

J. Mimic previously successful treatment approaches (2, 6)

K. Provide meaningful interpretation (2)

L. Maintain singular relationship (3)

M. Catharsis (3)

N. Confront aggressiveness in session (3)

O. **Provide context sensitive response (3, 5, 6)**

P. **Cultivate awareness, insight (3, 4, 6)**

Q. **Preserve alliance (3, 5, 6)**

R. Refrain from giving advice (5, 6)

VI. Clinical understanding (1, 2, 3, 4, 5, 6)

A. **Understand context (2, 3, 6)**

B. Reveal underlying motives (1)

C. Understand presenting problem (1, 3)

D. Understand military's intentions (1)

E. Understand big picture (1, 5)

F. Understand family dynamics (1)

- G. **Understand what is latent or concealed** (1, 2, 3)
- H. Understand patient's expectations (1)
- I. Understand defenses (1)
- J. **Rely on social/supervisory understanding** (1, 2, 3, 4, 5)
- K. Understand intuitively (1, 2)
- L. Rely on moral foundation (1)
- M. Rely on diagnostic frame (3, 6)
- N. Understand cultural/identity differences (5, 6)

Table I, Frequency of ideals expressed in subcategories:

Participant 1: 46
 Participant 2: 21
 Participant 3: 29
 Participant 4: 15
 Participant 5: 22
 Participant 6: 20
 Mean: 25.5
 Median: 21.5

Table II, Instances of repeated thematic consideration (frequency of returning to item at least three times during interview):

Participant 1: 15
 Participant 2: 12
 Participant 3: 14
 Participant 4: 9
 Participant 5: 12
 Participant 6: 11
 Mean: 12.1
 Median: 12

Interview Transcripts

Dissertation Interview 1

JJ: Imagine that you are the therapist in the situation. What ethical challenges or problems do you see and how do you think you would respond?

G: Well, um, the ethical challenges. I don't know. Maybe I'll just talk freely for a second and gather my thoughts.

JJ: Ah hmm (agreeing).

G: He comes into the session and is dressed to the nines. He projects a powerful image. He's very forceful. Then he goes through this long description of this party where you see all these different dynamics between him and his father, and his identity; and I'm sitting there watching not knowing the back story thinking that you know, so, the Navy is kind of a means to a kind of um, way to solve these identity issues that he has. So, when I watch I'm thinking: what is he in therapy for. If he's in therapy to make sure he's safe and able to go fly, then I think you have one set of it. That's one guidepost.

JJ: Hmm.

G: If he's in therapy to try to come to terms with, um, his relationships with his family, and to have a more meaningful life with his wife and his son. Umm. I did watch the very first episode with him in there, so I do remember that he has a heart attack when he's running with another guy, so that's kind of outside of this episode.

JJ: Ah hmm. Yes, that's a good memory. That is what happens.

G: And he has a hard on. I remember the guy runs a big marathon and he ran, um, and he had a hard on, um, but I don't remember.

JJ: You're accurate with that. It is involved. He has an erection when he has a heart attack and his gay friend performs CPR. His friend is a doctor.

G: A psychiatrist?

JJ: Um, a general practitioner, I think.

G: Yeah. Okay, so there's that bombing in Madrassa where he killed those people. And I remember it being about, um, they told him what to do and he did not have to make any decisions and it's their fault. And he's trying to figure out blame and this kind of thing.

So, um, knowing some of that, too, I'm thinking, you know, is he fit to fly, is it about creating meaningful relationships, is that what his presenting problem is? And then you have this third thing, this desire to place responsibility on others, place responsibility on the, um, military, so he becomes, ah, alleviated of, um, any kind of guilt or responsibility. But yet he's not able to because he has all of these problems.

JJ: Hmm mmm.

G: So, the question, I guess, is, um, figuring out, um, the more central issue of, like, figuring out, kind of, who he is and how he relates to people. This more kind of meaningful, meaningful life question. Um, it does kind of become intertwined with is he fit to fly kind of question because, um, um, because this propensity to kind of place, to try to avoid any kind of responsibility, yet still he gets caught up in it, later, so I think it becomes really entangled. Um, so with that kind of said I would think, okay, you know, what, what is this military doctor calling me for, asking me about? You know what I mean?

JJ: Hmm mmm.

G: Because what is it that he wants? And I think I would, um, make that very clear. And I think in the session I would have been a little bit more, just for my own sake, be a little more clear about what it is that he wants. Like, you know, because it seems like there is this, um, in the session where it becomes, um, the boundaries are beginning to cross because the client is asking you to lie, in a way. Or just say, you know, tell them what I really want to hear. Um, and there was no discussion about what do they want to hear. And I think I would have been a little more clear, I mean, um, a little more direct about that in the session. And I would have, um, then been able to have tried to been a little more clear with him because the one thing the therapist does not do is he does not tell him what he's going to say, he leaves it open, but I think for a t.v. show that is a great cliff hanger but I would be probably either make that call on the spot of think about this one and call you back and then I'd probably talk to a supervisor and a colleague or something. And have a little bit of a dialogue if I couldn't make sense of it in the session.

JJ: Hmm, uh-huh. Say more about that part- how it makes for a good cliff hanger but there is something more...

G: Well, I think when you, when it comes to, when a client is asking you for something especially when it comes to anything outside of the session.

JJ: Hmm-mm.

G: When it comes to “I’m going to be talking to this other practitioner” about something about you or something about their parents, kind of thing to, to really be, you know they’re your client, they’re the most important person and that’s who...it’s your job to take, well, not take care, but your job to, um, be concerned with them.

JJ: Hmm-mm.

G: Um, and not let this other person. So, it’s like I would want, in the session, to know the best I can what is being asked of me and then be real clear about what I’d be willing to do. And so if the doctor, if that other doctor is calling and saying is this guy having these symptoms, is he experiencing this kind of anxiety, and does he have kinds of things, I mean, I think it would be a simple thing, I’d be like “no.” Right?

JJ: Hmm-mm.

G: Now is there a chance that might happen? Um, I guess I’d want to know a little bit more. Now he’s saying that that up in the air... [trails off]

JJ: Um, you would want to more about the client?

G: Want to know more about the client. I don’t know what symptoms he has or anything like that. Like what, um, what, what would get in the way of him doing his job up there?

JJ: Hmm-mm.

G: You know, he’s saying that when he’s in the air he’s in complete control, and..., um,...

JJ: You are suspicious?

G: I’m suspicious, but I don’t know because I don’t know the rest of the history. And I’m also, I mean just from that one session, it might be true because it is something where he is alleviated of responsibility and, if I can remember from before, the problems come afterwards.

JJ: Hmm-mm.

G: Ah-um, so I guess that’s stuff I’d want more information about. Um, if it was that... um... [trails off].

JJ: You’re implying, then, that you would have done something differently?

G: Well, um, I was saying that, I mean I am saying that with figuring out what the Army psychiatrist wants. Um, and, being a little more clear with the client about what I’m

willing to say or what I am thinking. Um, that being said I was also kind of moving on to another thing where I'm thinking "okay what if the, um, you know, um, is it true that being in the air is a safe place for him?" Where these kinds of issues of identity and responsibility and guilt are set aside? Can I be certain about that? And I don't know. Like I said, I'd like to be able to have a little more information about the client I'm working with and make that kind of decision. Um, I can see it going either way....

JJ: Based on what you do know, from the one session you saw, even if you can only recall so much. Um, you made reference to issues of identity and relationships, what do you see there?

G: About his family?

JJ: Well, yeah, what did you pick up on there?

G: Okay, well, so I um, I mean I would agree with the interpretation that the therapist makes that when he is describing the party it is pretty much projection. So, he's projecting his feelings onto his son in a lot of ways. Um, wishing that he, you know, that his father would be out of the picture that his father would let him do what he wants. That part of the reason he feels he gets to get into the military is a kind of flight away from his father, and, um, you know, when he's talking at the end about the kind of vulnerability that his son feels, that's mainly projective. You know that he feels vulnerable by these forces he cannot control. Um, and, if he follows that path and continues to run away from those things, then he could jeopardize further his relationship with his son. And it seems with his wife also. Um, so, um...that's mainly what I was seeing and, you know, I think the therapist is right in here saying that he has a lot more work to do. And I think I would, I would probably, I think it was good to say "you've done a lot of good work, and I think you need to do more work." But the question is what is the presenting problem, I mean, you know you cannot force somebody to work on something that they did not come in for. Um, and maybe, maybe, you know, maybe even going to the point of being like, you know, if you really want, if this is the last moment, you know this kind of a gamble, but you might want to lay it out there. And say "look, if you really think this is the last moment," this is kind of a gamble, but you might want to just lay it out there.

JJ: Yeah.

G: And say, "look, this is why you're going into the military and you're going to jeopardize your relationship with your son." That's my opinion. "Now maybe you'll be safe up there. I don't know that. That's for them to judge." They're better at judging

that than me. But, by participating in this pattern, you're jeopardizing your life with your son and your wife. And it's my opinion that you could work those things out here and go back to the military with a clearer mind. You would be able to choose to go back into the military rather than feeling forced into it by forces you cannot control. That would be, that would be maybe an interpretation that I would make.

JJ: So, yeah, that's, um, an alternative to what Paul, the therapist, did?

G: Yes, um...

JJ: If you really pushed yourself in that position, how would you choose between that alternative and the one represented in the segment?

G: I think it would be a pragmatic decision because, ultimately, I agree with the therapist and think he should stay in therapy. There is no reason to rush into going back up there, um, except for these kinds of dynamics.

JJ: Hm-mm.

G: Now those dynamics, I guess, what I am saying, aren't really [pause] as important to the practical question: can he fly?

JJ: Hm-mm.

G: If, as I'm imagining the question to be. Um, I mean... [pause].

JJ: And, um, how would you respond if the [military] psychiatrist asked that?

G: I think I would hedge and say that it is out of my expertise. You know, um, what what is it that you are looking for? Is he a danger to himself or others, you know? I mean I think I would fall back on those ethical guidelines that we have first to fence in the territory. You know, these are, um, my boundaries, or my fence posts that are going to kind of mark off the conversation, and inside of which I can maybe speak a little more freely, but if he's not a threat to others or himself, he's not erratic, he's not having debilitating anxiety, or any kind of symptoms, um, you know, then I think they are better off to assess that through whatever simulations, cognitive testing; I don't think that's in the realm of therapy, you know.

JJ: Right. Do you feel, then, if you took that approach, and would you be letting down the client because he was asking you to not let him down and in sense, his ability. Do you think that would be part of your decision or not at all?

G: I mean, look, I don't think I would want to. I would not want to, you know, jeopardize his career at the expense of my own desire him to continue in treatment. That would be an ethical boundary that I wouldn't cross.

JJ: Part of it, then, is your inward concern, too?

G: I could see this client being very, or me having a strong desire for him to continue to do the work, I mean all of the work up to this point. But I would not want that to, um, to be what guides me into saying something like "he's got a lot more work to do." You know, I think that would be letting the client down.

JJ: Hmm-mm.

G: Because I feel his desire to fly is not a true desire to fly, it has more to do with these personal things, and I think that would be letting the client down and I think that would be unethical because it would be coming out of my own desire to see him in therapy rather than being concerned about him. I mean, look, if he wants to go to fly and avoid these issues, it is his life.

JJ: Hmm-mm.

G: I mean it would be counter-therapeutic to take that responsibility away from him since that is what he wants in the first place. Right?

JJ: Hmm.

G: I mean that's his whole M.O. so then I'd be colluding with him. And that's even more problematic. [long pause] No, I don't think it would be letting him down to be honest and direct about whatever the people are wanting from me, and what I can imagine them wanting from me is: does he have problematic symptomology and behavioral concerns and that kind of thing.

JJ: So, real concrete stuff?

G: I think so, I think so.

JJ: And you don't feel you could make that call?

G: What the concrete stuff?

JJ: Yeah.

G: No, I think you do. But let's assume that this is a six month therapy or something. You know, is he a threat to himself or others? Is he, um, you know, does he have problematic symptomology, does he have erratic behavior, these kind of things.

JJ: So, you feel you have enough information for that?

G: I would assume so, yeah, I mean, if this was the second session then, no. It sounds like they're settling up, they did a lot of work together, you know.

JJ: Although it does sound like it is kind of abrupt, you know, they're settling up so quickly.

G: And that would be my caveat, too. You know, I mean, I'd say "hey, look, I've seen this guy for seven sessions over several months, and these are the kinds of things I see." But that is something I would have been direct with the client.

JJ: Yeah.

G: The whole thing about letting him down, I think I'd be direct with him right there and say, "this is what I'd be willing to say, based on what you're telling me they are going to want." And then I might move into that more dynamic interpretation for him. I think from a more pragmatic point of view, that is more likely to keep him in therapy because I'm not going to use my desire to keep him, I'm not going to be blind to it and let it guide my decisions, and completely control his life. But maybe I'm wrong. Maybe my interpretation is completely wrong.

JJ: So, that being held in mind, how would you settle upon [...] the therapist had to do something, so [...].

G: Yeah, I would go with my gut I guess. I don't, um, know what the other sessions look like, but I'm sitting here watching this one, and, I'm like, I'd just be holding onto my seat. He's getting up and standing and it's very cordial. The therapist does a really good job of maintaining boundaries. But when they get to that moment when it kind of settles down into a more emotional level, I think there's a moment there where you have to make a choice, you know, it, um, it. Do I take this chance and make this kind of interpretation, which could jeopardize the therapy and which I'm imagining is way too much for this client, and that he may just chuck it away. Um, or do I let it go and then face this kind of, just, um, just as problematic of a position as it would be talking to the psychiatrist.

JJ: Hmm-hm.

G: And having this responsibility. Because I think both of those things threaten to jeopardize the therapy. Um, no matter what. So, I mean I would probably go with my gut, so I could imagine if I was in this situation it would be on my mind. Especially if he didn't settle down. I think if the whole session had gone like it did in the beginning I would be a little flustered because he was pushing so much and there's a lot of other stuff going on in the room. I might have just sat there and been like "what the hell just happened."

JJ: Hmm-hm.

G: And it would come down to maybe talking to a colleague, talking to a supervisor if I had a supervisor, and I don't see what would be wrong with calling the client back, you know. And saying "I've been thinking and whatnot and wanted to be a little more clear."

JJ: So, a follow-up?

G: Yeah.

JJ: So, that might be the most appealing path?

G: Hmm, yeah. But if you do a follow up, you're just being very clear about what you're willing to do and still not taking care of it. It almost seems like the client wants to send him, send dad to the principle and see if he can get back in school or on the football team, and it's behind closed doors, it's between the men, and I just don't think that's good for him, I mean he's the man. So, talk to him first. [Long pause]. It is a real sticky situation—that's for sure.

JJ: Yeah, yeah. [long pause].

G: Because I don't, I don't know. I don't know what the history is with this client. I mean why would he leave it like that?

JJ: If you had to know just what you know from this session, could you speculate then?

G: I mean maybe he's thinking that he doesn't need to be that, um, forceful. I don't know if it's really forceful, but um, making a big interpretation and bringing all these things together if that's really necessary. Maybe there's enough there. Maybe they've done enough work that what they've done and what he's been able to come to is enough to make that decision on his own. Like I said, I don't know. [long pause] And the guy, I mean, he's definitely very, he fights the therapist in a lot of ways, on all the interpretive levels. Maybe another interpretation again would have just, um, been reminiscent of his dad, you know?

JJ: Yeah, he has to walk the line, doesn't he?

G: Yeah, I mean, because that is um, and I could see myself falling into that trap.

JJ: And repeating the father's...

G: Yeah, I don't know if it's exactly that or not because the father is berating him for being a pussy, and I guess, in a way, you would be too, I don't know, if I said that. If you said that it would like, okay, like, "you're running away from your life and being a pussy." [laughs]

JJ: Yeah, so your touching on the counter-transference? So, that is a concern for you?

G: Yeah, that would be a concern also. And as I'm thinking this through, over again, I'm thinking, you know, maybe this is the best thing, maybe the way he left it is maybe a clear understanding about what the Army would want.

JJ: Right. So, maybe you're moving back to thinking maybe his path wasn't so bad.

G: No,

JJ: I mean maybe it wasn't less than ideal?

G: Yeah, it is one of those situations where maybe not [whispering to himself inaudibly], I'm thinking I would just have to go with my gut and take my chance. I mean, shit, I think chances are in this situation that it is not looking good for continuing therapy, right?

JJ: Hmm-hm.

G: Um, I think you just have to follow your instinct and, um, especially if your thinking for the client and trying to be very sensitive your own counter transference, and just take a chance, I mean what else are you going to do?

JJ: Hmm-hm.

G: I mean for one thing, I would be very angry at this client for pushing me around, and I think that would be a difficult thing, I think I would have to, I mean I don't know what the relationship has been like with this therapist, but for me I guess if I get pushed around a lot the safest path is to sit back and be more direct about you'd be willing to say and then just let it go.

JJ: Hmm-hm.

G: But if I felt very comfortable in myself with him, then I might be more apt to make a move like he did.

JJ: Go even more out on a limb?

G: Yeah.

JJ: Well, that's pretty good. In terms of going on, there seems to be some open-endedness to the way you're leaving it or...

G: Well, there are a lot of different ways you can take it, I guess.

JJ: It seems like you keep referring in this situation, reflecting on it, there is definitely a divide between this and what you think you'd do. What you'd think you'd do seems to be in the moment, thinking these things, and then saying something would happen through intuition. Like, you would weigh these things, is that what you're saying.

G: Yeah, um, I don't know what I would be thinking because I don't think, well, I do think in session, but I'm not just sitting there reflecting on it as much because I am in the session. When it comes down to a cognitive thought process, I would be thinking about the things I've been referring to, like: what do they want, what am I willing to say, and then kind of have a conversation with him. That's one thing I'm kind of looking at: what's my responsibility, what are my obligations, right?

JJ: So you would be attentive to your role?

G: My role, right. And my role at being very straight forward. But when it comes to my desire and what I think is ultimately at stake for this human being, not this fighter pilot, but this human being, right? So, it would come down to that: what do I think is at-stake here? Um, that's guided more by an intuitive process meaning that I am not, I'm not consciously mapping all the transference-counter transference, or all these things, and then assessing this big schematic and making a decision. It's more of like those things through my mind and then, maybe, having them register, but then kind of sitting there and making a move based on how it feels. Um, which is something that you can't really see, but, um, you had that session and when you're watching it, you can see when the session settled down. When he's talking about his son, when he's talking about how you don't get it, you don't get it, when I'm up there getting...you can see the vulnerability, you can see him settling down. And you know, in that moment, what is therapeutically possible. Um, you know, that's always an ideal. Because therapy fails. You know? When this guys life is over, you can look back and say maybe all the therapy in the world would not help him in his relationship with his son and his wife. I don't know. You just

don't know. Maybe he would have a better life just being a fighter pilot. And evading his responsibility, if that is even the case. You don't know. But I think there is a certain ideal that we as therapists have, you know—what is possible? And, I think, you hold on to that, you know?

JJ: Hmm-hm.

G: And that helps to guide your intuition a little bit, you know? And that's much different than assessing, you know like you put it, your role. And that's a good way to put it, but it comes down to when we look at the ethics, it comes down to these things like: would you harm yourself or others? You know, these guideposts which I think are there.

JJ: So, you're talking about a relationship between those things and then an ideal that's intuitive? That has qualities of being visual and emotional, if I heard you clearly? You described being able to see it in the context, see it on the video, but also there's an emotional thing that you're talking about that sounds like a combination of these feature?

G: Um, it's more of a feeling, you can feel it and its imaginative. You have a certain ideal of what is possible that is kind of guiding, um, what you're saying. But like he says: "we have a lot of work to do." He has certain image of what therapy is, what is possible, based on his experience but also on what he has been taught. Right?

JJ: Hmm-hm.

G: Because this guy, I mean, he is an actor, but you know, but he's supposed to be this really great therapist. And he's probably had lots of cases, lots of clients, lots of different outcomes.

JJ: Yeah.

G: Um, and, um, so he's at a different end, but even more me, for us, you know, doing therapy for three or four years, you see certain outcomes, you see certain things, but what really guides you a lot is the cases you read, the things that you hear, about what is possible, what goes on in your own therapy, what you've experienced kind of thing, you know, as a therapist. Um, there is this kind of thing of, um, this ideal, this kind, of thing that guides you an ideal, that I'm going to look at this situation and, you know, not just as "what am I obligated to do" but "what what is possible for this client" and that's really guided by experience and theory and you're world view [long pause].

JJ: Okay, good, well, let's stop there.

Dissertation Interview II

JJ: Imagine you're the therapist in the situation. What ethical challenges or problems do you so and how do you think you would respond?

T: Um, it's kind of a hard question to answer because I'm really [...] I started taking, um, real detailed notes of every move back and forth, and so I'm really caught up in what he did. I don't... In other words I don't know where to, um, where the dilemma, where to erase what he did and where to start. I mean I guess I could start from the beginning where he asks: um, for him to give an assessment of a report to another guy. And, I think in that way I don't know off the top of my head what I would say I would do because I think he worked, and I would work step-by-step, calm response in a dialogue, you know?

JJ: Hmm-hm.

T: So, um, I, um, I mean the first thing that grabbed me is that this is potentially the last session he has with this guy, and, um, this guy is going to go back to war and be in the air and whatnot, and so he just jumps in and just "are you really ready for this?" And, I think that would be the right way to go. I know my initial sense was that I thought, I thought that the question or phrasing of someone being ready for war was already flawed in a sense. But...

JJ: The way the therapist phrased it?

T: Yeah, now I'm rethinking it because it's his language, it's his—he's working with him and the guy's own world, but I don't know, you know, the whole "are you ready for this or not" doesn't really make sense to me.

JJ: How so?

T: Well, I mean, if the guy was traumatized by killing innocent people. Are you really ready to go back and possibly kill innocent people? Because it's a nonsensical question to me. It's like if, as for me, coming from the place of a psychologist because that's psychopathic, you know? It's like saying: "are you properly psychopathic enough to go back to that situation" and, um, that was my initial reaction, but I now see that that was good to work with, which was to challenge his initial assumption that he is quote "ready to go back" and needs this therapist's help. So, um, so then that started a lot of stuff. You have a number of questions?

JJ: Well, you can keep going.

T: You know, the next, I think just to heat it up a little more, he challenged him on the level of feeling. Like, um, you know and put out words like fear and guilt and asked him directly how do you really feel about this. And then for whatever reason the guy talked about his wife and father not wanting him to fly. So, similarly I would explore their reasons because it takes relief off you of being the antagonist and it you just get to let him in a way speak to their hesitations. But I must have confused that because I got the impression that his wife did not want him to fly but his father did. But it doesn't matter because it's the same principle: you just work with their perceptions because those are the perceptions he's working with. And, um, and I like the move he makes when he says, um, "look, we don't have time for me to talk about my father right now" and he uses that in a nice way because he says that he does think it's important for them to talk about that and then he slides in, "especially if you're trying to push me for an assessment" which, um, in a way is a very indirect way of saying, "I may not give you an assessment."

JJ: Yeah, hmm-hm.

T: And also, in a way, I feel like there is an indirect comment on the guy's manipulation. He's saying: "I'm not clear if this is what you're trying to do." And I think that there are these little seeds because of course the question is going to come back and it comes back at the end of the session. So, um, and then the guy comments on his father being good with his son.

JJ: Hmm-hm.

T: And that their connected. The therapist asks: "did your son ever ask you why you left home or moved out" and he's real vague about it, as though his son doesn't know the difference whether he's in Iraq or across town, and that 's when he gets into the heart of the therapy where he says to him, "it's probably a relief to him that I'm not there." And he says the party was loose to him when he wasn't there, the father was there and people were enjoying themselves and the child was able to spread his wings. And, um, and, um, this is I think the first time the therapist makes the move of saying, was, was he enjoying himself because he was happy to see you, which, um, who know what the truth to that possibility is, but I think this is the first effort of the therapist of just brining home, like, a real central thing that a son needs his father.

JJ: Hmm-hm.

T: In one way or another. So, um, and then not long after that he really challenges him and says "you're so clear that the Navy needs you, but you don't speak in any conviction like that about your sons." And, um, and he just kind of sticks with is position how his

son doesn't need him, doesn't want him, and then the therapist says "are you sure you're not projecting that" um, that, um, meaning, "you don't need your father, fuck your father; you're assuming your son means the same about you." And he just goes on to just push against that.

JJ: Yeah.

T: The idea that his son needs him or enjoys him and he gives that example of the chess game.

JJ: Hmm-hm.

T: So, um, and there's two things there, one is his father harshly judges him. One is that, if I am to put it as short as possible, his father calls him a pussy. Um, "you know you can't, if any little thing goes wrong, you're kind of soft," which starts to, um, bring into view that, um, some of the psychodynamics of him underneath, wanting to go back into the military. But there is more to that, um, at the end. Um, in terms of the interaction of what's going on, um, yes, the therapist asks him, a part of that is when the son goes upstairs and he sees him and it breaks his heart, still playing on the idea that he is packing a lot on to his son, the therapist asks him what about his son was it that broke his heart. Because that's, like, opening a huge window into what he feels about himself but what he cannot say directly. And so he talks about being under expectations and pressure and whatnot and again he hammers home these things about because he leaves the party and the therapist says "do you really think your son was better off without you there on his birthday." And, um, the guy goes to a bar, apparently a gay bar, I don't know?

JJ: Yes, he goes to a gay bar.

T: And, um, kind of consciously aware of his desire to hurt those guys, um, the therapist challenges him and says maybe that is not why he went there—he went there because it's a space in which no expectations are made of him.

JJ: Hmm-hm.

T: Um, which as he himself said, "look, they all stayed away from me and could see where I was and they looked at that and accepted that." So, um, the only thing, a couple things left that I picked up is, um, when he brings back the question of whether the therapist will provide the assessment, and I don't know if I would have done this, but I don't think I would have been sharp enough to, um, do this, but, um, I would have been compelled to answer yes or no. If not yes or no, answer more directly, like, even if I was going to write it, I would still need to think about this. I would have stayed on the

surface of the question. Because it seemed to be building on other examples, like, you want me to share responsibility for really big decisions, such as continuing to separate from your wife, and going to war and whatnot.

JJ: And you thought that that was sharp, is that what you mean?

T: Yeah, I thought that was really, really keen because, um, you know obviously the guy is macho and probably thinks of himself as totally autonomous, and makes his own decisions, and is a military man and is accountable for what he does. And so to play that and say “this assessment seems to be you trying to be a pussy, you know.” Kind of, um, not making a decision on your own.

JJ: So, let me just clarify a moment, you’re saying that you probably would not have, you would have been more direct?

T: Ah, no, I think I would have been really caught in my anxiety about getting a call from a psychologist. And not knowing what to say there.

JJ: Hm-hmm.

T: And so, maybe in a way, that is what you were asking there. Again that seems to be, that to me is an overall dilemma, but then given that, what do you do in the session?

JJ: Hm-hmm.

T: So, I think, um, I think I would worked it more psychodynamically in the way he did in the session, but, um, I still think more than he did I would have spent time on his request itself. Yeah.

JJ: How would have you done that?

T: I’m just kind of trying to be honest about this because I’ve never been in that kind of situation, you know? How I think I would have responded rather than my best, kind of right-thinking, on what I would do. [takes deep breath and exhales audibly.] I don’t know. I wonder what the risk would be in just outright saying, you know, you should have consulted with me first before giving my name as a recommendation because, um, yeah. I think I would have, in the same way he says at the end “you should have stayed in therapy,” I think I would have said “look, we” and in the same way he acknowledged that the guy’s done good work, I would have said, “you’ve done good work and I feel I know you pretty well, I don’t know honestly say I know whether this is the right decision for you or whether you’re so-called ready for it.” And, um, “Im not in the position to stand behind your decision.” I might still stand behind the...you know where the guy

says, “so you’re not going to tell me whether or not to fly again,” I might still stay in that position.

JJ: Hmm-hm.

T: I don’t see any purpose in telling he cannot fly again. I might say something like I can’t stand behind it but I don’t propose to know what is best for you, if you should do this or not. What is coming to my mind now is that I don’t get the impression that you know what is best for you. And so, um, and that would have been the kind of edge, that might have led me into something that he [the therapist] did in pushing him on some of this stuff and, you know, asking him to look harder at some of his motivations.

JJ: Hmm-hm. It sounds like what you’re saying is that you’re picking up on this dilemma of pretty much writing or responding to his request. So, this is kind of the central one you’ve identified.

T: Yeah, well, second to that I really was, um, more than that I was with the session, I was in the session. Because it is also, yeah, I mean with any client that comes in and says, apparently this was somewhat out of the blue, “this is our last session, I’m out of here,” um, I’m really, I don’t know, I think there is a huge dilemma, even an ethical dilemma, as to how do you use that session, depending on the client. And for the most part that is the central dilemma.

JJ: And when you say depending on the client, are you...

T: That some people, you know, have gotten what they could out of therapy and are done, and they can access that for themselves and there are cases in which I’d agree even if it was a surprise. There are certain situations in which it would not be a bad thing.

JJ: How about this situation?

T: Yeah, the dilemmas are really both equally important, they’re one in a way, you know. Um, so I don’t know, I could go back to the first dilemma, which is to whether to give an assessment. I think for one, you don’t want the guy to leave with a false impression where he leaves thinking you’re going to give him a positive assessment and then you turn around and say some stuff he would be surprised to hear you saying, especially to, um, another professional.

JJ: So, you’re saying you don’t want to be misleading or make promises that you can’t fulfill?

T: Yes, and what's unclear to me is he leaves it...it's ambiguous, you know? I don't know what he's going to tell the...well, it's a t.v. show, it makes you curious about that, but, um, so that's not clear.

JJ: No, it is not. They leave that hanging, eh?

T: Yeah, so...was it clarified when the doctor would be calling?

JJ: No, it wasn't.

T: See, that would be my issue. I would want to know when, exactly, should I expect this phone call? I would want to make this decision with the client.

JJ: In the session?

T: Yeah, so if he was going to call me that week, then I would have wanted to let the guy know when he leaves that I will not be supporting his decision potentially. And maybe he's done that as a hook, you know, if you can somehow give some more time.

JJ: How would that be better?

T: Yeah, well, in a way I'm doubting that now even as I say it because, okay, let's say the guy is able to say somehow, look we got another month and this doctor is going to be calling you, um, um, this is an interesting roll of the dice because you could definitely get to some pretty serious issues in a month, especially where this session was left. On the other hand, when you frame it as, at the end of it, we'll make a decision, and obviously he's thinking it's in favor to go to war, then you frame the therapy in a superficial way.

JJ: Hmm-hm.

T: So, there's a contradiction that's going through there something the therapist has to hope to get at some real depth and applying this or get this bill approved. So, in that sense maybe it is better in what he did, which is for him to leave unclear and to have been challenged whether this was the best decision for him in the first place, you know? And also with the very open invitation- call me anytime about anything. I don't know it's kind of, those are kind of my thoughts on that.

JJ: Hmm... yeah.

T: Again, it is really hard to say, you know, what would I do...

JJ: It sound like you're having trouble identifying...

T: Well, he's not my client and in this case, I mean, you know, I've seen probably two or three sessions with this guy so I have a little more context, but still there's not enough to, um, really identify with the therapist in this case and know.

JJ: So, in a way, you viewing this today, caused a bit of a de-identification or distance with the therapist?

T: Right, because I haven't gone along for the ride. It's hard for me to place myself...it would be easy for me to conceive of this guy as my client if I had been watching the whole season, I might have more opinions on what to do. But, then, maybe not. What I'm trying to highlight is that, um, that I mean, I think it's just different when you work week in and week out with somebody and they bring you or put you with a serious dilemma. I think a lot of the responses are intuitive and...

JJ: What do you mean by intuitive here?

T: Well, they build on a whole history of references and conversation, so I think in a moment like this, especially when somebody's going to end therapy there's already for me at least to recollect a lot of what has happened in therapy, more so than on a week-to-week basis. Um, and so, um, I think it's like you have this whole history with this person and to try to make a decision. But my sense of this case is that the therapist wants him to be in therapy and not jump back into war. That is his assessment. Oddly enough that cannot be spoken, but it is pretty clear.

JJ: Can you go back to what you said moments ago when you talked about how you make decisions. So, you said that when a client presents you with a difficult matter, you said intuitive, but then I asked you, well, it sounded like you had more to say.

T: Yeah, it's interesting that you work with a person, you have a relationship and history and a dialogue, so you're going to work from that standpoint with them, it's not, um, well, it's hard for me to say. I think it's just related to what we were saying. So, you're saying what would I do with this guy's plan?

JJ: Yeah, well being in his position.

T: Well, part of it, the reflection is limited. There is a certain barrier. What helps me think about it is, like it did, just to go through what he did.

JJ: But the barrier is not there otherwise for you, when you get at that?

T: I just think there is a gap. When you ask me about how, well, somehow I could conjure up a parallel dilemma and how I worked with that. I think that, my explanation,

would draw so much more on my history with that person and the details of that person's like and the details of our experience in therapy. So,

JJ: And so,

T: Well, at the end of the day it would only result in something that looked kind of like this, which is pretty sophisticated psychodynamic work under the gun because the clock's ticking.

JJ: Yeah, there's a lot of pressure.

T: So...

JJ: It sound like what you're doing is saying that you considered alternates, but find yourself agreeing, not completely, but largely with his technique? In a sense, his response to a dilemma. Because he's presented with a dilemma that you've identified at the beginning of the session.

T: Well, whether it is supervisions or whatnot there are plenty of time where I disagree with, well, maybe I don't think it's wrong, but I would do it differently. Whereas I think this, as you said it is drawn from a real case and real therapy with a seasoned therapist and it fits to me more or less. I think it's, you know, it leaves me with the realization with what I don't know about the therapist, the client and the therapy. I think it's that that was calling to the other question. It just pushes me to my limits of not-knowing what is going on. I mean, yeah, I think it is important for me to say is that I don't look at this as some kind of, some riddle, some riddle that has a right answer.

JJ: Hmm-hm.

T: You know, taking into account: this factor, this factor, this factor, this should be done. You know what I mean? Some real strategically, some kind of approach like, well, I don't buy it. That's what I'm saying: the limit of me being able to think through how I would do this differently. I'm not in other people's shoes or in other people's therapy, so as much as I can think things through at some point I reach a point of a mystery there that I want to honor and leave my own statements with some degree of ambiguity in the same way as.

JJ: And is that true of your own work? In this situation, you're looking at another, but does this occur inwardly for you, too?

T: I mean, yeah, in the same way, I'll joke around and say, well, in retrospect I fucked up, or, um, but, it's often when I say that to others that they open up the possibility that I didn't fuck up that maybe something else was...

JJ: An alternate?

T: An alternate or that the gravity of what I thought was really not that big or, like you said, an alternate and, yeah, so, but there's an, um, like in this case, it is the client that leads, so then on you don't know what their life is like and maybe it's fantastic. And maybe from their perspective they see therapy as having a positive impact, so these are all things you don't know. And yet you can look at it somewhat analytically and say, well, I fucked up and that would have allowed therapy to change or that would have allowed them to have some realization that they should have or whatever.

JJ: Hmm-hm.

T: And the opposite is true as well, like, I just tend to assume that things are going really well, I take a class in poststructural psychology and begin to think, well, what is really going on in here? So, um, yes, so I leave a little of mystery and ambiguity in what the right thing to do was or is. Um, yeah. Sorry, really long winded.

JJ: No, I like it. I've been trying to just kind of give you the space to, um, so it's good. I think it is really good material. We can finish there.

Dissertation Interview III

JJ: Okay, imagine you are in the situation of the therapist. What ethical challenges or problems do you see and how do you think you would respond?

A: The obvious one, um, is the boundary issue. Um, it's like I noticed that the client tapped the therapists leg, and it makes me think, hmm, their boundary seems pretty vague to begin with.

JJ: Hmm-hm.

A: And the last, the therapist gave him his cell phone number and told him call me anytime you want to talk. And, um, it just sounds to me more like a close friend instead of a psychologist.

JJ: Hmm-hm.

A: So, that's what I'm primarily concerned about—the potential, um, multiple relationships that I can see, like, is he a friend, a psychologist, or a helper. And also the client asking the psychologist to kind of endorse his readiness to go back to the Navy. That's something I'm not quite sure about. Some of the things, some of them might be like understanding or what I missed because of the language barrier. Like my first question would be what, exactly, is he seeing the psychologist for? And I think that would greatly influence how the psychologist can endorse him in terms of readiness of not. And it is not very clear for me from the psychologist's responses.

JJ: Hmm-hm.

A: Like, what are the actual reasons—he thought the client was not ready yet. He has to deal with his issues on the ground not in the air, and stuff like that.

JJ: Hmm-hm. So, you see the whole issue of boundaries as especially concerning here.

A: Yeah, like he, the psychologist, seemed to be having a real strong reaction, like “don't go, I don't think you're ready yet!” But, um, I mean it's just a push. It's not exactly clear to me what he's dealing with and why he's not ready. And, um, why he might be ready.

JJ: From what you were able to see, were you able to gather anything to answer that question?

A: Yeah, some part of it is that he wanted to beat people up, and I'm a bit surprised the psychologist did not deal with it in the session.

JJ: Yeah. Hmm-hm.

A: He just let it go and listened, and that's one of the things I see as necessary to address—that he won't hurt people. I'm not exactly clear why he went to that bar and the pieces I got from what the client said, it seemed very clear that he wanted to beat people up for some reason. I don't know if I got that wrong, though. Did I get it, see it correctly or...?

JJ: Um, he did say that he was, that he felt like beating people up, but that he did not.

A: Because nobody was there?

JJ: Well, because no one confronted him.

A: It seems that he, um, needs an outlet for his emotions instead of feeling like he needs to beat people up. Yeah, like, if no one confronted him he was just lucky that day, and I see no reason why not to address that. If I were the therapist, first of all, I would validate his feelings, like, where he might be coming from and what he has experienced and why he is having that emotion.

JJ: Hmm-hm.

A: And what is his motivation. And if it is possible, I would strongly suggest for him to find other outlets, and, um, for him to talk about it in therapy. Other outlets and develop a safety plan primarily for him but also for others. And it sounds like he is a potential bump if he just wants to beat people up.

JJ: Potential what?

A: Um, bump. Like, he's well trained and in the Navy and it sounds like, if I get it right, it sounds like he got some psychological issues. Is that why he's not flying anymore? Did I hear that right?

JJ: Well, um, he came on his own to therapy after he was, um, upset by a bombing he was involved in where he killed civilians.

A: Oh, um, yeah, um, I see. So,

JJ: Although he claims he is not upset by it.

A: Yeah, it sound like some sort of PTSD, but I'm not sure or clear enough to diagnose. It is some sort of PTSD related, and I really think to have a plan to not do it again. I thought about and if he puts himself in a situation he might do it, but the therapist can ask

the client if he's thinking about it again he can use an emergency hotline or whatever, but just not a cell phone. I think it is like, well, he needs something 24 hours.

JJ: What ethical challenges or problems do you see?

A: Hmm. Ethical challenges or problems. Let's see. One question is the competence. I'm not so sure about the psychologist's competence. Of course it is not addressed, but we're not sure he's competent to treat a certain population. It kind of sounds to me like the client might have PTSD problems and it is not clear to me whether the therapist is competent or got training in that.

JJ: Hmm.

A: He didn't deal with the primary issue. He just seemed to let it go.

JJ: The primary issue being...aggression?

A: Yeah, physical aggression and possibly hurting others. And, um, let me see. And also the fact that he didn't deal with the issue I heard, it is primarily his issue. The marriage and family part it sounds to me like most people have some concerns and conflict, but what is pressing me is that he could hurt somebody at any time. It's kind of hard—the principle of malfeasance. Because if he hurts someone it's going to hurt him as well.

JJ: Hmm-hm.

A: Like, how, just listening is benefitting the client. And there are some exceptions of just breaching confidentiality and I think it fits into that category because he does, um, have the potential to hurt other people, and he didn't go into that and ask, like, well, what would your plan and usually what would trigger that, and his potential of doing something that would hurt himself or others.

JJ: Yeah.

A: And I just didn't hear him doing that.

JJ: Hmm-hm.

A: Umm, the code and standards...one standard, I think maybe the eight. Let's see. I don't remember exactly which one, but it should be...which one. One is human relations.

JJ: And you said codes and standards?

A: Yes...

JJ: Which are you referring to?

A: About boundary issues.

JJ: That was the first one?

A: Yes, and I said competence should be the second.

JJ: Hmm-hm.

A: Um, I mean, it's just my assumption, though. If he asks whether he has a plan or if things trigger him, um, if it's immanent. I didn't hear that. He just talked about something in the past and I didn't access that, so, and I don't really know. But if he asks that then he might have to breach confidentiality at some point, but I don't remember where that ethical code is at. Recognizing confidentiality or therapy...A? or 4? I don't remember exactly where it is. I almost feel like I'm having another comprehensive exam. [laughter].

JJ: [Laughs].

A: Yeah, that's what I'm thinking. In the beginning I don't know if I heard him right. In the beginning he said something about next session?

JJ: Hmm-hm.

A: What did he say?

JJ: The patient?

A: Hm-hmm.

JJ: He said, "I won't be coming back for next session." That he would be terminating after this.

A: Did he say why?

JJ: He said that he would go fly again.

A: Hmm. He's going to fly again.

JJ: He's going back to the military.

A: Hmm. Yet, at the same time he asks the psychologist to endorse him! And it sounds like without his endorsement he will be unable to go back. I think it is fair for him to ask the psychologist to tell him how he progressed, how he worked, and if he has consent for some third party, for him to give him input about his situation. But I think the psychologist, if he is really not ready for flying again, it is important for him to tell him “you’re not ready.”

JJ: Hmm-hm. Yeah.

A: Like, okay, say what are the reasons.

JJ: Yeah.

A: And if the client does not come back the next session, it seems to me he would have to assess suicidality. Um, that’s what I would think of. Because if he’s not coming back, what will he do? That’s kind of strange.

JJ: You don’t feel he addressed that?

A: No, if he addressed that concern, the client might say “I just think I’m done in therapy” or...or the client might say “I’ll find another job or move away or whatever.”

JJ: Yeah.

A: At least he has to ask about it because clients won’t come and give him a reason that might not even be possible. I know it’s kind of complicated. It just, um, I don’t know if I understand the client’s situation correctly. Even, um, even if he self referred to the psychologist, the reason he’s asking for an endorsement might kind of indicate that he cannot fly unless the psychologist endorses him.

JJ: Right. So, he’s looking for his... he wants things very concrete from the psychologist? He wants him to write him a letter.

A: Yeah, so it just sounds like he is not allowed to fly. But he has to ask for something. Like an endorsement of the psychologist saying he is ready to go, he has dealt with all of his issues, can deal with his anger, and he’s fine. So, if he’s...that situation, then that excuse he gave is not valid—“Okay, I’m not coming back next session because I’m flying again”—and, um, yeah. But, anyways, I feel like what’s wrong with the delivery part.

JJ: Hmm-hm.

A: And of course, if it is that he's suicidal, then something, he's not coming back, he might commit suicide,

JJ: Yep.

A: If he's in imminent danger then, then he might have to do something. There are so many things.

JJ: Yeah.

A: Like, for suicidality. It's unknown. He didn't assess, like. He didn't assess at all. He didn't assess previous thoughts. Nor current thought. And, um, like frequency of thoughts. Or whether he attempted or not.

JJ: Hmm-hm.

A: Because, for PTSD, I think suicidality and irritability are primary. But, anyways, I have to go back—I don't have enough information to diagnose him.

JJ: Yeah.

A: I'm just saying, if he's suspicious of him having that diagnosis, then that's what I would go for. And, um, means, like, and plans, like, and how much detail, like, when he was going to do that and what way and where. And how, exactly he was going to do it, and whether he was capable of doing it or not.

JJ: Hm-hmm.

A: And, then, protective factors, um, yeah, and all those good things about suicidality. And also...

JJ: And what else?

A: Like, how fatal it could be.

JJ: Um, so considering those responses, your thinking that this therapist did not meet these requirements, which you see as essential?

A: Yeah. I would say he wanted to listen more.

JJ: Yeah.

A: That is a part I don't always do [laughs]. I think our styles are different as well.

JJ: Could you say more about that?

A: Style difference?

JJ: Or just you don't always do that and it's a style difference.

A: Well, what I mean is, um, I kind of hear something he tried to say. He kind of linked the client's responses about his son's birthday party to his father. So, I don't know what theoretical approach he's using, but, so it sounds kind of like a more active, I mean not so-active-one, so he will listen more, rephrase, and try to link it to his family history.

JJ: Hmm-hm.

A: And what the client might be. And also, I kind of feel, unless I had a very long relationship, I would not jump and tell the client what it is without asking for permission, and asking for, like, how right he was, like about father, and family history, and his reaction to his son.

JJ: Yeah.

A: And he just says "you're projecting." And that's something I don't agree with.

JJ: Hm-hmm. Can you say a bit more about how you don't agree with it?

A: Um, um, it's just like, again it is short clip.

JJ: Yeah.

A: So, if he does know the client, he probably has enough information to say that. From my standpoint, okay, if that's how much I know the client myself, I don't see myself being able to say that, unless I got some information, and usually if I do have to say that and say "yes, it's about you projecting" and "you think you want to do the same thing" and whatever he said. At least I would explain what information I got from previous therapy.

JJ: Okay.

A: Um, yeah, that's part of it. And I said it would be about style differences—it's not like I don't listen to the client, but it's more about letting it go. I wouldn't just let him go and talk about. My impression about the therapist is that he does very little, and he can do very little if those pressing issues were not there—if he were not hurting people, if his possibility of being, um, suicidal were not there, um, the boundary issues he did not address. If all those issues were not there, then I think he listens just fine.

JJ: Hmm- yeah.

A: He's just trying to listen to the client and let him talk about whatever he wants to, then I kind of feel he failed to stop the client when there is something he needs to ask the client more questions about. Or actively help the client to develop a plan. And I'm more CBT, so I talk a lot more and kind of like frame the questions a lot more and try to lead the client a certain way if I see there's something they need to explore.

JJ: Hmm-hm.

A: And if there's something, they need to do something, like potential harm of self or others. That's something I would make very concrete.

JJ: Hm-hmm.

A: And to make it a plan and with his agreement if it's necessary I would even consider, like, suggesting for involuntary hospitalization if, like, his suicidal risk is high, and homicidal risk is also high.

JJ: Hmm-hm.

A: But, um, I didn't hear homicidal, but he might accidentally kill somebody, though. That's my fear about this particular client. Because, I mean, my impression about Navy, Army, whatever, and Air Force people is that they got their physical training, and, um, a lay person might not be able to protect themselves if they want to hurt somebody.

JJ: Hmm-hm.

A: And their at that range, like, if there's a very traumatic accident.

JJ: Yeah.

A: And I didn't hear him explore the accident exactly, but I assume there was some kind of incident.

JJ: The incident when in the military?

A: Yeah.

JJ: Yeah, he was, um, a pilot and bombed a village and the coordinates were given to him of which village to bomb, but those bombed were not enemies, but school children. So, um, it was children, 11 children. It ended up killing civilians, but was supposed to kill soldiers.

A: Okay, and I heard about guilt in the therapy, but maybe his guilt is about the incident. But I didn't get very clear.

JJ: Hm-hm.

A: Yeah, that's difficult about watching the clip is that I cannot ask the client, "okay what's going on, tell me more, tell me more!" [laughs].

JJ: Right. So, everything for you is contingent upon what he asks.

A: Yeah, and I think for that incident he needs more than listening. He needs something like systematic desensitization.

JJ: Okay.

A: Yeah, and also for the guilt, you know what I mean? He needs schema reforming or whatever.

JJ: How would you do that?

A: How would I do that? Hmm.

JJ: Yeah, how would you do those two things?

A: Um, I would start with...systematic desensitization, like, um, let me think. Um, seems like he's, also I don't know if his anger problems started from that or before. That's one thing, but how I would do it. Well, um, I think. Let me think. Because he doesn't really have the anxiety about it, and he didn't mention flashback, so I'm not totally certain how I should get it done.

JJ: Hmm-hm.

A: Um, let me think if there's any emotional character, like that anger. I would probably ask what could trigger him, and identify more than one thing that could trigger his anger. From the very mild thing to the very bottom thing and what triggers him could be very big.

JJ: Yeah.

A: Um, like he got angry from the conversation with his father. Did I get it right?

JJ: Hmm-hm.

A: Um, well, actually just that incident can be informed by the systematic desensitization part. It's like helping to, um, go through the procedural memory of what happened first and second.

JJ: Hmm-hm.

A: And, what exactly is the thing that triggers his anger, and then, what he does afterwards. And, then, to reduce the trigger of anger, I would probably ask him to kind of identify similar situations with his father, and, like, also rate it, and then starting to ask him to imagine that. Kind of imagine it. And before he starts imagining it, I would teach him some of the relaxation techniques, like muscle scanning or breathing.

JJ: Hmm-hm.

A: Um, like using his good memories to interrupt what triggers his anger.

JJ: Hmm.

A: And just go through it and once the steps are identified and start imagining it, but also his breathing to imagine it until he reaches a certain level, like for ten seconds, and when he gets there tell him to stop imagining it, and then use more relaxation techniques until he calms down, and then repeat it.

JJ: Hmm-hm.

A: Repeat again and again until his level of anger can be reduced to a certain level, and then move on to the next one which will trigger a higher level of anger. Basically, it's just like that. It's steps, and try to go through and then, yeah.

JJ: Hmm-hm.

A: I think that might be helpful to him, for him to kind of ease his anger or even like, um, ask him—the cognitive reframing part—is ask him what, um, if he could what would he do different; if he could imagine he could go back.

JJ: Hmm-hm.

A: And I really don't think he can do a lot, and, I mean, usually in that process of exploring whether he can do anything different, and he's in the Navy—he has to follow orders.

JJ: Hmm-hm.

A: And, what he can do differently—then I would re-label it that he’s following orders and it’s difficult in a war, as far as my understanding is, a lot of the time, people are not segregated enough, so they end up killing civilians. It is something he may be able to identify. If he goes into enough detail, step-by-step, from when he was given orders to when he dropped the bomb, and figured out some civilians were killed.

JJ: Yep.

A: And, um, whether he can do anything differently. Maybe there were some things he could do differently.

JJ: Yeah.

A: But maybe not. And when he figures out there were not things he could do differently, then just help him figure out that it’s a war and is different. If he’s walking and is not supposed to kill a child. And when, also, when I’m thinking about this, he’s contradictory. He says he feels guilt, but it seems like there is some anger associated with that incident. And if he didn’t want to kill those children, why would he go to a bar and kill nice people. And, that doesn’t seem to be consistent. I would probably confront him and say “how do you see yourself doing that? How can they go together?”

JJ: Yeah, um, do you see other ethical challenges?

A: Um, let me think. Let me try to think because I don’t understand the whole thing, honestly speaking. Um, that’s so far I can see. If there are some little things, then I cannot remember. Yeah, I touched upon the major ones. And I would approach it to make sure everyone is safe. And it sounds like the client has pressing issues he has not resolved yet.

JJ: Hmm. Hm-hm.

A: And, I would probably do something different than giving him a card. I would probably give him a referral for someone for him to see. Probably in the Navy. Or, um, I know for Navy people it is kind of tough if they have any kind of record of severe mental disorder.

JJ: Yeah.

A: Like, we can see if he can see someone in the Navy. Or whether he wants to see another person if he’s not coming back or have him come in, come back to make sure he does not hurt himself. It’s just a failure I see.

JJ: The failure to follow up?

A: Yeah, I don't think the client is done yet. And he just goes and says, well, go and call me anytime. That's not responsible.

JJ: Okay. Yeah.

A: Other things are more about content and how I would deal with it. From my limited understanding of his family situation and children, and his wife, I don't know what else to say in terms of an ethical thread.

JJ: Thread?

A: Yeah, thread. I didn't hear a lot. He just says he's upset. It seems he's got a lot going in his family life and maybe that's why he wants to leave. And, um, I am surprised why he didn't approach him to develop ways to either better communicate with his family or, it can be something simple, like, tell them he is really hurt when they act like they can't see him. And, are you going to understand why his family treats him like that, and to be able to work it out in terms of his family's relationships.

JJ: Hmm-hm.

A: To look into what is going on with his father. That's something that was not encouraged much. And to develop other social support, like who he would talk to. Who he can talk to if he is really upset. I didn't hear anything about that, and that's not quite how I would deal with it.

JJ: Hmm-hm.

A: It is kind of an interest to me.

JJ: Can you say more about how you would do that?

A: How I would do that...hmm...let me see.

JJ: And you said leave the bump?

A: [laughs] Leave the bump there. Yeah, well, what I mean is, leave the client that way. I kind of put the client... well, the client is in a position where he might hurt himself or others, which he would certainly regret. And, um, if the psychologist didn't treat him properly then it might happen, and I'd feel bad for that.

JJ: Hmm-hm.

A: Did I answer your questions?

JJ: Yes, yes, you did.

Dissertation Interview IV

JJ: Okay, imagine that you are the therapist in the situation. What ethical challenges or problems do you see and how do you think you would respond?

K: Well, it appears, based on the segment, that this gentleman has been in therapy with the therapist for a time. And, um, they obviously touched upon some pretty deep-seeded and, um, complicated issues. There's all that going on. And I think the biggest dilemma for the therapist is that, obviously, he has some pretty complex issues that would make one question whether or not he should be put in a very active and high stress military role.

JJ: Hmm-hm.

K: And, he's asking the therapist to essentially vouch for his mental and emotional stability to be put in that kind of situation, and, um, he's asking the therapist to essentially give him a favorable sign off. Obviously, he's not too concerned about confidentiality issues because he said several times, you know, I've already told several people about our work. And, I'm surmising that he would have signed off on anything to allow this therapist to talk to the military shrink, as he put it. And, um, he... he's really asking the therapist to violate some key ethical things, so that he can go back into active military duty. And, so right away that jumps out at me.

JJ: Hmm-hm.

K: Um, also, I mean, and thinking about the issues again. To potentially have him, he's obviously dealing with some identity issues, marital discord, unresolved things with his dad, and there's a lot of unresolved issues that make one question whether he would be okay. Not to mention to ask someone to pre-determine an assessment and ask for what would need to be heard. It's all very troubling.

JJ: Hmm-hm.

K: And he was obviously not troubled very much at all by it—the patient. And he's willing to say, you know, can you do this. And he had no insight into what he was asking. There's just a lot of issues with him.

JJ: Hmm-hm. So, you kind of identified this primary ethical issue. How do you think you would respond?

K: Well, I really think, and the therapist in this case did not explore this with Alex, the client. And it appeared that he's not planning on coming back, so I don't know, um, if Alex would have the opportunity to talk with him again about this or not. But I really think, um, Alex needs a conversation with the therapist to delve into, um, what he's asking, and to maybe help him gain some understanding and insight into this implications of what he's asking. I mean, I've never seen this, so maybe that happens in another segment or something, but I, um, I think that that needs to happen.

JJ: Hmm-hm.

K: And, I also think that then the therapist is going to have to make some choices. Um, ultimately, about it. He wants to continue to work with Alex; he says that. Yet, depending on what choice he makes, he may sever that therapeutic relationship. But I really think he's going to have to go through ethical processing—the therapist—as to what's being asked of him. I thought about: what could he do? Well, he could do nothing, he could say to Alex that I just cannot do that, and then face those implications in his work with him. He could get the consent from him and then tell him that he'll share his assessment with him, but the assessment will be my professional assessment—you're not going to tell me what, well, direct, how the assessment will go.

JJ: Yeah.

K: Or, well, he could go along with what this guy's asking. And, um, provide sign off, if you will. And, I started going through in my mind several things that you could do. Um, it's pretty intriguing because I wondered what he did do [laughs].

JJ: Yeah?

K: Yeah [laughs] it got my interest. Now I know why people say they like this show.

JJ: [laughs] Hmm-hm.

K: So, those are a few things off the top that I thought about.

JJ: So, you're saying you see several options in terms of what you've identified as the core ethical dilemma. Um, how might you choose between those options?

K: Well, um, you know, of course, in going through the training I'm going through, they teach us our ethical dilemma- decision making models. And, I think that at the core of

the ethical decision making models is the decision you make if another person were to evaluate it. If it were evaluated by a peer. Would they say that was an ethical and reasonable decision or would they say this goes against every professional standard and ethical model and ethical practice. That would guide me.

JJ: Hmm-hm.

K: I mean, you know, I mean.

JJ: That thought about another practitioner or peer?

K: Another peer—if they were looking at my decision in this scenario. Would they look at my decision and think, objectively and uninvolved, that that was reasonable, or would they say that that was unreasonable. And, how would I then, if I was questioned about it, um, from a legal standpoint or another standpoint, could I justify the decision I made on ethical standards, model of care standards, um, really that's what would guide me. Because at the end of the day, your professional integrity really has to win out. And I think that would be the key thing for me.

JJ: Now, kind of taking that and applying it to what you've seen in the situation, um, if you had to make decision in that session, it sounds like you had some qualms with how the therapist went about this?

K: I don't necessarily disagree with how he handled it because he took it back to the treatment issues at hand, the clinical issues this guy obviously has. But what I don't think he did was delve into the request. He did, well, I guess there were so many issues this guy had that he took it down the track and, you know, those family conflicts, those internal conflicts, and other things. But I don't think they really got to talk about, back to, the implications of this request. And, um...

JJ: They got away from that?

K: Yes, they got away from that, and I think that discussion needed to be held.

JJ: Hmm-hm.

K: Alex seemed to believe that this...that question is out in there, but he does not know how the therapist is going to handle it. I need you to not f-this up for me, and just do it, and then I'm on my way. And you don't know, um, what the therapist will ultimately do with it. But I just felt like it would be helpful to stick with it a little bit and process that.

JJ: Hmm-hm.

K: But, again, in the context of the situation, the therapist might have thought you're supposed to handle it this way and not try to process it with him at all. I mean, obviously, he obviously based on what seems to be his life, he should be capable of insight. So, from what I was surmising and just looking at that clip, it seems that it might be a reasonable, it might be reasonable for the therapist to process some of the issues around that request, but I don't know. So, I felt like some of it around those issues was left unfinished.

JJ: Hmm-hm. Can you say a bit more about the insight issues you picked up on?

K: Well, what I mean by that is that he, again, it seems that he, the client is professional, high functioning, obviously has had a career and done some things, he talks about being the best and all of that. So, he doesn't strike me as being the kind of client who, um, would not maybe, is maybe not as high functioning and would not be able to do process oriented, insight treatment. This man seems like he probably could, but, um, he, well, seems somewhat narcissistic and somewhat into what he wants.

JJ: Yeah.

K: And I just felt the therapist could have pressed him a bit more, somewhat around that. And, um, I thought it was very presumptuous and somewhat narcissistic, you know, that you just need to that work for me. So, I guess what I'm getting at is I think there was an opportunity. Maybe the guy could do some of that processing, who knows. Maybe he just doesn't want to because he doesn't have that much caring and emotion and empathy. You don't know, though. Just seeing that one clip, you don't know.

JJ: Yeah.

K: I don't know. It just seemed like it might have been an opportunity.

JJ: Hmm-hm.

K: Did that answer?

JJ: Yeah, um, so kind of going back a little to what you've been saying, um. You've kind of identified what you see as the center piece. Do you see any other, what you would say is a dilemma from the, um, session?

K: Yeah, I do because, um, the therapist touches upon on it when he says to him you've been dealing with these complicated issues, and it might be better for you not to be dealing with the kind of high stress situation that you'll be dealing with in active military, combat role, I guess. Um, with all of those unresolved issues kind of emotionally

impacting you, sure, because one would have to question this guy's fitness for duty or fitness for active military role.

JJ: Yeah.

K: Um, clearly I see that as an ethical piece for the therapist to discuss, potentially he's going to be out in a combat role where he could hurt people. I think he makes some reference to some past thing that has happened to this guy. I didn't, um, it sounded like a possible combat issue that occurred. He said that what's brought you into me.

JJ: Yeah, what brought him in was that during his first session he spoke of being the, um, Madrassa Killer or Madrassa Murderer because there was a town in Iraq that he was given coordinates to bomb. And I guess he bombed it, but it was actually school children—12 school children. That's why he came to therapy, although he denied that it bothered him.

K: Something had occurred. So, the ethical dilemma it would put the therapist in to know all that, and he's also asking him to—to know all that history now—he's asking him to talk to the military psychiatrist or military psychologist, and, um, provide confirmation that he's stable. That's concerning.

JJ: Yeah.

K: Okay, so those are some key things. I'm asking this therapist to basically whatever his assessment is to put it in his favor. And, also thinking about if this guy has PTSD, I wrote down, because what's going on? And then to go back to...do you really think it's a good idea to put yourself in active duty? So, it'd be a really big burden, I think, for the therapist to have to deal with and sort all this out.

JJ: And, if you were in that position, what would you do with what you're perceiving he's asking?

K: Well, one thing I would do is maybe seek some consultation help because I would, I think, to just get some other objective perspectives. He's basically, from what I saw, a private practitioner in his home space. But, um, I think that would be one where whatever way he could consult colleagues and a lot of times private practitioners make arrangements to talk with peers. I think this would be a good situation where one might want to do that, and that would be done before talking to anyone. Whether Alex wanted me to talk to this person, and I wouldn't talk to anybody, and if it were me, I would have to get guidance and consultation. And, going back to what I told you in the first place, ultimately, would I feel comfortable if this decision, if some others had to look at my

practice, would they say what is she doing, or would they say, given those set of circumstances, that makes sense.

JJ: Hmm-hm.

K: So, I think I would need a consult and would need to objectively think about what the best course of action is. The therapist leaves him with: I want to keep working with you, um, so that's also a dilemma because you want to keep working with the guy but you know that some action that you might take could sever that possibility.

JJ: Hmm-hm. It sounds like you would engage in some sort of, um, thought process in which you think about—besides consultation directly—what would other people do in this situation?

K: Hmm-hm. Absolutely, that why I go back to almost, that I think the therapist needs to be able to talk to Alex again and in an honest and direct way about what he's asking. I think Alex has a right to know and understand. Understand that on his own, let's talk about what you're asking me to do and what that means and what that's all about. And in the context of the therapeutic relationship, I, um, think that's needed. So, I think that's needed, consultation is needed, and I think just logically thinking what would be the best course, those are some pieces that are missing.

JJ: So, one of your responses is that you would want to talk with Alex again. What would you do there? If that's an alternate response, what would you do?

K: I would say to Alex, I've thought about that request that you've made of me and I feel like we need to talk about the implications of that and why you believe that that request is okay, and, you know, how the therapist and how me the therapist is responding to that. You know, and obviously, it has appeared to me with all of this—his issues, he and the therapist seem to have a good rapport and they've done a lot of work. So, they're probably in a place where they could talk through some of that.

JJ: Hmm-hm.

K: And I think he owes Alex, and I would feel I would owe Alex, the conversation about, you know, at the end of the day, I will have to do what I believe is best from an ethical practice standpoint. And you would not necessarily have to say to him this is what I'm going to do, but at the same time he would have to understand that that's going to happen. Um, and um take it from there. And then I would still follow up with the other things I talked about. And I would want Alex to come back and talk about those issues

particularly. Well, he has all the other issues going on, but this is the most salient—he wants to go back and wants this favorable assessment given.

JJ: Hmm-hm.

K: And that is a very important issue right now. All the others are very important also, but I would say that this is the most pressing—that this request has been made and that's what needs to be addressed. It's what I would want to do.

JJ: Hmm-hm. Um, how about any other ethical dilemmas that pop up, that, um you feel would need to be considered as well. It sounds like the issue of the letter is your big concern.

K: It is the most pressing concern—and his fitness for active military duty. Um, I guess there is a concern that Alex is obviously been telling, he's violated his own confidentiality many times. He says oh, you know, this one that one, if I were the therapist I would want to know what that's going to mean. His wife, his dad, the military—he's told a pretty, it sounds like pretty casually about this. I don't know what impact that will have.

JJ: Hmm-hm.

K: Are those people going to start calling him, calling me? He's opened boxes and doors because he's violated his own confidentiality. It sounds like he told his wife and then she told others. And to me, that can cause other possible problems. I just hope I would never have to be in that kind of scenario. [laughs].

JJ: [laughs]. Yeah, it sounds like you feel it's all pretty complicated.

K: Yeah, I do. Absolutely.

JJ: Yet, you did and summarized very clearly and pragmatically the steps you would take. It's pretty clear.

K: I don't know if they're all the right steps, but just right first impressions I think that's what I'd probably do.

Dissertation Interview V

L: What has happened to him that he wasn't allowed to fly? Or, um, was he allowed?

JJ: He, um, he had been in a very controversial situation, which, um, he bombed a village in which there were a lot of school children present. And, um, he ended up killing a bunch of civilians in the mission he was ordered to carry out.

L: So, um, what did the heart attack have to do with it?

JJ: The heart attack, um, happened, um, I want to say a couple months before he entered therapy. And, um, and he had been running, um, just kind of wearing himself down to complete exhaustion, from that part of the story.

L: So, the bombing thing, he, was it accidental that he ended up taking out all of the civilians? Like, was that part of his job and then, consequently, because of having done that he was struggling?

JJ: It was considered collateral damage, yeah. But he denied that he was struggling; he denied coming in for those reasons. He said he was actually coming in for other reasons.

L: Yeah, yeah. I just didn't know...

JJ: What initiated it?

L: Yeah.

JJ: Yeah, even when he came in for the first session he denied that he was coming in for the collateral damage issue. That he had no problem with what he did. He looked at it as just a consequence of military involvement.

L: Alright.

JJ: So, let's just begin with kind of, um, just to reiterate—imagine that you are the therapist in the situation, and what ethical challenges or problems do you see and how do you think you'd respond?

L: Um, the situation with the tank, what was that? Some of this I didn't get because it was so quickly.

JJ: Yeah.

L: Did he...it was like a training thing where he was training other...?

JJ: Yeah, um, hmm. Other pilots.

L: Was he hurting them? Because I know he has, like, a big control thing.

JJ: Um...

L: Like, the harm to others thing came up, but I was not clear on the situation or what not.

JJ: Hmm-hm. Um, I don't think he was hurting them. He brought that issue up or that aspect of himself up to prove—or kind of demonstrate—that he's still on top of his game. And that he's capable of doing this really difficult exercise where you go into this tank and...

L: Okay, so he wasn't hurting...

JJ: Well, it may sound painful; it's simulated drowning, it's about kind of if you were in a plane that crashed can you maintain a level of composure; he was bringing it up in that moment to display to the therapist that, well, nothing gets to him.

L: Okay. Um, um, asking the therapist to lie and tell them all good things—that is not good. Um, like, don't take my world away, wanting the therapist to lie, um, about his ability or his, um, status. That's an ethical dilemma.

JJ: Hmm-hm.

L: Um, I, I first would consult. I don't know if he has supervision. I don't know if that's the case. Um, I wouldn't lie.

JJ: Hmm-hm.

L: Um, but, ...

JJ: You wouldn't lie for...?

L: I wouldn't lie for him. No, I wouldn't lie for him.

JJ: So, you might risk giving him an assessment that he would not like?

L: Hmm-hm. And I would tell him beforehand. Um, what else would you say?

JJ: So, in that sense...

L: Just from what I saw, I would tell him that I would not lie beforehand.

JJ: So, do you think that was an error on the part of the therapist? Something that he missed?

L: What do you mean?

JJ: He didn't say that. He didn't go into that.

L: I don't think he decided what he was going to do. Um, I don't know if he's going to see him again. Is he making a statement or...?

JJ: He would, yeah, I think the patient thinks he is going to be making a statement.

L: Well, yeah, before that I would tell him. At least, I am not going to lie for you and I intend to give my honest evaluation.

JJ: Yeah.

L: But I would tell him, that I'm going to give my honest evaluation, but I would tell him before I did it, but, again, at least, at the very least I would consult with somebody else and make sure that I was on point.

JJ: What would you take to that other person, your supervisor?

L: I would present the situation and ask for feedback and how to approach it best because there's a risk of obviously damaging the relationship between the therapist and client, um, so the least harm you can do to the client would be paramount, too. At least in terms of their relationship and his trust with him. He's got some issues with his dad, so he would have to be careful about how he deals with it to ensure the least harm. But I'm probably missing a lot, so consulting would be good. And does he have anything in his informed consent about what he will and will not do for clients?

JJ: Does he? His therapist?

L: Yeah, his therapist. I'm completely over thinking this.

JJ: No, no, that's good.

L: If he were like doing any forensic evals or military evals. You know, like, I would do this or maintain this.

JJ: Hmm-hm.

L: So, I'm just wondering.

JJ: That's something you'd be concerned with.

L: I'm wondering—if his role is to do these kinds of things and to do evaluations, I would put in that I will not or will do these certain things. So, he could...I would use that as a... as something to protect myself.

JJ: Hmm-hm.

L: Hmm... I don't know.

JJ: So, it sounds like, first, first off, immediately there's some resonance for you with this whole lying thing.

L: The lying, yeah. Yeah, hmm-hm. I think that's the biggest thing. Um, yeah. And what else.

JJ: Well, you covered the first one good.

L: Do you want more?

JJ: About the lying?

L: Yeah.

JJ: Well, if you feel there's more, then yeah.

L: Um. That's just it.

JJ: Hmm-hm.

L: He paid in cash and didn't give him a receipt [laughs].

JJ: Yeah.

L: And I had in my head that you always have to have some kind of record or documentation.

JJ: Some sort of documentation, yeah.

L: [laughs]. Um, I was worried with him, and just what's going on with him, and his power and control issues, and he said he wanted to go to the bar and beat the hell out of someone. And he may or may not be doing that, but kind of... I don't know, I wrote it down because it must have been meaningful at the time.

JJ: Hmm-hm.

L: But, and then the situation in the tank. There's these little themes of him maybe abusing power or having thoughts of harming others, but not necessarily acting on them. I just...it was something that popped up a couple of times.

JJ: Yeah.

L: Um, just keeping an eye on that. I don't know what his rule is...in the Air Force ... Air Force or Navy?

JJ: Navy.

L: If he was in a position where he has control over others and he can abuse that power. I don't know if it's impulse control or being aggressive.

JJ: Hmm-hm.

L: So, I would at least keep that in mind if not pointing that out whenever he has to give a statement.

JJ: Hmm-hm.

L: And, then, I wrote down flying, which is a pretty, can be, a dangerous and very important responsibility. So, just how his decision making might impact that.

JJ: Hmm. Hm-hmm.

L: I'm just thinking of things he may say whenever he is giving his assessment. Whoever he has to report to.

JJ: Hmm-hm.

L: Um, and giving advice. Because he asked him for advice. And the only advice he gave was for him to stay in therapy, which I think is okay. But I was waiting for him to tell him yes or no you should not fly, so I'm okay with that.

JJ: You're okay with him leaving it open-ended? Or would you take a different approach?

L: I would leave it open ended. About that decision...

JJ: So, you would have followed what the therapist...

L: I would have gone with the therapist on that decision, yeah. I would not have given him advice about whether he should or should not fly. Um, I'm very anti-advice giving. Just in my orientation, so I would not have. I may have explored that more, like, maybe, does he think it's okay or not to fly. Maybe have him explore his thoughts more. Um, I don't know.

JJ: So, you think, perhaps, that that issue...he should have challenged him more on that?

L: Or just, spend more time with it because he brought it up and it was something that was important to him. So, I think that's something. It should be something he would use for...when called to give a statement...he should have sat for that for a moment.

JJ: So, you feel he moved on pretty quick from there?

L: He didn't take advantage of talking about that, especially when the client was the one who brought it up.

JJ: Hmm-hm.

L: And the cell phone. That was ridiculous. Telling him call him anytime, day or night. I thought that was a very grey area. I know some people give cell phone numbers. I hope that was not a personal cell phone. And I don't think there's any lethality to this client, so I don't understand what would necessitate him having access to a cell phone. That's a boundary issue.

JJ: Yeah, so you don't think there's any reason to have him... give him an emergency number?

L: Anytime day or night, about anything. It's not saying if there's a crisis or if you want to communicate and you cannot, but it doesn't sound like he communicates well with anyone. Having that opportunity, maybe, but not calling him.

JJ: What do you think is implied by giving the cell phone number?

L: Um, more of a friendship even. We're kind of getting into that grey boundary area.

JJ: Hmm-hm.

HA: I'm waiting for you to give me feedback [laughs]. Like, yeah, you're right on! [laughs].

JJ: [laughs].

L: Yeah, I know some people do it, but I think it's very, very specific about the use of cell phones, if you do use them.

JJ: Hmm-hm.

L: Those are the biggest things... [inaudible, reviewing items to self]. I would also... Was this a psychiatrist or psychologist?

JJ: Seems to be a psychologist.

L: Military psychologist?

JJ: Private practice.

L: I would probably consult with a military psychologist because, um, I have a lot of close friends in the military, and their frame of mind is very much...um, they kind of have a different world view of what is and is not important, and where they should be, and what their responsibilities are, so, I think, given that, he would get a better picture of what this guy is thinking and grappling with if he had insight into the military. So, I really think he would benefit from consulting because that would have painted a more clear picture.

JJ: Hmm-hm. Are you saying in some way the therapist doesn't have the knowledge that...

L: He might not. I don't know. But, I mean...

JJ: But for you in that position as therapist, it is something you would...

L: It is something I would do. Because it's a cultural piece and that's his lifestyle and it's obviously very important to him, so to be able to kind of get into his, I want to say his head, but into his identity. It is obviously very much a part to get into that and I would want to know about his identity.

JJ: Can you say a bit more about what you meant by the cultural piece or identity piece?

L: Well, just from my experience of people who have had time in the military. There's a lot of things that are clear to them about what their responsibilities are. Where their loyalty is and how that shapes them personally. Um, and you could see a lot of that coming out just in terms of order and discipline and he had a certain responsibility to what he was doing.

JJ: Hmm-hm.

L: And that was carrying over into a lot of things and just to understand where he's coming from and how'd he do things. That would paint a clearer picture for the therapist.

JJ: Hmm-hm. And so, the cultural piece is something that would be very key in your mind and crucial for you?

L: Hmm-hm. You couldn't challenge him. I mean that's what he knows. But that's what he's invested in. And you don't have to agree with him, but at least you could understand where he's coming from and why he's thinking what he was.

JJ: From what you're saying, is there any indication that he therapist was treating him with an awareness of the cultural dynamic here?

L: I don't know. I wasn't paying attention to it. I did think of it afterward, and I think he might have. I don't know. Generally, the issue with his son, but he did more on the relationship with his dad and not as much on his son. Though he was more in tune to being in the Navy than being a father.

JJ: He was?

L: Was he? I don't know [laughs]. Yeah, so that's more of a piece worth, um, expanding.

JJ: How would you respond to that part, um, just specifically that part? You seem to be aware of it. You're taking note of it.

L: I don't know, um, maybe I'd ask him or tell him that's what I mean. I'd tell him I hear you talking more or talking more passionately about your military experience than your family and I'm just wondering why or more about your responsibilities to your family, and see if he's aware of it.

JJ: Hmm-hm.

L: I don't know. I don't know. It's hard to make decisions based on twenty five minutes. Hmm. Not doing military psych that's for sure [laughs].

JJ: [laughs]. Yeah.

L: There's some decisions there you don't want to have to make! Because that's life shattering for him if he can't fly.

JJ: Hmm-hm. Hmm-hm. So, yeah, I think what you're getting at when said life shattering a moment ago is that you're, for you, you're starting to observe and hone in on that identity thing.

L: Yeah, that was more important or seemed to be more important to him that the other things in his life, including son, or his marriage, or his relationship to his dad. To the point that he'd ask someone to lie so that he could get back in.

JJ: So, what other possible responses can you imagine?

L: About anything in particular?

JJ: Well, whether or with regard to honing in on the identity issues that seems to be emerging...that's kind of a big one for you.

L: Um, maybe why that's so important to him. Why that's become so paramount, why he's so invested in it, um, wait. I don't know. I'm kind of biased because I had a close friend in the military and he re-enlisted because his friends re-enlisted. Um, and everyone was drafted and he was out, and he would go back in just to do it. And he left his family and his fiancée and he just left and he just did it. And so, it was in his head that he would do this before anything else. So, it was just, it is interesting to hear someone say, like, I'll ditch everyone and everything just to serve.

JJ: Hmm-hm.

L: And so that's, like, in the back of my head. And the identity piece is really sticking.

JJ: And you said you had a bias, and that bias is sort of magnifying this?

L: I think the identity piece is where I'm leaning so much. It's obvious without even considering that I know that, but I keep hearing that knowing the discussion in the back of my mind, like, so I can kind of understand a lot of this, but...

JJ: Hmm-hm.

L: Am I missing something [laughs]?

JJ: Um, no. I mean, I don't know [laughs].

L: I'm, like, what else? It's right there! [laughs]. Yeah, I just think it's going to be very difficult for him if the therapist should choose to say, no he should not be flying. Um, it's really going to be painful for this guy. So, he's going to be careful about the best way not to damage the relationship, and is he going to want to go back to therapy? Is he going to want to go back if he has a bad experience or is going to want to communicate or talk to people? Is he going to want to come back in? He was mandated? Or was he?

JJ: No, he brought himself in.

L: I don't know. He's just going to have to really be careful not to...

JJ: Do you think he was careful in the session?

L: I think he was, yeah, I think he told him he was courageous at the end. I think relatively careful, or at least he was...he told him he was courageous, if I can recall his exact words. So, he might of even been setting up knowing he was going to throw him

under the bus whenever he went to give the recommendation. I would still tell him, though. I would process it with him.

JJ: So, you would do that differently.

Dissertation Interview Transcript VI

JJ: Imagine you are the therapist in the situation. What ethical challenges or problems do you see and how do you think you would respond?

A: Is that a general question?

JJ: Yeah.

A: Okay.

JJ: Yeah, a starting point.

A: Well, the biggest ethical dilemma to begin with was him was the Navy pilot asking the therapist to, um, do whatever he could regarding that assessment. And a lot of thing that, even if he does have problems he just wants him to say okay so he can keep flying and doing flight school. Um, and that ethical decision was when he asked him his opinion if he should fly or not. And I think that is pretty tough to do because as a therapist you don't want to sway the person. You want to allow them to have their own direction and see it for themselves.

JJ: Hmm-hm.

A: And then the little things I saw were, like, paying for the session in cash, um, allowing them to talk on their cell phones during a session, and, one that was kind of moderately, I didn't think was good as a therapist was giving him his cell phone number and saying, contact me day or night. There has to be some boundaries.

JJ: Hmm-hm. So, for that one you would have not gone along with that?

A: No, I mean work hours keep in mind that the person could come to depend on them and call them constantly.

JJ: So, um, that seems to be kind of on the side. It doesn't seem to be a major dilemma for you. If you were to focus on the major dilemma you identified, are you able to narrow that down to one or two dilemmas?

A: Yeah, I would the number one dilemma was asking him to, um, lie in the courts and allow him to go through the process with the shrink and his assessments so he can continue as a pilot in training. And the number two one would be, um, the pilot asking him his opinion, and I think he handled that really well. He didn't give him a direct answer. He kind of let him make his own decision.

JJ: Hmm-hm. How about the first one, the major one? How do you think he handled that?

A: Um, I thought it was handled correctly. I don't know how he followed up with it. It didn't show what he did in the future, but he didn't go allow with it, he didn't tell him he'd falsify his reports, and he, um, didn't change his opinion or anything like that, and there was no indication he would.

JJ: Yeah. If you were to base kind of what you see just on this session, would you imagine a different response that you'd engage in?

A: For myself?

JJ: Hmm-hm. For your self.

A: No, I don't think I'd respond differently. I think he, he... handled it directly. The pilot asked him not to screw up the assessment when it came along, and he kind of brushed aside the issues that he did have, and I thought that the therapist responded appropriately in telling him that, you know, he got more and dug into the issues more rather than, um, just straight up saying this is what I'm going to say, this is what my opinion is.

JJ: Hmm-hm.

A: He kind of got to the core and redirected him back to what the therapy sessions were all about.

JJ: Can you say more about that? How he did that, and how you kind of... apparently, you're kind of saying that you, you agree with his technique?

A: Hmm-hm.

JJ: Yeah, what about it do you see as, more specifically, do you see as what he was doing well?

A: I think he did question if the pilot was really ready, and I think that in a therapeutic relationship you can have the feelings as a therapist that maybe the client is not through

the whole process. It, um, you know, it's difficult to do that especially when it's cut off in circumstances like this. You know, they're not going to be in the same area; they can't continue the same relationship; now it's going to be by phone, if at all, instead of concrete sessions. It seems like the therapist wasn't really able to come to a resolution with what he was trying to come to with the client.

JJ: Hmm-hm. So, there was a lot left open-ended?

A: Absolutely.

JJ: Would have you wrapped things up differently? Given that he came in and said this was his last session. Would you have handled that at all differently?

A: Again, I don't know the context. I don't know how many sessions they had before that. You know, in this therapeutic interaction, it was the relationship between the pilot's son and his father. I don't know if those were the core things they talked about in the past, but I'm assuming it is.

JJ: Hmm-hm.

A: So, if they were really able to, um, remedy a lot of this stuff and that was the main things they talked about other than, you know, civilian casualties, and it sounds like he has some PTSD, if that's it.

JJ: Hmm-hm.

A: Then, I would be okay with that because it was something we discussed over and over again. Obviously, the pilot is reflecting a lot more than he had in the first initial session because it seems like he was someone who was closed off, um, and they probably had a really hard time being open with each other.

JJ: Yeah, um, yeah that's accurate.

A: Hmm-hm.

JJ: So, um, you're not seeing a lot of sort of alternate or alteration from what the therapist was doing in the session. You're not feeling a lot of sort of, um, I would have done this differently or I would have pursued that differently.

A: No, I guess because, you know, what I'm in right now—I'm a voc-rehab counselor and our relationships are very concrete, you know, we have certain things we need to do in the process and, you know, it's counseling and guidance, but it's not directly therapy, so I think I'm coming from the opinion of, you know, it'd be difficult unless I know the

perimeters, so I agree with the way that the psychologist handled it. I don't think I would do anything different. You know, as far as him asking him to falsify the assessment, and even, um, him asking him directly what would you do. I think he responded well to that. He didn't in any way say you should do this or if I were you this is how I would handle it.

JJ: So, you definitely praise him for that and applaud him for the neutrality he took on the issue of advice.

A: Yeah, um, complete neutrality.

JJ: Hmm-hm. How about the bigger one, though. That whole assessment? Did he handle that well?

A: I think he could have been a bit more direct with him probably and told him, you know, I cannot be biased in this assessment and it's basically coming back on my professionalism; I need to be as unbiased as possible and really be, um, give an accurate assessment, so I guess he could be a little more direct and come back to that. But he didn't give any indication that he wasn't going to. He didn't give any indication that he was going to lie in the assessment and kind of push him along and allow him to do, you know, continue to fly.

JJ: Yeah, right, he certainly didn't. He, um, in that sense, was he doing something you agree with? There was a lot of neutrality that you seem to be picking up on?

A: Yeah, I think, um, the pilot sounds like he's not so much in the session, but he's aggressive in a lot of situations outside of the session, too. So, I think that, um, maybe the therapist didn't want to get off on a bad foot that early in the session and tell him directly that, you know, this is what I need to do and what I'm going to say. I'm going to neutral and not going to, you know, the opinion of you going in for training and going on as a pilot. I think he had to be neutral so they could actually do work in the last session.

JJ: Hmm-hm. Yeah. Had he come out right away and said, blatantly, this isn't going to happen.

A: Yeah, I think that would have been a wall right there because the pilot is—he seems like he has an aggressive personality, you know, going out drinking and looking for a fight. I mean obviously that was circumstantial and might not be a trigger that that's much, sometimes it can put him over the edge, but also, you know, I think he wanted to leave everything on a good foot. He wanted the pilot to realize that, in the end, he did a lot of good work and he was brave for doing it. And I don't think he could have done it if he was direct and said, you know, I'm not going to lie in this assessment.

JJ: Yeah, you know what do you think would have happened if he would have said that?

A: I think that whole session would have gone completely different. I think that the pilot, um, there would have been an argument between the two of them and possibly the pilot walking out, and I don't know in the past if there was any kind of aggression. It could have brought out other issues, too.

JJ: There was, yeah.

A: Hmm-hm.

JJ: Yeah, you're definitely picking up on that.

A: Hmm-hm.

JJ: There was actually a session before, one or two before this one, between this one and a session earlier where they actually had a physical confrontation because the pilot became pretty aggressive toward him.

A: And you can see that even when they were first talking it seemed very stiff and very rigid, you know, here's my money, and as they kind of dug into the issues, that's when everything there was some warmth and some sharing back and forth.

JJ: What you're picking up on there with the rigidity, did you feel like you seeing the session at the beginning, what was your impression?

A: It just seemed very framed. It seemed kind of like they were kind of just going along with the process. And then when the therapist I think realized that they were touching on core issues that happened between the therapeutic sessions, um, that there was stuff that he could kind of relate to what was going on in his past, too.

JJ: Hmm-hm.

A: So, it kind of gave the therapist a framework, too, um, but yeah, I work with veterans now.

JJ: Yeah.

A: And, um, it's tough. You have to...you can't just come out and say what was your experience in Iraq and Afghanistan. You have to be, you have to build a relationship with them before you can get into any of the details because they're just going to see you as a civilian. There's a huge thing between talking to each other and talking to a civilian.

JJ: Yeah. That brings up an important point. This was a civilian-soldier situation right there. Did you see anything about the way the therapist was responding and acting and treating the situation that maybe you'd have done differently?

A: The big thing was, you know, when he kept referring to faggots.

JJ: Yeah.

A: He said that a couple of times.

JJ: He did.

A: And, that reminds me a lot of military language. You know, friends that I have they'll use the language of... they'll call people retards and stuff like that. And it's extremely offensive to myself and other people that are a little bit more open minded, but to them that's just how you talk between people in the military, you know, between privates and officers, and, um, I don't think the therapist really needed to address that because it wasn't really pertinent to what they were talking about, but you can tell there's a difference between talking to a civilian and talking to the pilot. He wasn't referencing a lot of the details of actually flying. He talked of the dunk tank and, um,...

JJ: As though he was explaining it to a novice?

A: Yeah.

JJ: Or an outsider.

A: Yeah. He couldn't be detailed about anything in the military. All the acronyms and everything else. And, um, but I think that's good because I think that he struggles with—the pilot struggles with—the relationship with his dad.

JJ: Hmm-hm.

A: And even his wife, he had mentioned. Um, and I think a lot, um, that probably has to do with, um, he's in the military life nine months out of the year, and on a full time basis. And when he's deployed he's completely wrapped in that, and it's two different worlds.

JJ: Hmm-hm. So, again, you're kind of praising the therapist as handling that pretty well, not making an issue out of it, not honing in on it. Did you pick up on anything else with that situation where he was using the word faggot? Did you see anything else that might have been a dilemma that the therapist missed or did not seem to address?

A: Um...no because I, um, he could have kind of confronted that. I mean confrontation is good, and he could of kind of—not educate—but get a kind of understanding and dig into why he’s aggressive when going to a bar and wanting to knock somebody’s teeth out.

JJ: Right.

A: But, I don’t think that those were the core issues. I think he would have been distracting what they were really working at. And the straight lines of what he was talking about, which was is he ready to go back as a pilot.

JJ: Yeah.

A: Is he just—it really seemed he was trying to get at— is he just brushing aside all his personal things that are happening. And kind of using this as an excuse to kind of get away.

JJ: Yeah. Did it look like he brought that to the fore enough?

A: No, I don’t think he did.

JJ: The therapist didn’t?

A: No, I think the therapist hits at that a couple of times and I think the therapist wanted him to come to that conclusion himself, but he never did.

JJ: Yeah.

A: And I don’t know that he will. I think he—the pilot sees it as— as personality flaws between him and his son, and his father, but what the core might be is, you know, him really, um, him being away and not being close enough or wanting to be close enough. I mean he brought up a point that his son, is it better for his son to have his father at the birthday party or not there at all.

JJ: Right.

A: And, the pilot brushes that off very easily.

JJ: What do you think that was really about?

A: Um, I think it has a lot to do with the time away, you know. His son growing up at a young age when he’s developing and he doesn’t have his father around and he has his grandfather around and it seems that they are butting heads on a constant basis.

JJ: Yeah.

A: So, um, I think it's the pilot not understanding his son.

JJ: Yeah. So, there's a distance there between them?

A: Yeah, and I don't think that the therapist really addressed that. You know, I think he was trying to have the pilot come to his own conclusions, but those are times that whenever you...the confrontation can be there. But, then also, if in past sessions there was aggression and on that particular subject – and I don't know what the subject was— then I don't know if I would go and poke at it.

JJ: Right. Hm-hmm. So, this whole idea of letting the client draw their own conclusions that you're kind of touching on.

A: Yeah.

JJ: You don't like that, at least in this situation from what you're seeing?

A: Um...

JJ: You envision an alternate situation for yourself. That you as the therapist would not do that?

A: Yeah, I think I do like... I think that if you really had a feeling that there was other issues, then they need to be brought up, like if the client is not getting it or they keep scathing away from it. I think that would have been a, you know, saying this is the core issue. Why do you keep redirecting? Why do you keep getting this distance from what we're really trying to get at?

JJ: Yeah.

A: And I think you can get at those issues, um, instead of...you know, I think that he really let the pilot kind of dictate what was going on.

JJ: Yeah. So, you're saying there was passivity there?

A: Yeah, and I think he was being reflective which is a great thing, and you know, every question he was responding with neutrality, and he was responding with collected responses. But I think that he could have directed the conversation a little more.