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IDEOLOGY AND THE VOCATIONAL REHABILITATION OF THE
PSYCHIATRICALY DISABLED

City University of New York

Ph.D. 1983

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IDEOLOGY
and the
VOCATIONAL REHABILITATION
of the
PSYCHIATRICALY DISABLED

by

Melvyn L. Fein

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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This manuscript has been read and accepted for the
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Apr. 26, 1953
date

Gen. H. H. H. H.
Chairman of Examining Committee

Apr. 22, 1953
date

Reginald Dinitz
Executive Officer

Fred H. Goldner
Supervisory Committee

The City University of New York

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Chapter I

INTRODUCTION

Since the 1920's, state governments have engaged in efforts to "rehabilitate" the "disabled". Their proclaimed goal has been to try to establish a viable vocational adjustment in people who, for one reason or another, have not been able to create or maintain sustained work roles. Using methods such as "counseling" and "skill training", they have tried to move people into competitive employment or into "sheltered workshops". Historically, rehabilitation counselors primarily have worked with the physically disabled, but in the past two decades people with "mental illness" have assumed a large and sometimes the major place in rehabilitation caseloads. Today, nationally, almost 40% of the clients seen by state rehabilitation agencies suffer from so-called "psychiatric" disabilities (Rogan, 1980).

Vocational rehabilitation (VR) of the psychiatrically disabled is a new field and apparently a very difficult one. Only since 1973 has federal legislation mandated that the severely disabled psychiatric client be served by the state rehabilitation agencies, and recent literature indicates that the rehabilitation community has had limited success in dealing with this new population. William Ten Hoor of the National Institute of Mental Health unequivocally states that "Both rehabilitation and mental health have had difficulty in effectively serving the chronically mentally disabled" (Ten Hoor, 1980). Donna Rogan of the Massachusetts Rehabilitation Commission asserts that while rehabilitation agencies have usually been effective with "the physically disabled clients, these agencies have been too structured and too sketchy to achieve rehabilitation for the 40% of clients with psychiatric disabilities" (Rogan, 1980). She writes that these clients are both difficult to help and frequently overwhelming in the problems they present to the counselors who are asked to help them. Deitchman et al. (1980) go so far as to say that "chronic (VR) clients are never successful closures (in rehabilitation agencies) because they need followup indefinitely".

Originally, it had been my intention to study the vocational rehabilitation of the psychiatrically disabled in order to understand how this new field worked. My hope was that better insights into how psychiatric VR functioned might lead to a better understanding of how to serve psychiatric clients more effectively. After beginning my study, however, I found that there were some other questions which demanded more immediate attention, namely: "What is vocational rehabilitation of the psychiatrically disabled?" and "What do the participants and agencies in the field think that they are doing?"

Initially, it seemed to me that these two questions were related, and that psychiatric VR was largely determined by what people thought it was. Participants in the field very often talk about how it should be conducted. There are elaborate rationales for various courses of action and involved conceptual frameworks for communicating about what is being done. It seemed to me that these pervasive conceptual systems must be having a great deal of influence on how rehabilitation was being performed, and hence were worthy of study.

As I began examining these conceptual systems they seemed to me to have a very ideological character, that is, they seemed more like political programs than like scientific hypotheses. They had a dogmatic quality about them, plus an orientation toward specifying actions. They were clearly more than just a part of a flexible search for knowledge. Concepts such as psychiatric diagnostic categories were clearly negotiated products (Spitzer and Williams, 1982). The American Psychiatric Association's decision, for instance, that "homosexuality" is not an illness was the result of intense political lobbying and not a piece of scientific reasoning per se.

In the rehabilitation community the concept of "ideology" is not used, but a related one, namely the "treatment model", is. These models are often thought of as conceptual blueprints for working with clients. Unfortunately, however, treatment models are frequently confused with "scientific models"; so-called scientific "paradigms" (Eisdorfer et al., 1981). In science, models are supposed to be conceptual analogies which help frame scientific hypotheses. They emphasize the understanding and defining of problems. In rehabilitation, on the other hand, action is of paramount import. Nevertheless,

psychiatric rehabilitation has, in part, evolved from medicine and from clinical psychology. In both of these fields, "science" is an honorific, and so there is a strong tendency even in rehabilitation to claim its mantle (Reisman, 1981). The concept of "ideology" is different from that of a "model" in that it does not imply that the framework used is "scientific". It more explicitly implies that there is a political and philosophical aspect to the ideas and actions to which it refers. Utilizing the concept of "ideology", therefore, may make it clearer that it is "treatment" models and not "scientific" models which are being discussed. In what follows both the concepts of "ideology" and "model" will be used, but it should be born in mind that the conceptual systems being examined often have a political, action-oriented, and even dogmatic character about them. It should soon be evident that rehabilitation is much more an arena for social action and faith than of dispassionate scientific inquiry.

When I began to examine the conceptual systems operating in psychiatric VR, my expectation was that these ideologies were being used to help define the nature of "psychiatric vocational rehabilitation" and to help determine the nature of this new field. After some years

as a participant in a psychiatric VR organization in the role of a counselor, I had come to believe that ideology was being used to guide VR counselors, administrators, and clients in deciding the kinds of changes they were trying to make, and how they were trying to make them. I expected that ideology would be defining counselor, administrator and client roles, and helping to decide what were appropriate psychiatric VR "problems" and what were the preferred VR "solutions" to these problems. I was especially interested in the impact ideology was having on how VR counselors defined their tasks and the degree to which they were being helped by ideology in their search for effective rehabilitation strategies. This was partly because I was working as a VR counselor, and partly because Marvin Sussman (1965) had proposed that, "the counselor role is the crucial operating one in the rehabilitation system".

Upon a closer analysis of the ideologies used in the psychiatric VR field, I found that my original expectations were not fully sustained. First, most of the ideologies which are current in psychiatric VR do not effectively guide rehabilitation practice. Attempts are made to use them in this way, but in the end most of these

fail, or at least do not live up to participant expectations. Often ideologies come to be used merely as tools for justifying actions which have been taken, rather than in determining what actions should be taken. Second, of the ideologies which are used in psychiatric VR easily the most influential in determining the nature of the field are the "moral" ideologies. Notions of "right" and "wrong", and "good" and "bad" are both ubiquitous and salient. Though most participants in rehabilitation do not seem to realize the extent to which these ideologies determine what they do or their perception of it, moral ideologies virtually saturate psychiatric VR. The goal of this study is to analyze and document just how dominant the moral ideologies are, to see how they operate, and to show some of the consequences of the relative invisibility of these moral ideologies on the field and its participants.

The Ideologies in Psychiatric VR

Ideologies, according to the dictionary (Webster's, 1959), are integrated systems of "assertions, theories and aims constituting a politico-social program". They are

systems of ideas, beliefs and attitudes" which constitute "a philosophy or world view" (English and English, 1958). Theodorson and Theodorson (1969) define ideology as "A system of interdependent ideas (beliefs, traditions, principles and myths) held by a social group or society, which reflects, rationalizes and defends its particular social, moral, religious, political and economic institutional interests and commitments. Ideologies serve as logical and philosophical justifications for a group's patterns of behavior, as well as its attitudes, goals and general life situation....The elements of ideology tend to be accepted as truth or dogma rather than as tentative philosophical or theoretical formulations".

For the purposes of this study, ideologies will be seen as having two major components:

- 1) A "conceptual framework" which may be used to understand some portion of the world, and

- 2) An "impetus to action", that is, a kind of "faith" which directs people into certain lines of activity.

Put another way, ideologies a) define the "problems"

people face, and b) indicate the preferred "solutions" to these problems. In the rehabilitation field this means that ideologies define a) what "disabilities" are, i.e., what is "wrong" with the people who are being helped by rehabilitation organizations (Freidson, 1965), and b) what "rehabilitation" techniques should be used in working with the disabled. Ideologies also can and have been used to justify and explain what has been done with rehabilitation clients. In other words, ideologies can be used after the fact to support work that has been done, as well as before the fact to determine what should be done.

The rehabilitation field does not contain only one ideology. Rather, there are several, often conflicting, clusters of ideologies which compete for dominance. I have identified five of these groups of ideologies as being of special significance for understanding the nature of the field and will concentrate on trying to gain insight into who employs them and how. The five to be examined most closely are:

- 1) the medical models,
- 2) the psycho-social models,
- 3) the educational models,
- 4) the moral models,

5) the religious models.

Within the psychiatric VR field other ideologies, such as "placement" and "welfare" models, have been delimited (see chapter 10 for a more complete list of these), but the five we will concentrate on seem to me to be the most comprehensive and influential. None of the ideologies selected, however, should be thought of as completely self-consistent, or self-contained entities. They are better understood as conglomerations of concepts with varying degrees of consistency and cohesion. Thus, there is not one "medical" model, e.g., the "disease" model, but rather many different models based on analogies with different diseases, conditions, injuries and treatments. There are, for instance, medical models based upon the notion of curing infections by using drugs to kill the bacilli which are thought to cause them, and very different models which posit physical and/or genetic faults which may be corrected by surgery or genetic engineering. The more closely one examines psychiatric vocational rehabilitation ideologies, the more diverse and labyrinthine they appear. Indeed, the very elaboration of these ideologies is one of their more interesting characteristics. Nonetheless, there are justifiable

grounds for grouping them into five clusters as the following discussions should illustrate.

The Medical Models

The object of this present study has been described above as the ideologies current in the "psychiatric" VR field. The use of the word "psychiatric" implies that the conditions dealt with in this field are somehow "medical". Psychiatry is, after all, a medical specialty. The target population of VR might have been identified as the "psychologically" or "emotionally" disabled, but they were not. Instead, I have followed a standard practice of my colleagues at the VR agency where I worked and labeled VR clients as "psychiatrically" disabled. In effect, a medical label has been used to identify our field of inquiry. Medical models currently function as the "official" ideologies of many of the organizations involved with psychiatric VR. This is true of "mental hospitals", of community mental health centers, and of many rehabilitation agencies (at least to the extent that the latter work with clients referred to them through medical systems).

Medical models most frequently assert that the people who concern them are suffering from a "disease". In the psychiatric arena they are called "mentally ill". This may seem fairly straightforward, yet the notions of disease and illness are not simple ones. In the construction of medical models, they serve as idealizations. Diseases do not all come in one form, e.g., infections, nor are all conditions treated by medical doctors considered diseases, e.g., doctors also treat injuries. The Diagnostic and Statistical Manual III (DSM III, A.P.A., 1980), the official guide which doctors use in classifying mental illnesses, uses the term "disorder" to describe the full range of the psychiatric conditions. This latter is a very broad concept which seems only to imply that "something" is wrong with a client, but without committing the physician to the belief that there is an underlying disease "entity" which is the hypothesised problem.

In general, though, a belief in medical models implies a belief that something physical, chemical and/or genetic is the likely cause of problems which are identified as being diseases (Sarbin and Mancuso, 1980).

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If no organic condition can be identified as the causative agent, and for the most part with psychiatric conditions none can be, then these diseases are described as "functional", i.e., that there is some physical system in the subject which is simply not working properly. Historically (Alexander and Selsnick, 1966), the conditions now called mental illnesses were thought to be caused by organic problems such as brain lesions. Discoveries like the connection between general paresis and the syphilis spirochete strengthened this belief in organic causes. Diagnoses such as "neurosis", which means "inflammation of the nerves", then came into vogue, but when neither nerve inflammations nor brain lesions could be found for most psychiatric patients the analogy with disease still remained, and does till this day.

At present this analogy functions not only as a model used to guide inquiry, but as an ideology which determines how the subjects of psychiatry should be handled. This method of handling subjects is invariably called "treatment" in analogy with other medical treatments. Its subjects are called "patients"; its practitioners called "doctors" and "nurses"; and the settings in which it is performed are called "hospitals" or "clinics". The type

of treatment used also shadows standard medical practice, e.g., drugs are a preferred treatment modality, and, if talking is used to try to change people, it is called "therapy".

Since diagnosis is an extremely important tool in other medical specialties, it is given heavy emphasis in psychiatric practice. There is much concern with "symptoms" and "syndromes", and there is an expressed belief that accuracy in diagnosis leads to accuracy in treatment. Furthermore, mental diseases are said to have standard "onsets" and standard "courses", and in individual "cases" "prognoses" are made and "complaints" attended to, and so on. In other words, the analogy between "mental illness" and more conventional forms of illness is pursued in very great detail in the "medical" models; both in concept and in program.

Medical models are very controversial as applied to psychiatric clients. They are often attacked by non-medical people (Scheff, 1966, 1970; Gove, 1982) and even by some doctors (Szasz, 1961, 1970). Nevertheless, in the organizations we will be analyzing, medical models are often adhered to without question. This is especially

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true of the hospitals, and, within them, of the doctors and nurses. In chapter 5 we will examine in greater detail how these ideologies function in psychiatric settings, but for the moment we will continue our enumeration of the ideologies most used in psychiatric VR.

The Psycho-Social Models

Of the ideological clusters which have been selected for examination, the psycho-social is the most diverse. Its sub-models range from the "psychoanalytic" to the "behavioral"; from speculative philosophy to the utterly pragmatic. What holds them together is a general perspective about the causation and potential treatment of those labeled psychiatrically disabled.

If medical models hold that the problem faced in rehabilitation is a "disease" entity (or more vaguely, a "disorder") and the solution to it is a "treatment" (or "cure") based on a medical analogue, then, in contrast, psycho-social ideologies hold that the identified problems of psychiatric rehabilitation clients are really "problems in living"; that these problems are caused by personality,

behavioral or social circumstances; and that their solution lies in changing client personality, behavior or social circumstance.

Psycho-social ideologies would seem to have in common the fact that their major focus of change is the "social role" and not the human body (as in medicine). Yet these ideologies are generally not conceived of in this light by their adherents. In some cases, in fact, role change is explicitly denied as a major goal, e.g., role change is sometimes negatively compared to "personality" change (Goldberg, 1980). Sometimes these ideologies are even thought of as basically medical or educational or moral. Nevertheless, they are substantively different than these latter in that their orientation is not toward physiological change, or skill acquisition, or moral rectitude. When examined, their object of change almost always seems to be how people are interacting with other people. They seek to change people's actions within individual, group, family or organizational contexts, and it is at the junction between personal and social worlds that they operate. This junction is, of course, the social role. Still many adherents of psycho-social ideologies think of themselves as oriented toward

"personal" change or "growth", and though they may make a bow toward the social contexts and goals which condition personal actions, change of the individual psyche usually holds the place of honor in their conceptions. Even though most of the change techniques they use operate through the mechanism of interpersonal relations, the psyche is generally conceived of as the site where the relevant change occurs.

Generally, the psycho-social models operate through what are typically called "therapies". These therapies are exceedingly varied, and continue to become more so. It is not possible to enumerate here all of these ideologies or all the change techniques they employ. Lists of hundreds of these have been compiled (Reisman, 1981), but a partial list of therapies, one which has some relevance to the rehabilitation of the psychiatrically disabled, is as follows: psychoanalysis, neo-Freudian therapy, ego psychology, client-centered therapy, transactional analysis, rational emotive therapy, behavior modification, stress reduction therapies, gestalt psychology, existential therapy, family therapies, and labeling perspectives.

These ideologies are implemented through techniques such as: free association, dream analysis, role playing, relaxation techniques, rational disputation, paradoxical interventions, interpretation of transference, confrontation, reflection of feelings, desensitization, ventilation, emotional support, "working through", suggestion, and assertiveness training (Choca, 1980). Cognitive, emotional and volitional factors are all employed, and, whether done explicitly or not, the orientation is usually toward the individual within his social context.

In the rehabilitation arena, it is psychologists who are typically the bearers of psycho-social ideologies (and hence the emphasis on the psychological versus the social aspects of these ideologies). These psychologists tend to be eclectic in the views they hold, i.e., to utilize several models simultaneously. Significantly, however, there is no major organization in the psychiatric VR field which is constructed around a psycho-social model per se; and hence in the rehabilitation field these ideologies are of far less moment than the medical, educational or moral models, though the lay public will often have a psycho-social model in mind when thinking about

rehabilitation.

Educational Models

A third cluster of ideologies used in psychiatric rehabilitation is the educational. These conceive of rehabilitation clients as suffering from a knowledge deficiency and posit the solution to this problem as the teaching of some information or skill. Thus psychiatric clients will be conceived of as deficient in their knowledge of social rules and/or of the ability to act on these rules. An attempt will then be made to teach them these rules and how to act upon them. Grooming and communication skills are, for example, often conceived of as client deficits, and so many educationally modeled rehabilitation programs incorporate in their curricula classes in personal hygiene or in how to hold a social conversation.

If it is believed that a given client lacks the ability to acquire a particular skill, then an attempt will often be made to teach a compensatory skill. The analogy here is to the training often given those who

suffer from physical disabilities, e.g., teaching a man new ways to operate a machine despite the fact that he has lost a hand. This, of course, should not be surprising for rehabilitation began with programs to re-train the physically injured and only lately has been expanded to include work with the "psychiatrically" disabled.

In part because educational models have a built-in bias toward the acquisition of information, programs based on these models often include attempts to impart knowledge for its own sake. Thus psychiatric clients are frequently urged to acquire G.E.D.s (i.e., General Equivalency Diplomas), or to increase their math and reading skills, whether or not these are relevant to the client's vocational or other rehabilitation goals. Furthermore, programs which others might consider medical or psycho-social may also be cast in educational terms. What may be called "therapy" by some, will often be called "relaxation training" by the educationally oriented. And what some would term psychological interpretation, may alternatively be thought of as the "teaching" of reality testing.

Some of the teaching techniques employed under the

banner of educational ideologies are didactic and very direct. Often classrooms, textbooks, and homework assignments are used. Sometimes this teaching is done in groups, and sometimes it is one-to-one as in a tutoring situation. Often the techniques employed are indirect and not of the sort usually connoted by education. Foremost among these are milieu techniques and vocational workshops. In these cases, living on a hospital ward, or doing arts and crafts in a "day" hospital, or engaging in bench assembly at piece work rates in a sheltered workshop will be conceived of as "learning experiences". These experiences are given labels such as "personal adjustment training" and are thought of as educational, though often the only thing remotely being taught is how to comply with demands for work discipline.

Educational models are most popular within organizations explicitly designated as rehabilitation organizations. The state vocational rehabilitation agency where I worked as a counselor, local rehabilitation agencies to which I referred clients, and even the rehabilitation programs of the state psychiatric hospital where I had my office were all at least in part built around these ideologies. Within these organizations,

those explicitly hired in an educational capacity (e.g., G.E.D. teachers) had the greatest allegiance to educational ideologies, while others, such as counselors, used them mostly for justification purposes. Thus it was not at all unusual for those who identified themselves as in the rehabilitation field to openly oppose medical and psycho-social models with educational ones, as have various authors in the field (Anthony, 1980; Scott, 1965).

Moral Models

Morality is not always thought of as an ideology, but moral models of psychiatric rehabilitation are probably the most pervasive and potent in the field. Rehabilitation has been described by some observers as a "social movement" whose aims are "humanitarian" and whose object is to avoid the "waste" of human life (Wessen, 1965, Parker and Hansen, 1981). Others, with equal vigor, insist that it is the task of vocational rehabilitation to reduce social "parasitism" by the potentially self-sufficient. And within the psychiatric community there is a plethora of other competing moral ideals.

Typically moral ideologies understand the problems with which they grapple as issues of "good" and "bad", and of "right" and "wrong". They conceive of human beings as having "rights" and "duties", and as being creatures with "desirable" or "undesirable" "characters". In general, one may say that moral ideologies are based on the acceptance of specific values. These latter may be thought of as biological or cultural, as intrinsic or extrinsic; but they are always thought of as of paramount import.

If values define rehabilitation problems for moral ideologies, then the mechanisms they stress for solving these problems are "praise" and "blame", and "punishment" and "reward". These mechanisms rely on underlying human functions such as our capacities for "guilt", "shame" and "pride", and may be divided into those which rely on "positive" or "negative" "sanctions". The former sanctions often appeal to "common sense" values and rely on a sense of social solidarity, while the latter may utilize "moral outrage" and exploit personal vulnerabilities.

In the rehabilitation field there are many salient

ideals, i.e., many values which are widely and strongly held. As mentioned above the goal of not "wasting" people is one of these. So also are "work ethics"; a belief in "honesty"; a belief in "personal growth"; in "compassion"; in "equity"; and so on. Less comprehensive values which are also extensively held include: "punctuality", "teamwork", and a negative appraisal of the "passive-aggressive" personality.

The various moral ideologies are spread throughout the rehabilitation field. Most of the organizations I observed as a vocational rehabilitation counselor were to some extent built upon them. Likewise almost everyone working within the field had strong moral commitments which affected his work. Usually these commitments took precedence over commitments to the other four ideological clusters. Furthermore, the moral ideologies were especially strong among the personnel newest in the field, while, in contrast, a reaction against them, namely cynicism, flourished among long term staff members.

Interestingly, there seems to be no special value attached to one of the major tasks in the psychiatric rehabilitation field, namely "social control". Thus, for

example, there seems to be no "custodial ideology" operating within psychiatric hospitals for their clientele. (To some extent, however, control ideologies may be present among some publics which affect rehabilitation policy, e.g., outraged citizens or legislators who feel themselves threatened by the potential clientele of psychiatric hospitals.)

Religious Models

The last set of ideologies with which we will be concerned are the religious ones. These may be thought of as a sub-set of the moral ideologies, but there is a sufficient difference in how they conceive of rehabilitation problems and solutions to warrant making a distinction. For religious models, "sin", not merely "good" and "bad", is the problem. It is not a mere value, but an offence against God, the supernatural, the spiritual or the sacred, which is at stake. The person to be rehabilitated is not simply the victim of a disability, but is possessed of an "evil"; often of the devil himself.

This means that religious solutions must incorporate

mechanisms beyond those encompassed in the moral models. Praise and blame are not enough; often evil spirits must be driven out of a sufferer; i.e., "exorcized". This feat may be accomplished by the correct performance of a ritual, most usually "prayer". Then too a sufferer may "cleanse" himself by becoming a person pleasing to God. Thus a person labeled disabled by other ideologies might be urged to live a good and "holy" life by those committed to a religious ideology.

Religious ideologies are among the most ancient which have been held by mankind. While they are not official guides for any of the organizations with which we will be concerned, they do receive some endorsement in the form of institutional chaplains and chapels. More importantly, they are often strongly held by the clients and patients of rehabilitation agencies and psychiatric hospitals. They are often invoked to explain phenomena such as disembodied "voices" or specific personal failures. Low ranking organizational staff members, e.g., ward attendants and group home counselors (i.e., those least socialized into other ideologies), also have significant allegiance to religious ideologies, and literal attempts at exorcism or religious conversion are not rare.

The antiquity and persistence of the religious models are major reasons why competing models, most notably the medical, are held so strongly by some of their adherents. A sense of the intensity with which these models are often held and contested may be gathered from the words of an advocate of the medical models (Ausabel, 1967) who has written: "The most significant and perhaps the only real advance registered by mankind in evolving a rational and humane method of handling behavioral aberrations has been substituting a concept of disease for the demonological and retributitional doctrines regarding their nature and etiology that flourished until comparatively recent times."

A Participant Observation Study

The method I have elected to use in studying how ideology is employed in the psychiatric vocational rehabilitation field is participant observation. After being hired from a state civil service list, for a period of over four years I worked as a vocational rehabilitation counselor for a state VR agency. In this capacity, I had

ongoing access to the way ideology actually functions in psychiatric VR organizations and among their members. While a counselor on the staff of the state VR agency, I was assigned to and worked in an office located at a state psychiatric hospital. At any one time, I had a "caseload" of over a hundred psychiatric clients, most of them referred to me from the hospital. I was treated by my own agency and by the various other organizations and individuals with whom I interacted as an ordinary VR counselor, not as a researcher. Though most of my colleagues knew that I was completing a Ph.D. in sociology and was in the process of writing a dissertation, few knew that I was studying psychiatric VR ideologies. At no time was I allowed special privileges as a researcher, and in day to day practice was never considered one.

During my period as a VR counselor I took extensive notes on what was going on around me. I habitually carried a notebook with me, but because I was expected to keep records in my capacity as a counselor my note taking did not intrude upon my interactions with others. Often they too were taking notes. Beyond merely observing what happened around me, I also asked questions and initiated conversations in order to clarify what I was observing. I

also read records, attended conferences and in-service training sessions, counseled clients , made referrals, worked as a liaison with other agencies and professionals, and, in short, tried to ascertain in any way I could what were the realities of ideology in psychiatric VR.

Because I was an ordinary VR counselor information was available to me that was often hidden from the outside observer. I was a party to conflicts which the agencies and individuals in the field tried to keep private. I was also a party to "off-stage" conversations about what was going on and why, and to that ubiquitous organizational "gossip" which can be very revealing. As a counselor I was allowed to know which pronouncements were only for public consumption, and which were really believed by VR participants. Most important of all, because I was a counselor I had personal reactions to what was going on around me which gave me insight into how others were reacting to these same circumstances. Thus I would never have known how morally frustrating working with a psychiatric VR caseload can be had I not experienced the magnitude of these frustrations myself. My personal reactions helped me understand how and why ideologies are used, and most especially the limited way in which

non-moral ideologies guide rehabilitation practice. It was also initially through my own moral obtuseness that I came to appreciate how blind most participants in the field are to their own moral commitments.

Counselor ideologies were probably given more attention in my observations than were the ideologies of others in the field. I certainly had greater access to these, and to client ideologies, than to those of other participants. Perhaps, however, this was a fortunate happenstance, for counselor ideologies were central to the work done directly with clients by VR agencies. It is counselors who turn out the product of these agencies, namely counseling and client referral services. In a sense then, most VR ideologies must ultimately refer to what VR counselors are doing, or should be doing.

But counselors also have a pivotal role in the psychiatric VR field. They are uniquely situated to interact with administrators, psychiatrists, and rehabilitation facility personnel because they 1) function as case coordinators, 2) accept referrals from medical personnel, while making referrals to rehabilitation facilities, and 3) must interpret VR agency policy in

conjunction with their own superiors. This varied participation gives them an opportunity to see how many different participants in the field utilize rehabilitation ideologies. Because of this role I had a unique opportunity to learn about rehabilitation ideologies that I might not have otherwise.

A Look Ahead

In order to set the stage for the analysis of psychiatric VR ideologies which forms the bulk of the report that follows, it will be necessary to start with a description of the VR and psychiatric organizations in which I worked. Also necessary is a general description of the process of vocational rehabilitation, and these will be furnished in chapter 2. Chapter 2 will also include a discussion of my research methods to help the reader in making critical judgments about the materials presented. It will then be possible to discuss the ideologies which are built into VR agencies and psychiatric hospitals, and this will be done in chapter 3.

Chapters 4 through 7 will be concerned with the

ideologies of participants in the psychiatric VR field. First will come a consideration of counselor ideologies, and it will be observed that counselors function as "free-lance" ideologists. In a real way they have an opportunity to choose their own ideologies, and ultimately they wind up choosing mostly moral ideologies, though they do explore the psycho-social and educational ones too. Psychiatrists, whose ideologies are considered in chapter 5, are, as one might expect, most committed to medical models. The surprise is that these are used in a very moralistic way in the psychiatric field. In chapter 6, VR administrators will be seen to have their greatest commitment to public/political moralities. In general, though, they are the least ideologically committed of participants in the VR field, and the most concerned with organizational goals. Finally, chapter 7 will discuss the ideologies of psychiatric VR clients. They function most as idiosyncratic ideologists, that is, they have very private understandings of their problems and often pursue very unique solutions to these problems. Nevertheless these clients have very strong commitments to both religious and moral ideologies. They very much want to be helped and very much want to be normal. Their influence on VR practice, however, is minimal, and hence their

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ideologies tangential to those of the other participants in the field.

Chapter 8 will be concerned with the role ideologies play in the very pervasive conflicts current in psychiatric VR. The moral intensity of the most prevalent ideologies probably contributes to the sharpness of these conflicts. These conflicts, in turn, help demonstrate the degree to which VR ideologies are used to justify VR practice. For example, it will be seen that educational ideologies are used by the state VR agency more to guard its organizational independence from psychiatric interference than to guide how it works with its clients.

In chapter 9, the combined impact of client and professional demands, and rehabilitation failure on counselor ideologies is examined. Because the resources available to them are grossly inadequate and because the ideals they aim for are so high, it is virtually inevitable that psychiatric VR counselors will experience an intense sense of failure. When they look to ideologies such as the psycho-social or the medical to help them out of this predicament, counselors experience additional frustration and hence with time become less likely to use

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these ideologies in their work.

Finally, in conclusion (chapter 10), the dominance of the moral ideologies in the psychiatric vocational rehabilitation field is stressed. It will be seen that morality acts as a "baseline" and a "default" ideology in the field. When other ideologies fail to produce the expected results, it is usually moral ideologies which then become salient. It is also suggested that there exists a kind of reflexive blindness to this morality among VR personnel and that this blindness has some unfortunate consequences. In particular, it seems to leave many participants in the field unaware of the impossibility of some of their goals, and hence more frustrated than perhaps they need be. It also makes it more difficult to consciously ration the limited resources available to meet the moral demands they seek to satisfy. On the other hand, it seems possible that this blindness makes it possible for VR counselors to serve very important social needs. They may, for example, be representing a form of institutionalized social idealism. -Lastly it is noted that some conflicts usually thought of as between professionalism and bureaucracy are more properly understood as conflicts between public/political

and personal/private values, and that these conflicts are very deep-seated and not subject to extirpation by such simple exigencies as organizational reform.

Chapter II

THE SETTING

The State VR Agency

The VR agency for which I worked was part of a larger governmental structure. Much of the legislation under which it operated was federal and was administered by the federal Rehabilitation Services Administration (RSA). The RSA set standards and priorities for rehabilitation which governed many of the operations of individual state rehabilitation agencies. The federal government also allocated monies which helped to finance many of the services provided by the state agencies, and in some cases provided special funds for services which it wished to encourage.

Each state, in turn, was responsible for organizing

its own rehabilitation agency. In my state, the VR agency was part of the state education department. The Director of the agency and his staff were located at the state capital, and there were area offices located in all of the major cities of the state. Below the Director were several regional administrators, and below them were directors of the local area offices. Most of the personnel at the state central office performed staff functions. There was a director in charge of finance, another in charge of policy planning, a third in charge of relations with the independent rehabilitation agencies which provided services for the state, a fourth in charge of training, and so on. None of these central office administrators had any regular contact with clients and very few had ever done counseling or been trained in rehabilitation counseling. Probably the most time consuming function they performed was budgeting. One of their main goals was to make the agency "cost effective", and most of the policy decisions which they promulgated concerned procedures for spending money on client services.

Each of the local area offices had its own director. The VR counselors who actually worked with the agency's

clients reported to several "senior counselors" who, in turn, reported to the local office director. In Northern City, where I worked, there were 5 or 6 senior counselors (the number varied), and 35 to 40 counselors at any one time. Almost half of the counselors supervised by the Northern City office did not work at its downtown location but were "out-stationed" in offices located at hospitals and schools in and around Northern City.

Northern City itself is a prosperous city in a metropolitan area with a population of over 700,000. Its industrial base is heavily dependent upon advanced technology and its economy is dominated by a few very large companies. The local community prides itself on its modernity and rationality, and engineers and executives dominate the local culture. Medicine is also one of the largest of the local industries. There are many hospitals in the area and they are proud of their professionalism. At one point while I was in Northern City, the local newspaper ran an article which cheerfully proclaimed that a national survey had shown that Northern City was a good place in which to get sick because of the quality of its hospitals. Medicine, including psychiatry, is seen in Northern City as a scientific enterprise, and this

attitude even affects the vocational rehabilitation of the psychiatrically disabled, for it too is expected to be done in a scientific manner.

The downtown office of the state VR agency is on the second floor of a small office building. It houses the local office director, all of the senior counselors, about half of the office's counseling staff, and most of the local support staff including clerks and secretaries. The office director and all of the senior counselors occupy rooms of their own, but most of the counselors work in cubicles which provide them with only limited privacy when talking with their clients. The office director and all of the senior counselors at one time had been VR counselors with the state agency. Each had taken written tests in order to become eligible for advancement and once they made the civil service list, had to undergo an interview process before being promoted into their new jobs. Besides having worked as VR counselors, most of the seniors and the director had had some formal training in VR counseling and so were familiar with the nature of VR counseling. The local office director's job requires him to spend much of his time interacting with the administrators located at the state central office.

During the time of my employment, he was often on the phone with them and made frequent trips to the state capital. Much of his job consisted of interpreting state VR policy to the local staff. He also spent much of his time performing liaison functions with the heads of other Northern City agencies which either provided the state VR agency with its clients or with the services it purchased for its clients.

The senior counselor's primary job is to review the work of the VR counselors. The counselors and their seniors met regularly to discuss the services being provided individual clients. They talked about what kind of rehabilitation was appropriate and made sure that the relevant paperwork was correct and complete. This was no mean task, for the provision of any given service required substantial documentation and certification. Client case records often grew several inches thick due to the amount of paperwork they contained. The senior counselors were also responsible for approving the provision of many services. They had to sign vocational plans and authorization forms before the agency would pay for many services.

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VR counselors worked directly with clients. Most had caseloads of over a hundred active clients. These caseloads were assigned on the basis of geographical area or of specific referral source. If a person applied directly to the agency he would be assigned to a VR counselor on the basis of where he lived. If he were referred by a hospital or school he would be assigned to the counselor who covered that hospital or school. Of the Northern City VR counselors, between 6 and 12 had caseloads which included primarily psychiatric clients. The reason the number of these caseloads varied is significant and will be discussed in chapters 5 and 7. How counselors worked with their client will be seen shortly when we discuss the rehabilitation process.

Counselors who were out-stationed performed essentially the same job as those who were located at the downtown Northern City VR office. The main differences were that they had less access to their senior counselors, who usually came to visit them one day a week, and they were more subject to supervision by their referral sources. Because out-stationed counselors' offices were located at hospitals and schools and so on, the employees of these organizations often did not realize that the VR

counselors worked for the state VR agency. While I was out-stationed at the state psychiatric hospital I constantly had to remind hospital counselors, social workers, psychologists and psychiatrists that I was not a hospital employee. Nevertheless, many of them wanted me to report to them about how I was doing my job, and the hospital secretaries almost invariably sent me copies of hospital personnel forms, and other such information.

Also associated with the Northern City office of the state VR agency on a part time basis were two medical doctors. They functioned largely as consultants to the agency, one for issues which related to physical medicine, the other for psychiatric concerns. Often they gave advice on how particular cases should be handled, or they certified that a particular client was indeed disabled or that a particular service was medically correct. In such cases, their signature was often required before a counselor could provide a client with a service.

The Northern City office of the state VR agency was a busy organization and by the standards of the state agency a successful one. It achieved almost a thousand "rehabilitations" a year, perhaps a quarter of which were

for the psychiatrically disabled, and had the second best ratio in the state of "rehabilitations" to clients served. Nevertheless, many of the VR counselors, and especially those serving psychiatric clients, did not believe themselves to be rehabilitating many clients, and, as will be seen in chapter 9, were quite dissatisfied with the job they were doing.

The Rehabilitation Process

The rehabilitation of VR clients was supposed to run a fairly standard course. First they were supposed to be referred to the VR counselor who was to take their application for VR services. He (or she) was then to try to determine if the clients were eligible for these services and if they were, was to work in conjunction with them to determine which of these services was appropriate. The clients were then to receive counseling, or "physical restoration", or some form of training, whichever seemed best suited to their needs. After this service was successfully completed, the clients were presumably ready for placement in competitive employment, or in a sheltered workshop, or to return to their own homes as "homemakers".

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Once this placement was accomplished, the clients could be considered rehabilitated. In theory, at least, that was how things were supposed to go.

This theory was taken quite seriously and, in fact, was built into the legislation which established the governmental VR agencies (e.g., the Smith-Sears Act of 1918, the Smith-Fess Act of 1920, and the Vocational Rehabilitation Act Amendments of 1954 -PL 565). The device used to do this was the so-called "status" system. It created a series of statistical categories through which clients had to pass on the way to rehabilitation. The first of these categories was status 00. This was the referral status. When a person came to the state agency and asked to be made a client, or when a hospital staff member filled out a referral form and sent it to a VR counselor an agency clerk would fill out a form and send it to the state capital to register the client in status 00.

The VR counselor could then start working with the client. His (or her) first task would be to acquaint the client with the agency and its services. He would explain that in order to be eligible for VR services he (or she)

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would need to be disabled, that this disability would have to be such that it interfered with his employability and that there would have to be some possibility that the services the state VR agency could provide would restore him to employability. That is, he had to be both functionally disabled, and "feasible", for rehabilitation. If the client believed that he met these criteria and that the counseling and training services, which the counselor had described sounded like what he wanted, then the client could apply for agency services. After an application form was completed, the client would be registered in status 02.

After this, it was up to the VR counselor to determine if the client was in fact eligible for agency services. To do this, he had many sources of information at his disposal. He had, for instance, the referral forms sent him by social workers or psychiatrists. These usually included medical diagnoses, and when signed by a doctor were considered evidence of a medical disability by the state agency. These forms also described the client's condition, his likely prognosis, and often suggestions of possible avenues for rehabilitation. The counselor could also get further information about the client's vocational

potential by sending him to physicians for physical examinations or to psychologists for personality and aptitude assessments. In addition, he could send for high school or college transcripts, hospital discharge summaries, or any other form of documentation he believed to be relevant. He could also send the client to a rehabilitation facility to be evaluated for employability. There he would be given a battery of hands-on tests and the results of these returned to the VR counselor. If after all this, and after talking with the client and/or his therapist and/or his parents, the counselor felt that the client was vocationally disabled, but did have a potential to be rehabilitated, then he could assign him to status 10. This category affirmed that the client was eligible for agency services and feasible for rehabilitation. If the counselor still could not determine eligibility, he could put the client in status 06. This signified that he was in "extended evaluation" and that within a period of 18 months an eligibility determination would be made about him. If, however, the VR counselor believed that the client either was not disabled, or not vocationally impaired, or too disabled to benefit from rehabilitation services, he was supposed to close his case. He did this by assigning the client to

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status 08.

Once a client was deemed eligible and put in status 10, the VR counselor was supposed to begin the process of developing a vocational plan for the client. It was during this period that counseling was supposed to occur. The counselor and client were to work together in deciding what sort of vocational goal the client should aim for and what sort of program might best realize this goal. The counselor was then to translate these ideas into a written vocational plan and when this was done and approved by the counselor's senior, the client moved into one of the service statuses. Along the way, the client moved into and through status 12. This was largely a paperwork category and indicated that a plan had been completed. Clients never stayed in this category, however, because the plan itself moved the client into a service category.

There were three service statuses. Status 14 indicated that the client was to receive "counseling, guidance and selective placement". Status 16 signified that the client needed "physical restoration", e.g., that he needed medical services and/or psychiatric help and/or physical rehabilitation equipment such as braces or

glasses in order to become ready for the vocational goal which had been chosen. Status 18 was the training category and it covered a host of possible programs. Clients placed in this category might be going to college, or receiving "personal adjustment training" at a sheltered workshop. They might alternatively be in a placement program which was actively trying to get them a job, or at a transitional employment program which was giving them emotional support by using group counseling and voluntary employment to prepare them for work, or they might be doing arts and crafts in a hospital "day treatment" program, or be enrolled at a private vocational school, or working at a government sponsored job program such as C.E.T.A. The possibilities were virtually limitless. Almost any sort of activity could be considered vocational training if the counselor writing the vocational plan were creative enough in his writing. (Counselors and their seniors literally spoke of the need to do "creative writing" when putting plans together.) Training was a favored service category with the state VR agency because it was seen as a substantive service, i.e., a product which was usually purchased from other organizations.

When a training, counseling or physical restoration

program was judged to be successful the client was supposed to be put into status 20 by the counselor. This signified that the client was ready for employment. Clients were often placed in this category by virtue of having completed the training program to which they had been referred. In this category the counselor was expected to help the client in his job hunting activities. Some counselors took their placement responsibilities very seriously and devoted many hours to cultivating job contacts and to preparing clients for job interviews, etc. Others did very little to place clients and simply waited for them to find jobs on their own. Counselors had almost as much latitude in their placement activities as they did in their referral activities. As often as not, some counselors never put their clients in status 20, but waited until they were employed then moved them into status 22. Status 22 signified that a client had achieved employment. If he then retained this status for a period of over two months his case could be closed in status 26 and he was considered "rehabilitated".

Occasionally this process did not proceed smoothly. If a counselor believed for one reason or another (e.g., hospitalization) that a client was not able to continue in

his rehabilitation program, but might be at a later date, the client could be put in status 24. This status meant that the client's program was being interrupted. If the counselor judged that the client was not going to be rehabilitated and he had already been placed in a service category , then his case could be closed in status 29. If a counselor reached this judgment before a vocational plan had been approved, but after client eligibility had been established, then the client was supposed to be closed in status 30. There also existed a status 32 which was to be used if a counselor was providing supportive services for a client who had already obtained employment, but this was not frequently used.

The status system which defined the ideal rehabilitation process was very neat and logical. In practice, however, especially with psychiatric clients, it was anything but. The statistical categories were used because they were mandated by law, but they often did not coincide with what counselors were doing with their clients. With psychiatric clients, it was often difficult to ascertain a suitable vocational goal until a service program was well along, often until it had been in effect for years. Thus the goals which counselors were required

to specify in their vocational plans were often genteel fictions. Similarly, it was very difficult to ascertain which clients were likely to achieve rehabilitation and which would fail. Determining the eligibility of psychiatric clients thus assumed the character of a guessing game, and not the realistic evaluation process envisaged. Even after four years on the job, I had a difficult time predicting what would happen with my clients, and like many other counselors often postponed eligibility decisions until a client was in a program and doing well. By referring a client to what would ordinarily be considered a training program, but indicating in a plan that it was being used for evaluation purposes, the orderly progression of the status system could be circumvented. More about the status system and its implications and limitations will be presented in chapter 3. There the ideological ramifications of this system will be our main concern.

Counselors varied considerably in how they used the rehabilitation process. Some, like myself, fancied themselves "counselors", and tried to do as much "counseling" as they could. They hoped that by devoting a lot of time to talking things out with clients that they

could help them to figure out what they really wanted to do and what would be the best way of doing it. Some counselors considered themselves really to be case coordinators and devoted most of their time to acting as intermediaries between clients and the various programs and agencies with which the clients were involved. Others believed that they were essentially referral specialists and put their energies into finding better ways to make referral decisions. Still others thought of themselves as placement specialists. They believed that their primary function was to get their clients jobs and that is what they tried hardest to do.

The State Psychiatric Hospital

I was out-stationed at the Northern City State Psychiatric Hospital. (Initially, I had also been out-stationed for two afternoons a week at a community mental health center.) The hospital was a large facility with over 1,000 beds. Once it had been a largely custodial institution for the area's most troubled and chronic psychiatric patients. Now, though the emphasis of the state mental health system was on treating people

outside of hospitals, it still dealt with the area's most difficult cases. Most of the patients who came through its doors were diagnosed as "schizophrenic". A very substantial proportion were classified as "manic-depressive". Relatively few were considered "neurotic". During my tenure at the hospital, there were still some patients on the "back wards". My knowledge of them, however, was sparse, for I had little contact with them. They were rarely referred to me for vocational rehabilitation services.

People usually became patients at the state psychiatric hospital because they had been behaving "bizarrely" in the community or had been getting in trouble at home, or with their employers, or with the police. Sometimes they came on their own; sometimes they were sent by other institutions. The local teaching hospital, for example, often referred its more difficult, long-term cases to the state hospital. The ostensible goal of hospitalization was not curing patients, but getting them to behave more appropriately so they could be discharged back into the community. The standards patients were supposed to meet were overwhelmingly behavioral. In an attempt to achieve these standards, the

hospital and its staff often referred patients to the state VR agency. Vocational success was just the sort of behavioristic measure of accomplishment which the hospital used to confirm its own success.

The hospital was organized according to the kind of client served and their place in the treatment sequence. There was an admissions ward for people first coming into the hospital and for patients expected to be short term residents. There was another ward for chronic patients, and a third for those in-patients who were engaged in active rehabilitation efforts. All of these were located in one very large multi-story tower. Other buildings located on the extensive hospital campus housed an adolescent unit, a geriatric unit, and an alcoholism unit. The building in which I had my office housed the hospital's rehabilitation unit. When I first came to the hospital, it was a very large unit, but it was considerably pared down during my stay. It ultimately consisted of a dozen rehabilitation counselors, four education specialists, and about two dozen assorted support personnel such as workshop supervisors. The rehabilitation building contained recreation facilities, craft shops and a sheltered workshop. It also contained

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offices for the rehabilitation staff, though in time, many of these were occupied by counselors from other units (e.g., the out-patient unit). The main responsibility assigned to the rehabilitation staff was to give patients vocational and occupational therapy in the hope that these experiences would help prepare them for discharge from the hospital.

When I first arrived at the hospital, it had been organized on a "geographical" basis. Both "chronic" and "acute" patients from the same "catchment" areas were sent to the same ward. The new "functional" system put in its place was supposed to help put patients back in the community more quickly. Emphasis was placed on teaching patients the skills they would need in order to maintain their own apartments or to move about the city. To this end, the rehabilitation counselors took patients on shopping trips, visited patients in their new homes, and ran a "psycho-social" club where they could drop in for emotional support. These services were dictated by the increasing insistence of the state mental health office that patients be "deinstitutionalized". Psychiatric opinion at the state department of mental health was that long term hospitalization, per se, could be harmful to

psychiatric patients. Protracted stays at a hospital were said to encourage dependency symptoms in patients, and these were said to interfere with improvement in the patients' condition. It was believed that by keeping hospitalizations short and by trying to maintain people in the community, that this problem could be avoided or limited. It was also felt that this strategy was cheaper than long term hospitalization. There was therefore pressure to find outside living arrangements for patients and to help them find jobs so that they could maintain themselves in the community. This then became the rehabilitation staff's main assignment.

The urgency with which the state department of mental health viewed this matter can be gauged by the fact that prior to my arrival a director of the hospital had been fired over this issue. He had adamantly believed that sending people out into the community before they were ready was counter productive. He considered this to be a case of "dumping" and believed that its detrimental effects were at least as bad as those of institutionalization. The new hospital director, however, was committed to achieving state quotas for patients released. He used all the means at his disposal to

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accomplish this.

One of the chief beneficiaries of the hospital reorganization and of the deinstitutionalization movement was the hospital's reorganized out-patient unit. It grew to include about 20 therapists and about 15 "alternate living" specialists. Patients who were to be relocated outside the hospital were assigned primary therapists at the new out-patient unit. They were supposed to visit them at regular intervals (e.g., weekly or monthly) in order to receive medications and supportive therapy. Most of the staff members of the out-patient unit were either social workers, nurses or psychologists. Few had any formal training as therapists, and for the most part they functioned by merely asking their clients how they felt. If the patients seemed to be doing poorly, changes in their medication schedules were likely to be recommended. Change orders would be taken to one of the three doctors on the unit. They usually ratified the therapists' conclusions, and the patients would then be given new prescriptions for drugs which it was hoped would control their symptoms. The reorganized out-patient unit was the apotheosis of deinstitutionalization, and as such it aggressively sought to assert control over the patients it

served. It perceived itself as being in charge of making the deinstitutionalization process work, and, in order to achieve this, its therapists were labeled "primary therapists" and were told that it was their mission to specify and coordinate the activities of other professionals working with their clients.

The in-patient staff at the state hospital was both very differentiated and stratified. Doctors and administrators were at the top of the hierarchy, and below them were nurses, social workers, psychologists, occupational therapists, recreation therapists, teachers, rehabilitation counselors, work supervisors and ward attendants. The formal psychological training of most of these people was fairly limited. Most of the 20 or so doctors who headed the in-patient wards had not had a residency in psychiatry and the majority had not passed the psychiatric boards. There were few Ph.D. level psychologists on the wards either, though most of the staff members designated "psychologists" by the hospital did have Masters level training. Few members of the staff, however, whatever their designated role, had had much experience in working with psychiatric patients before they began work at the state hospital. Ostensibly,

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doctors were in charge throughout the hospital system, but as individuals they did not always command the respect of other staff members. Some of their functions were beyond challenge; doctors, for instance, had control over all medical prescriptions; but in other areas, such as counseling, the other professionals exercised considerable leeway.

A "medical model" dominated the kind of work which the hospital did with patients. It was assumed that any person admitted to the hospital was suffering from an "illness". Upon admission they were "diagnosed" and referred to an appropriate ward. There they were medicated and their behavior observed to see if and when it was appropriate to refer them to another ward or hospital unit, or to recommend their discharge. If discharge was recommended, they were likely to be sent back to their families or into "group homes". They would also become clients of the out-patient unit and/or of the rehabilitation unit. From these they would receive medications, therapy and/or rehabilitation services. Throughout this process, detailed, "problem-oriented" treatment plans were developed and theoretically followed. The object was to achieve measurable results with

patients, and the plans were used as instruments of "accountability".

Referrals to the state VR agency, and specifically to me or my co-counselors, could be made by any of the hospital's treatment personnel. All they needed to do was fill out a referral form and have a doctor sign it. I received referrals from the in-patient wards, from the rehabilitation staff, and from the out-patient unit. The proportion of referrals I received from these different sources varied with the state of my relations with the staff involved. If relations were strained, I might get no referrals, but if, for example, I had just made a successful presentation on the nature of state VR agency services to the staff of some particular unit, then I might expect an upsurge of referrals from that unit. The number of referrals I received also varied with the momentary needs of particular staff members. If, for instance, a ward was becoming crowded, and its social workers being urged by their superiors to get patients jobs so that they could be discharged, I was very likely to be the recipient of many new clients.

Besides the state psychiatric hospital, there were

several other local hospitals which had psychiatric facilities. The most important of these was the teaching hospital. It was associated with a large local university; one with a national reputation. Its medical school included a department of psychiatry, and a major function of the teaching hospital was to serve as a source of patients for the doctors in training. The teaching hospital, therefore, chose its psychiatric patients very carefully, and saw them only for a limited duration of time. Chronic patients were referred to the state psychiatric hospital. The teaching hospital was very medically oriented. It was the chief upholder of the medical models in the community. Members of its faculty served as consultants to the other area hospitals, including the state psychiatric hospital, and advised their staff on how patients should be treated.

The teaching hospital and some of the other area hospitals had community mental health centers affiliated with them. These were supposed to serve as psychiatric support centers so that their clients would not need to use the services of the state psychiatric hospital. The major types of service they offered were chemotherapy and supportive therapy of the sort practiced at the state

hospital's out-patient unit. Connected with the community mental health centers were programs known as "day hospitals". These were limited term treatment centers to which clients came in order to engage in activities such as occupational therapy and group therapy. Their purpose was to offer a haven of safety for clients during periods of crisis. By keeping people occupied and safe, it was hoped that they might not need round-the-clock hospitalization. By teaching them skills such as assertiveness, it was believed that they might acquire strengths which could prevent further psychiatric difficulties. In this way they functioned as an alternative to the state psychiatric hospital.

Other Rehabilitation Programs

The state VR agency often referred people to other agencies for the rehabilitation services it was believed were needed. Among these were the so-called "rehabilitation facilities". The most important of these for the clients whom I served were a program I will call The Workshop Agency and another I will call The Private Placement Program.

The Workshop Agency was primarily a sheltered workshop. It included an evaluation area, a woodworking shop, a clerical skills training area, a janitorial program and a large benchwork area. When originally established, its purpose had been to help retrain the physically disabled so that they could re-enter the job market. This physical orientation remained visible in the tasks used to evaluate its clients' work potential. New clients were asked to go through a series of tests measuring motor skills. They were asked, for instance to pick up small round pellets with tweezers, or to fold cardboard cartons, or to tighten screws on breadboards. From the way they performed these tasks, a profile of their physical disabilities was constructed.

The Workshop Agency had no comparable system for measuring psychiatric disabilities. This area of functioning was evaluated as a by-product of a client's performance on the physical tasks. If someone, for example, had a difficulty with authority which manifested itself in their deciding to perform assigned tasks in their own way instead of according to instructions, this was seen as illuminating their psychiatric state. An

effort was made to be responsive to the needs of clients in emotional stress by having a substantial social work staff attached to the agency, but the efforts of these social workers were largely auxiliary to those of the workshop supervisors who worked most closely with the clients and who controlled their activities on a day-to-day basis. Staff members, with whom I talked, freely admitted that they did not have the expertise or the facilities to handle the psychiatric clients I referred them, and complained that even if they did, the regulations of other state agencies, such as the labor department, would prevent them from fully using the resources they had. They would simply shake their heads and tell me that there were "rules to be followed".

The Private Placement Program was the subsidiary of a large, diversified corporation. It had established itself in business in Northern City to work in conjunction with the county's department of social services. Its object was to make a profit from the fees it charged for finding jobs for the clients who were referred to it. The program functioned by first evaluating the work potential of clients sent it. To do this it utilized a system of realistic work stations which had been designed and

manufactured by its parent company. The purpose of these stations was to determine what kinds of occupations clients liked and what kind they performed well. This information was then passed on to a placement specialist, whose task it was to help clients find competitive jobs. These specialists contacted employers and tried to sell them on the virtues of particular clients as potential employees. If necessary, clients were sometimes accompanied to job interviews by the placement specialists. This method of operation seemed to have real virtues, for though most of the jobs it got its clients were "entry level", the Private Placement Program's placement record was the best in Northern City. Because of this record, I often sent it clients who seemed to me to be job ready and who strongly expressed a desire for immediate employment.

Sources of Information

As an active participant in the psychiatric VR field, I obtained most of my information about how ideologies in the field work through this participation. It was chiefly through my interaction with others that I discovered what

was believed and how it affected what was done. Thus, I learned a great deal about client ideologies via my daily and intimate contact with psychiatric VR clients. Over the course of four years I worked with hundreds of them (at least four hundred), and did so under conditions which allowed them to express very personal, and often deeply felt, convictions. Most of the clients with whom I worked I saw on an individual basis and in a private office. Appointments were almost always scheduled for an hour, and allowed time for clients to express their feelings at some length. I also saw many clients in an informal way. We met in hallways, or in the lunchroom, or on the hospital grounds, and at such times they were often eager to tell me what was happening in their lives. Other contexts in which I saw clients included hospital planning conferences, rehabilitation facilities, and interviews held in conjunction with their families. In all of these instances, I took notes. I kept a steno pad propped on my knee during interviews in my office, and carried a pad with me when I went out for meetings. Because my note taking was so ubiquitous, most of my clients got used to it. Sometimes they felt that it kept me at a distance, or that what I was writing might somehow be used against them, but when counseling relationships developed, or when

an interview was dealing with important subjects, almost invariably my note taking was ignored.

As with clients, I learned a great deal about the ideologies of VR counselors, doctors, and VR administrators through my contacts with them. Some of these contacts were formal and work related. I talked to many counselors, either in person or over the phone, while we were coordinating our work with mutual clients, or during referral processes , or when we were comparing notes about clients' histories or how they interacted with us. Many of my formal contacts with VR counselors and doctors occurred during case conferences and planning sessions. With VR administrators, much of my contact occurred during supervision, or at VR agency meetings.

Informal contacts with my colleagues were probably just as important as the overtly work related in helping me understand their ideological orientations. Often I held casual conversations with the counselors down the hall, or at the end of case conferences, or during in-service training sessions. Most of these informal contacts were with counselors, few with doctors or administrators; and often they consisted of office gossip

or the comparing of notes about clients and caseloads. Frequently these conversations were attempts to cope with difficult situations. People asked one another what was happening in a particular instance and why they thought it was happening. Often, counselors just wanted someone to commiserate with.

Another important source of information regarding psychiatric VR ideologies was written documents. These virtually flooded past me. There were case records; mine, those of VR colleagues, and those of the hospitals and community mental health centers. There were also memos, and administrative bulletins, and staff minutes, and evaluation reports from facilities, and hospital discharge summaries, and so forth. I also made close note of what was written in staff newspapers, and in the professional literature, and, most especially, in the procedure manuals of the state VR agency. How these various documents explained what was being done with clients, or how an agency was supposed to function, gave me insight into the ideologies being used to define the psychiatric VR field.

Of special importance to me in understanding VR ideologies, were the frequent in-service training sessions

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I attended. The Northern City office of the state VR agency held these on a monthly basis, but there were others which were sponsored by the agency's central office, and still others by a regional training program funded by the federal government. These "in-services" were often explicitly ideological in their character, and sometimes fostered a candor about the workings of psychiatric VR which was very revealing.

After I had worked for the state VR agency for some time and was getting ready to analyse the data I had collected, I wrote up some detailed case records on some of the clients I'd worked with most intensively. I also compiled some chronologies on work I'd done with some other clients and on some of the inter-agency conflicts to which I had been a party. I reviewed my memos and notes, and started to develop ideas about how the ideologies were actually functioning. Some of these ideas surprised me, and in order to clarify my own thinking, I asked some of my colleagues how they perceived things. Their feedback helped me further refine my thinking, and led to some of the observations recorded in the chapters which follow.

Before proceeding to these, however, a caveat is in

order. Counseling is a very personal business, and as will be seen, a very moralistic one. Having been an active, and often very subjectively involved participant in the VR field, may well have colored my views in ways that even now I am not aware of. Nevertheless, I have endeavored to stand back far enough to provide an accurate and informative perspective on the ideologies of psychiatric VR.

Chapter III

ORGANIZATIONAL IDEOLOGIES

Ideology at the State VR Agency

The state VR agency by which I was employed was guided by not one, but several ideologies. It utilized medical, educational and moral models. To a much lesser extent, and generally through its counselors, it also employed psycho-social models. In order to understand how these models were used, we will begin with a historical perspective on the rehabilitation field, and then move on to discuss the current operations of the state rehabilitation agency and its local office in Northern City. We will observe the evolution of the concepts of "disability" and "rehabilitation", and in the end will be concerned with how the rehabilitation ideologies actually function within the state agency, e.g., how clients are

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selected, and how they are "helped". In particular, we will examine the role of ideology vis-a-vis the psychiatrically disabled client.

The concept of "disability" guides the state agency in deciding who its clients are and what is wrong with them, i.e., it delineates the "problems" the agency works with. The concept of "rehabilitation" tries to define what services are offered clients, i.e., it identifies acceptable "solutions". These two concepts are therefore not totally distinct. They are a part of a package; one in which "rehabilitation" is of the "disabled".

In the United States in the late nineteenth century, rehabilitation was largely a private matter. (For what follows, see Sussman, 1965; Obermann, 1968; Benney et al., 1978; and Anthony, 1980.) It was in the hands of independent philanthropies which were concerned with aiding injured seamen, crippled children, the blind and the destitute. The recipients of their concern suffered from palpable physical limitations, for which they were not personally held responsible. They were considered worthy of help, and the services they were offered aimed at their physical restoration and/or some vocational

adjustment. Toward the end of the nineteenth century, groups such as the Shriners raised money to help "crippled" children by providing them with medical treatment, shelter, crutches, and other of their needs. By the start of the twentieth century, "sheltered workshops" had been introduced. Organizations such as Goodwill Industries, which was affiliated with the Methodist and Episcopal Churches, encouraged the crippled to perform benchwork tasks at their factory-like facilities. In promoting these activities, they used mottos such as, "not alms, but opportunity" and "not charity, but a chance". Founders of this movement, such as Edgar James Helms, saw themselves as doing "good" works (Plumb, 1965).

In 1917 and 1918, the United States federal government entered the picture. It passed legislation mandating "vocational training" for disabled veterans (Smith-Sears Act - PL 178; Smith-Fess Act - PL 236). This was considered their due in light of their heroic efforts in behalf of their country. By 1943, and with the advent of another World War, it was deemed necessary to offer expanded services to injured veterans, and more medical services, including psychiatric ones, were offered (Public

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Law 113). Disability continued to be defined by palpable physical injury, but emotional damage was also recognized, and vocational rehabilitation was expanded to include "any services necessary to render a disabled person fit to engage in remunerative occupations" (Strauss, 1965).

In 1954, with the return of peace, legislation expanded federal rehabilitation assistance to the civilian population (Vocational Rehabilitation Act Amendments - PL 565). In doing this, the rationale for help was changed. Productivity, per se, was designated a desirable end. It was considered a means to personal independence, and was presumably valuable to clients themselves, and not just society.

The year 1963 saw yet another extension of federal support for rehabilitation. Now to be included in government aid programs was assistance for the mental health and mental retardation communities. Then President Kennedy left no doubt about the "humanitarian" aspirations of these changes; and it was well publicized that much of his concern derived from having a mentally retarded sister. By 1965, another amendment to previous legislation (Vocational Rehabilitation Act of 1965 - PL

333) helped expand the concept of disability by substituting the term "handicapped" for the phrase "physically handicapped" in several statutes. Finally, in 1973, new laws (the Rehabilitation Act of 1973) mandated that government supported rehabilitation programs must serve the "severely" disabled, and not just those with moderate limitations. Among other things, this meant that the chronic psychiatrically disabled, e.g., the chronic schizophrenic population, were also entitled to rehabilitation services.

It may thus be seen that since the nineteenth century, and at an increasing rate since World War II, the concepts of "rehabilitation" and "disability" have steadily been broadened. Where first they were concerned with palpable physical injuries, they have come to include the more intangible psychiatric disabilities. And where first rehabilitation connoted specific vocational skill training at workshops, it grew to embrace "any services" needed not only to engage in "remunerative employment", but even in "independent living", i.e., the ability to live at home and/or to travel in the community.

The concepts of "rehabilitation" and "disability"

have been truly "elastic" (Bloom, 1965), and, in part, for that reason more than a little vague. They have become exquisitely politico-social concepts readily adjusting to the social and political needs of the time. They have, in turn, been used by the socio-religious reformers who started the sheltered workshop movement, by veteran's groups reacting to the ravages of war, and by the friends of the mentally retarded and the mentally ill who believed that even the severely impaired deserved the dignity of "rehabilitation".

The concepts have first of all been part of the ideological framework of a moralistic "social movement" (Wessen, 1965). From its start, rehabilitation has been grounded in moral ideology, e.g., "humanitarianism". Organizations such as Goodwill Industries saw rehabilitation as giving dignity to the disabled. They saw it as an alternative to charity which enabled the disabled to help themselves. As the twentieth century progressed, those seeking to achieve the moral aims of the rehabilitation movement have increasingly turned to political institutions to help them realize their goals. It is therefore no accident that the state VR agency is a governmental body, and that its political mandate has

moral roots.

Educational ideologies have also been part of the historical legacy of the rehabilitation movement. The early rehabilitation workshops were conceived of as ways of "training" the physically disabled to do real work despite their physical limitations. Rehabilitation might have been initiated for moral reasons, but it was the lack of a marketable "skill" which was understood to be the deficit which "handicapped" the disabled, and this problem was to be remedied by teaching them new skills. Indeed, when the federal government entered the rehabilitation field in 1918, it specified that the disabled were to be given "vocational training" (Allan, 1958).

As rehabilitation expanded to deal with the broader and more insistent injuries of war veterans, medical ideologies increased in saliency. The physical and emotional restoration of the terribly maimed became a major concern. Since this was a time when medicine was making extraordinary strides, it was asked to do what it could in the rehabilitation process. Eventually, medicine and its institutions took a leading role in this endeavor, and many came to define rehabilitation as a sub-specialty

of medicine. For example, Bloom (1965) in an article on the rehabilitation process, calls it an "aspect of healing".

Of special concern to us is the fact that since the nineteenth century medicine has won increasing favor in defining "insanity", "lunacy" and "craziness" as "mental illness". This ideological achievement facilitated the 1963 rehabilitation act's extension into the "mental health" field, and in so doing helped define what is meant by the "rehabilitation" of the "psychiatrically disabled". It firmly established the medical models as an integral part of this area of rehabilitation.

Today, though the psychiatrically disabled represent almost 40% of the caseloads of state rehabilitation agencies (Rogan, 1980), medical models for the specific rehabilitation of these clients remain sketchy. Medical models began with physical restoration, and their deepest analogies remain physical. There seems to be no distinct medical model for the rehabilitation of the psychiatrically disabled. Thus the Fifth Institute's manual on the "vocational rehabilitation of persons with mental disorders" (Benney et al., 1978) counsels that "the

nature of the relationship of the vocational rehabilitation counselor working with a mentally disordered client is essentially no different than that necessary when working with any vocational rehabilitation client". The only acknowledged exception to this is that the psychiatrically oriented counselor must sometimes cope with "bizarre" client behavior.

A recent federal pamphlet (1980) aimed at vocational counselors working with the "mentally restored" tells them that the most important tool they need in their job is "common sense". In other words, no special rehabilitation techniques are seen as applying to the psychiatrically disabled, and no special ideology has been geared to the needs of this population. To understand the full extent to which physically oriented ideology dominates the rehabilitation field, one need only observe that in the "Disability and Rehabilitation Handbook" (Goldenson, 1978) of the 420 pages devoted to describing disabling disorders, only 15 pages are set aside for mental illnesses.

State vocational rehabilitation agencies have ganerally been set up to comply with federal mandates, so

their ideological underpinnings reflect the growth of federal vocational rehabilitation programs. They too proceed from a moral base, and utilize both educational and medical perspectives in understanding their tasks. In a pamphlet designed to explain its programs to potential clients, the state VR agency I worked for declared that: "vocational rehabilitation is a process designed to develop - improve - restore - a handicapped person's ability to work." The services it promises to provide are: 1) individual counseling and guidance, 2) medical examinations, 3) physical restoration, 4) instruction and training, 5) transportation and 6) individual job placement. Thus, in its public presentations, the agency portrays itself as seeking to help people, and on the operating level, this is translated into an offer of primarily medical, educational and placement services. Counseling and guidance are also offered, but as will be seen (e.g., in chapter 6) these are supposed to be used mostly to guide clients into appropriate medical, educational and placement services, and not to change people, per se, as "therapeutic" counseling might.

In current practice, the organizational backbone for the delivery of rehabilitation services within state

vocational rehabilitation systems is the scheme of so-called "client statuses". This record keeping device and service control mechanism, which has been described in chapter 2, is a direct response to federal legislation, and reflects distinctly educational and medical philosophies. It is a scheme which was instituted for work with the physically disabled, and has not been changed to reflect more recent emphases on psychiatric disabilities. It offers little evidence to indicate an awareness that the latter may require a different rehabilitation approach than the former.

The status system, as it is presently constituted, contains some implicit ideological implications. It will be recalled that in order to enter status 10, the plan forming status, a counselor first had to determine if the client were eligible for VR services. A determination of "eligibility" demands 1) the documentation of a client disability, 2) evidence that this results in vocational impairment, and 3) reason to believe that rehabilitation efforts have some likelihood of improving the client's vocational performance. Step (1) is the most important part of this process, for if a "disability" is established, then step (2), vocational impairment, almost

always follows, while step (3), so-called "feasibility", becomes a matter of counselor judgment, which in practice is often decided by a client's program performance, or by the quality of the counselor - client relationship.

In order to facilitate the decision about whether a client has a substantive disability, state VR agencies provide manuals which define disabilities. Thus the agency for which I worked indicated that the eligibility factors for "mental illness" were: "1) a diagnosable DSM III disorder; 2) not of a temporary or transitory nature; 3) a substantial loss of vocational functioning; (and) 4) in or a graduate of a recognized treatment program, which holds a promise of ameliorating the condition and improving the prognosis". In practice, this has meant that VR counselors have been required to obtain a signed referral from a medical doctor, one which includes a diagnosed "medical" disorder. The effect of this procedure has been to freeze medical ideology into the structure of the rehabilitation program. Rehabilitation of psychiatric disabilities is automatically described in medical terms, and M.D.'s (and some Ph.D.'s) allowed to do an initial screening to see if a person is a valid candidate for rehabilitation services.

When a client is in status 10, the counselor and the client are supposed to engage in planning activities. They are required to decide what sort of service is appropriate to the client's circumstances. When a vocational rehabilitation goal has been decided upon, the client's case is supposed to be changed into one of the service statuses. The three available service statuses, 14, "counseling, guidance and selective placement", 16, "physical restoration", and 18, "training", are part of a procedure which presumes that planning and rehabilitation can and should follow an orderly course. Before statuses 14, 16, or 18 go into effect, a vocational goal is presupposed. A statement and justification of this goal are required on the planning form necessary for the status change. This practice was put into effect when the state and federal governments were working primarily with the physically disabled. Since most of these clients entered vocational rehabilitation with some idea of what they wanted to do, and/or with the ability to make rational decisions regarding their future, the logic of the status system fit their circumstance. With the advent of the psychiatrically disabled client, however, things changed dramatically.

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Psychiatric clients often don't know what they want to do, or are too frightened to make a personal vocational choice when they enter a vocational rehabilitation program. For example, when state psychiatric hospitals were trying to "deinstitutionalize" patients, hospital staffers put a great deal of pressure on patients to seek a job. Patients then came to vocational rehabilitation counselors claiming that they wanted to work, when in fact they did not. The result was that clients were often placed in training before it was discovered that they really had no vocational goal at all.

More importantly, psychiatric client's goals are often intimately entwined with their psychiatric symptoms. Thus it may happen that the same fear of a parent which led to mutism may also lead to a vocational goal which is based upon parental, not client wishes (see cases discussed in chapters 5 and 7). In this sort of instance, guidance and counseling, and even training, might justifiably serve the purpose of helping to establish a vocational goal, and not be dependent upon an artificially pre-established goal. Nevertheless, such a goal is required at the start of statuses 14, 16 and 18.

VR counselors and state VR agency administrators all recognized that pre-established goals were often not efficacious for the psychiatrically disabled. In fact, I was warned about this problem during a training session at the state VR agency's central office when I started the job. In practice, counselors often change client goals and goal plans when events in counseling or training so dictate. Fictitious goals are not closely questioned by supervisory staff, and should a plan lapse, a client can be left in a status with no active plan at all until a new one is evolved.

Nevertheless, the conceptual underpinning of the status system has not been adjusted to meet the realities of work with the psychiatrically disabled. This is, in part, because rehabilitation's ideological roots rest on medical and educational models derived from work with the physically disabled. A consequence of this is that there exists an ideological bias built into the status system which encourages counselors to treat the psychiatrically disabled as if they had a physical disability, e.g., as if they were prepared for the rational sort of goal planning expected of the physically disabled.

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Statuses 14, 16, and 18 reflect the type of service which the VR system anticipates providing its clients. Despite its well balanced appearance, there are biases in this tripartite service scheme besides the over all physical bias of the status system itself. The way the three service statuses are used in vocational rehabilitation is strongly weighted in the direction of educational models. Thus, though status 14 (counseling) and status 18 (training) are both applicable to psychiatric clients, it is status 18 (training) which has found the most organizational favor with the state VR agency for which I worked, and which reflects an agency tilt toward educational versus psycho-social models of rehabilitation. Referrals to external programs, which are almost invariably thought of as "training", were considered to be "real" services. They were bought and paid for and could be documented, while the counseling provided by the agency's own counselors was regarded as ephemeral and insubstantial. Referrals for educational services were systematically encouraged by the VR agency and its the status system; while lengthy counseling was actively discouraged. As will be seen in chapter 6, the director of the state VR agency believed that

"therapeutic" counseling, by which he meant lengthy counseling, was not the agency's business.

In my caseload, I averaged four or five clients in status 14 (counseling) and forty to fifty in status 18 (training). (Most of my other clients were in referral (00) or applicant (02) status). While I have not been able to obtain agency-wide breakdowns of clients in these statuses, an informal examination of the case lists of VR counselors in my local office revealed a ratio similar to my own. This overwhelming preponderance of training plans, as opposed to counseling plans, is thus no accident, and seems a reflection of agency policy.

While counseling is virtually the only service the state VR agency is set up to provide directly with its own personnel (i.e., with the VR counselors), it is training services which it uses to sell itself to potential clients and referral sources. My agency referred most of its clients to schools, training facilities, workshops, and/or placement programs, and it usually had to pay these organizations for their services. When agency representatives talked to potential referral sources, it was these re-referrals which were emphasized. Thus, when

the director of my local VR agency office was asked to explain VR to the out-patient staff of the state psychiatric hospital where I was out-stationed, he began by telling them that VR counselors spent an average of \$100,000 per year on client services such as training and placement. Subsequently during this same presentation, I was delegated to detail the nature of the training and placement facilities we used. By prior arrangement, it was decided that I was not to mention the agency's own counseling services lest friction arise, this though I, a VR counselor, was physically present at the meeting.

We followed this plan because VR agency money for the purchase of training and placement was very attractive to other agencies. It was seen as enabling them to provide services that they could not provide directly, e.g., vocational training. Counseling, on the other hand, was a service most psychiatric organizations felt themselves pre-eminently qualified to provide. They conceived of themselves as "therapeutic" specialists, and VR counseling was perceived of as unwarranted competition (see chapter 8 on ideological conflicts).

Though a recent revision in the state VR agency

procedure manual (1981) noted that VR counseling with psychiatric clients was likely to have "therapeutic" overtones, agency personnel were not oriented to defend such counseling, and were more likely to conceive of themselves as referral specialists (see chapter 4). Virtually all were untrained in counseling psychiatric clients; few received support for counseling efforts from their superiors; and most had learned through unpleasant personal experience that attempts at intense counseling led to conflicts with medical or other rehabilitation staffers. These circumstances thus tended to favor the use of training programs and the educational models upon which they were based, rather than counseling and the psycho-social models upon which it more comfortably rested. Hence, psycho-social ideologies tended to be personal matters among counselors and to have little official sanction.

Other agency sanctions also favored a training orientation. For example, the agency's need for paperwork encouraged training referrals. Referrals needed documentation, and documentation was a palpable sign that something had been done. Monies were dispersed, plans were written, and "rehab" obtained, and all of these left

tangible evidence of a job accomplished. These paperwork trails could then be condensed and forwarded to the state agency's central office or to Washington as proof of something done. The result of this was pressure for "documentation", which on the local level manifested itself in the fact that the local office director never inquired about how counselors worked with their clients, but rather judged counselors by tabulations of the numbers of clients they had made eligible, or referred to program, or "rehabed". (Similar phenomena occurred at a state employment agency studied by Blau (1963), and are apparently very common in government human service organizations.) Since paperwork was based on referrals, and referrals were usually for training, training became a preferred option.

A further device, which was built into the agency's status system itself, and which served to encourage a training orientation, was the "asterisk system". Each counselor received a monthly compilation, a so-called "master list", of all his clients. These lists were organized by client status, and one column showed the number of months that a client had been in a given status. It had been decided at the state central office that

clients should remain in certain statuses for only a specified period of time. If this time limit was exceeded, then an "asterisk" appeared beside the client's name on the master list, and supervisory pressure was exerted to eliminate the asterisk.

Status 14 (counseling) was a category with a time limit and was subject to asterisks. If counseling lasted for more than a year, then the counselor needed an explanation, or he needed a referral or a closure. Status 18 (training), on the other hand, had no time limits or asterisks. Training could presumably take a long time, e.g., college programs might easily last for four years, and therefore was not subject to pressures for quick action. The result was an organizational bias in favor of training. Indeed, many clients in status 18 were doing nothing. They had been in training programs which either had not been completed or which did not lead to employment, but since there were no asterisks, and no one asked questions, they could comfortably be left in this status. Theoretically, their statuses should have been changed by their counselors, but since a change might eventually lead to asterisks, and more supervisory pressures, there was a tendency for counselors to leave

clients in status 13 though they were no longer in training. This then was another structural bias toward training which transcended individual counselor preferences.

The historically rooted physical and educational orientations of governmental vocational rehabilitation thus made themselves felt on the state and local level. In the specific area of "psychiatric" disability, local practice very closely reflected larger governmental policies and thus changed when federal policies changed. It was not until the late 1960's that Northern City's VR office began dealing with mentally ill clients, and in this followed federal legislation mandating work with the psychiatrically disabled. By 1972, the local agency office was outstationing a counselor at the state psychiatric hospital. After the advent of the 1973 law requiring that VR agencies work with the severely disabled, the number of VR counselors at the state psychiatric hospital grew to three. At that time, work with the psychiatrically disabled was described by the local office director as having become politically "glamorous".

During the mid-1970's, the state agency experienced a time of expanding budgets, and a "can do" attitude toward psychiatric rehabilitation prevailed. Indeed, the state VR agency fought the state mental health office for the right to rehabilitate psychiatric clients, and it won. By 1980, however, the prospect of reduced budgets led the state VR agency's central office to demand increased numbers of vocational "rehab" in order to justify its accustomed levels of spending. This, in turn, forced both the state central office and the Northern City local office to confront the fact that few rehabs were being generated from work with chronic psychiatric clients, and so rehabilitation of these clients was de-emphasized, and even considered for elimination. At the local state psychiatric hospital, the number of state VR agency counselors was reduced from three to two and then to one. Over all, Northern City's VR office saw the elimination of four psychiatric caseloads out of a total of eleven.

Even during the glamour days of the psychiatric caseload, neither the local nor the state VR office provided any special training or support for counselors doing this work. Locally, there was a psychiatrist who functioned as the office's psychiatric consultant, but his

chief role was to verify that clients had psychiatric disabilities. He was rarely used to provide insight into how to counsel clients. Clients could also be referred to local Ph.D. psychologists for vocational testing. Since this included personality surveys, these tests did serve to aid psychiatrically specialized counselors in their work, but only to a very limited degree.

Within the local VR office, psychiatric competence and/or commitment was rare. The one senior counselor who specialized in working with psychiatric counselors got his job by default because no other senior counselors wanted it. He then learned his job on his own by trial and error, first employing the methods he had used with the physically disabled, then learning to make modifications in his style, e.g., in the way he used the status system. Eventually he came to feel that his task was hopeless and he resigned from the agency. When he left, there was no supervisory staff at the local office with special competence in the psychiatric field, and thus there was no one in the office to whom psychiatric VR counselors, especially the counseling oriented ones, could turn for support. In any event, as we shall see in more detail later, few counselors had a deep commitment to the

rehabilitation of the psychiatrically disabled. Local office psychiatric counselors tended to leave these caseloads as soon as they could and were usually replaced by junior counselors new to the office.

In sum then, the state rehabilitation agency can be seen to have had its origins in a moralistic social movement, which continues to give an over all flavor to the agency's mission. Originally, vocational rehabilitation was supposed to give the "worthy" "crippled" the dignity of being able to help themselves, and the state VR agency continues publicly to represent itself as helping the handicapped (for more details, see chapter 6). The specific shape of its policies, e.g., the clientele it serves, are grounded in the political mandates which emerged from this social movement. Early rehabilitation ideology was also educational in character, and this aspect of it has clearly been preserved in the current agency orientations toward training. Medical models too have been grafted onto VR agencies, largely to define client populations. Though these models have had their origin in the treatment of physical injuries, they have emerged to define a category called "mental illness", and this in turn has defined "psychiatric" disability. No

separate model for the rehabilitation of the psychiatrically disabled has developed, however, and so educational programs are favored for what are presumably medical problems. This has resulted in psycho-social models playing only a marginal rôle in the rehabilitation of psychiatric clients. What constituency there has been for psycho-social models has not the VR agency per se, but rather its counselors; namely those in the agency who have the most client contact, and who in name, at least, are responsible for "counseling" services.

The above ideological melange bespeaks a deep identity confusion regarding the nature of vocational rehabilitation, especially for the psychiatrically disabled. This is reflected in the very names which are used to describe the people who work directly with VR clients. In the 1920's, they were usually called VR "agents". In recent decades, the term "counselor" has been favored. Most recently, the state adjacent to my own began calling its counselors VR "representatives". It should also be noted that in this state the VR agency is a part of the state labor department, while in my own state it is part of the state education department. Thus, even at fundamental levels, there is ambivalence about whether

training, or employment, or counseling is the major task at hand. It will be my contention, as this report unfolds, that this is because rehabilitation, and in particular rehabilitation of the psychiatrically disabled, is most influenced in its operations by moral ideologies, and that one of the most salient characteristics of these ideologies is ambiguity. The state VR agency is deeply committed to giving the public appearance of helping the disabled, but in order to do this must tolerate a considerable amount of ideological confusion. The full extent of the moralistic orientations of psychiatric VR will only gradually be revealed, but it is interesting to note that moral models tend to be invisible to those who use them, and are often clothed in the guise of medical and/or educational and/or psycho-social ideologies.

Ideology and the State Psychiatric Hospital

Other organizations, besides the state VR agency, which specialized in working with "psychiatric" clients, also had ideological perspectives built into their structures. Probably the most important of these organizations in Northern City, certainly the one which

worked with the largest number of them, was the state psychiatric hospital. This was where my office was, and where most of my clients came from. In the early 1970's it had been renamed a "psychiatric center", and it patterned itself after hospitals concerned with physical disease. It was constructed very much in accord with medical models, and thus it had "wards", "doctors", "nurses", hospital type beds, white uniforms, medical language and medical "charts". Its major "treatment" modalities were "hospitalization", per se, and "psycho-active" drugs. It also dabbled in other modalities, but these were of secondary, and often transitory, importance.

State hospital procedure in many ways imitated physical hospital procedure. A new "patient" initially went through "intake" procedures. Here an attempt was made to see if the potential patient had a "diagnosable" "illness", and was therefore subject to hospitalization. Records of this first examination invariably began with a notation about the clients "complaint"; this in imitation of the physical complaints which patients brought to hospitals specializing in physical medicine. A sample of these complaints lifted at random from hospital records is

as follows:

- "I don't have any complaints. My brother-in-law has."
- "I don't need to be here."
- "I'm nervous and unable to sleep at night."
- "I feel the loss of control of my emotions."
- "Because everyone was forcing me to.... but apparently I'm dead." (This seems to have been a response to the question "Why are you here?")
- "I need rest."

The artificiality of many of these so-called medical complaints is apparent. Their main purpose seems to be to maintain a medical appearance.

Also included in intake procedures, and also very artificial, was the "mental status examination". This was generally very brief and usually very stereotyped description of how the "patient" appeared during intake. Common in these were descriptions of the person's mood and feeling tone, e.g., "flat affect"; and standard phrases appeared time and again, e.g., "patient appeared stated age", or "grooming poor".

Analogous to the intake summary was the discharge summary. It briefly recounted the course of the patient's hospitalization, and recorded the "disposition" of the patient at its conclusion. It invariably included a "diagnosis". In the past this followed the DSM I, then the DSM II, and most recently the DSM III. Again, this was imitative of physical hospital procedure.

While associated with the hospital, either as an in-patient or an out-patient, all clients required "treatment" plans. These too were ideologically stylized instruments. At the state hospital, out-patient "therapists" (who were usually psychologists, social workers or nurses) were required to enumerate a series of patient "problems", e.g., "does not socialize well", or "poor vocational adjustment", and then had to enumerate the "goals" of treatment, e.g., "improved socialization", or "competitive employment", and then the specific "treatment" modalities to be used, e.g., "supportive therapy", or "psycho-tropic medication". Therapists were asked to record observable behavioral problems, to seek measurable results, and to employ specifiable therapeutic interventions. One interpretation of this procedure is that it was an effort to make "mental illness" as

observable, and "psychiatric" interventions as "rational", as illness and therapy presumably are for physical disease. In any event, many therapists grumbled about these demands because they felt themselves to be working with ambiguous, unquantifiable, and very long term problems.

In the out-patient unit, and throughout the hospital, the highest authority was shared between doctors and administrators. Indeed this system had been formalized by the hospital's having separate medical and administrative directors. This reinforced the doctors' reliance on medical models as a source of their power. One result of this was their insistence that "treatment" be "medical". In the out-patient unit, this meant that a major task assigned to non-M.D. therapists was the quasi-medical function of supervising patient medications. The psychologists, social workers and nurses were required to be aware of what patient was taking what drug, to be constantly alert for untoward medication side-effects, and to insist that patients take their "meds". These tasks put them under close psychiatric supervision, for it was the M.D.s legal responsibility to be the final arbiter of medication decisions.

Nevertheless, close supervision of patient medications put non-medical therapists in the role of making regular recommendations regarding changes in patient medications, and since these were routinely accepted by the doctors, made control over medication a source of therapist power too. Thus drugs also tied them to the medical models.

Therapy, in large part, consisted of convincing patients that they had an illness, and of persuading them that medication was the way to health. Beyond this, "therapy" tended to be "supportive" and "directive". Patients were frequently told that "everything will be all right" and encouraged to rely on the authority of their therapists. If therapists thought that a patient was doing something dangerous, for instance, leaving a group home or the hospital "against medical advice", they often sternly warned against it. The object, though not often explicitly elaborated upon, was to do "covering therapy", i.e., not to "cure" a patient, but to "reinforce their defenses" (Nicholi, 1978) so that they could manage to sustain themselves in the larger community. This meant that psycho-social models received little reinforcement

from the demands the hospital made of therapists. Questions about patient psycho-dynamics were not prominent in patient charts or as subjects of case conferences. Questions about family relations and patient living conditions were much more an issue for patients themselves, and for therapists when they were talking directly with patients.

During my work period at the hospital, one of the major changes which occurred was an increase in the power of the out-patient unit. This was a hospital response to state demands that patients be deinstitutionalized, i.e., released to the community. To do this, an enlarged out-patient staff was required, and much of this growth came at the expense of the hospital's rehabilitation unit. Out-patient staff literally took over what had been rehabilitation offices and rehabilitation staff began performing what had been out-patient jobs, e.g., over-seeing group homes.

During this transition phase, in an attempt to demonstrate its value to hospital administrators, the rehabilitation unit put together a pamphlet ostensibly directed at its clients in which it glowingly described

its services. (Note: Few clients saw this pamphlet, and higher level hospital administrators apparently remained unimpressed because the rehabilitation unit was later reduced in size anyway.) It claimed to offer three major types of services, namely: "educational services", "personal-social services", and "vocational services".

Educational services were said to consist of tutoring in "reading, math, H.S. equivalency preparation, foreign languages, language rehabilitation, music and drama." "Education specialists" were assigned this task.

Personal-social skills were described as covering a broad gamut of skills necessary for "independent living". According to the pamphlet, this service would teach "planning skills, community orientation, consumerism, apartment management, weight loss, meditation, assertiveness", and much more. "Rehabilitation counselors" were in charge of this area.

The vocational services were described as including: "in-hospital jobs, a sheltered workshop, and pre-vocational groups". The emphasis of all these was on teaching work discipline and in imparting a vocational

outlook and motivation. This area was also the province of "vocational counselors", with some assistance from "recreational aids" and "workshop supervisors".

The educational orientation of the rehabilitation unit is patently visible in its list of services. Its staff members were not considered "therapists", i.e., they were not considered "medical". Some rehabilitation counselors thought the work they were doing was more "therapeutic" than that done by the hospital therapists, and they resented the therapists' occasional intrusion into their work, but they usually kept this opinion to themselves. There was thus a kind of friction between rehabilitation and the more "medical" units of the hospital. (In chapter 8, a similar kind of friction between the state VR agency and the state hospital's out-patient unit will be described at some length.)

This friction was much the same sort as has been described by Wessen (Sussman, 1965). He claims that in his observation medical units are not very receptive to rehabilitation philosophy. They believe that the medical doctor is the "superior", and treat patients as "dependent objects of procedure"; while rehabilitation is more

oriented toward "normality, and adjustment, and training". He claims that medically oriented personnel tend to think that they know what should be done for patients, while rehabilitation staffers often complain that other hospital personnel do not treat patients as people. This certainly seemed true of the state psychiatric hospital. At the hospital, rehabilitation was definitely subservient to more medically oriented units, and became more so with time. At the state hospital, medical models dominated the educational ones.

This pattern of medical dominance also existed at the Teaching Hospital, and at the community mental health centers. Chemotherapy, supportive therapy and directive therapy predominated; and therapy was given precedence over rehabilitation. This was so much the pattern throughout Northern City, that many counselors and therapists had come to call it "medical model city".

To reiterate then, at Northern City State Psychiatric Hospital, medical ideology was dominant. It was built into the structure of the hospital and into its stated objective, i.e., to treat "illness". Ultimately there was a great deal of moralism in the way the hospital practiced

medicine, but more will be said about this in chapter 5. Like the state VR agency, the hospital had its origins in a moral movement. It came into existence in the wake of Dorothea Dix's nineteenth century call for humanitarian places of "asylum" for the insane. Seeing itself as "medical", and ultimately "humanitarian", neither the hospital as an institution, nor its staff as individuals, held custodial ideals; this though much of the hospital's work was patently custodial, and widely acknowledged to be so. Rather, there was a resigned acceptance of this social control function, especially on chronic and geriatric wards where its reality was a part of everyday life. Patients were physically taken care of, and kept physically separate from the outside society, but these were not the conscious goals of psychiatric or social work staff members; "therapy", and "treatment" were their goals. Only when they were pointed out by an outsider, such as myself, were the hospital's custodial functions acknowledged.

Educational models were also a part of the hospital, and were built into the structure of its rehabilitation unit, but their role was clearly subservient. Education was an adjunct; not a major treatment modality.

Similarly, psycho-social models were present at the hospital, but were not built into its structure. What official sanction they got was as methods of coping with "functional illness". Rather, the psycho-social models were the province of individual practitioners, e.g., therapists. Many of those who had to work face-to-face with patients, and to deal with their many and sundry living problems, felt a need for "understanding" and for intervention techniques that went beyond those of the medical models.

Ideology at the Workshop Agency

A major referral resource of the state VR agency was the Workshop Agency. It was primarily a sheltered workshop which was funded in the main by the state VR agency, by the local community chest, and by the county department of health. It had started as a place for the rehabilitation of the physically disabled. In the late 1960's, it served a clientele which was 80% physically disabled and 20% mentally disabled. By the late 1970's, this ratio had been reversed. Nevertheless, the workshop

agency had been built in accord with an educational ideology directed toward helping those who suffered from a palpable medical trauma, and this remained true.

The man who was the agency's program director, an ex-state VR agency senior counselor, was himself physically disabled. He was a man of powerful personality, a man many of his subordinates described as "willful" and "arbitrary". He strongly believed that clients should work and be productive, and he believed in work discipline. If clients daydreamed or acted strangely, as some psychiatric clients were wont to do, he became very upset. On numerous occasions, he forcefully declared that his program would not be a "baby-sitting service", and summarily asked that a client leave the program. Almost invariably this would be directed at "mentally disturbed" clients, for he did not understand how they could be so obtuse. Appeals to him by his staff, or by state VR agency staff, rarely changed his decisions. For him, rehabilitation was a deep moral commitment, and he worked hard to maintain the structure and goals of his agency's program.

For most of its clients, the workshop agency's

program began with a five week "evaluation". Clients were asked to pick up metal pellets with tweezers, and to perform similar tasks, and the quality and speed of their work were assessed in an attempt to gauge their physical limitations. The questions asked were about "fine motor dexterity", and "hand-eye coordination", and so forth. When dealing with amputees and others with physical disabilities, these were very important questions, but even the workshop agency's evaluation staff felt that they were largely irrelevant to the types of disability, e.g., disturbed social functioning, from which their psychiatric clients suffered. Nevertheless, physical evaluations were what the workshop agency was set up to perform, and no one expected that to change. A physical orientation was part of the agency's identity.

If a client passed his initial evaluation, more than likely he would be referred to the agency's workshop. This was a very large room in which clients, usually seated at benches, worked on such tasks as collating company reports or disassembling and cleaning small plastic parts. For this clients were paid on a piecework basis at rates which averaged half of minimum wage. If referred to the workshop through the state VR agency,

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these clients were described as being in personal adjustment training (PAT). Though they received no special instruction, and were treated as low status employees, the rationale for calling this "training" was that the clients were presumably being taught work tolerance. Efforts were made to get clients to work longer hours, to be disciplined in their work habits, to increase their production levels, and above all to have good attendance records. This was done largely through exhortation by the workshop staff. Clients were expected to be compliant, and indeed often literally to say "yes, sir" when answering workshop staff. There was a very moralistic tone to this whole endeavor, and the general assumption was that a work ethic must be instilled in clients. When urged, e.g., by a VR counselor, to be less demanding of a particular client, or to try to understand why a client was being "resistant" in a particular case, workshop staff members were wont to insist that "standards must be met". On one occasion, when I asked why this was so, the workshop counselor simply shook his head and repeated, "standards must be met".

To some extent, this insistence on standards was a product of the federal and state regulations which the

workshop had to meet. The department of labor set standards for hours and pay; and funding agencies demanded that the workshop meet a percentage of its costs through its own efforts. This meant that workshop clients had to produce, or be replaced by clients who could. Nevertheless, the "moralism" that accompanied these very real constraints seemed more a response to the "social agency" aspirations of the workshop, than to the need for meeting external demands.

These social aspirations were specifically manifest in the social work and psychology staff that the workshop agency maintained. Each client was assigned a social worker, and she was to help the client with personal problems or workshop adjustment. In practice, this meant that social workers acted as an adjunct to the workshop. Often they were reduced to appeasing clients when things went badly on the workshop floor. Many social workers wished to have a more "therapeutic" function, but in the press of keeping production levels up, none was able to sustain such a role.

Ideologically the workshop agency was a mass of contradictions. While structurally it proclaimed itself

to be doing training, in reality it followed more of a moral model, -one dedicated to a "work ethic". Once, perhaps, it actually did train the physically disabled to work around their limitations, but now key personnel were frustrated because its evaluation and workshop apparatus did not seem to have the desired effect on its new, psychiatric clientele. The assumption, therefore, became that something must be wrong with the clients for not meeting the "standards". The workshop agency's primary moral goal was not to help individual clients attain the personal dignity of work independence, or to help them meet their own needs, but more a matter of: "if you can work, then you should."

Medical models had only a marginal place at the workshop agency. They helped identify its clients, and perhaps helped maintain its heavily physical orientation, but they provided few techniques for working with the psychiatrically disabled. As at the state hospital and the state VR agency, the psycho-social models were restricted to personnel responsible for one-to-one interactions with clients about "problems of living", i.e., in the workshop agency's case, the social workers. Yet psycho-social models were not part of the agency's

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system, and so social workers were frustrated in their attempts to use them.

Ideology at the Private Placement Program

During my stay with the state VR agency, one program increased dramatically in the number of referrals it received from psychiatric VR counselors. This was the "Private Placement Program", and it gained its popularity in what seemed direct proportion to the workshop agency's loss of favor. On several occasions during which VR counselors favorably compared the placement program to the workshop agency, I heard them comment that for the former placement was a "job" and "not a mission". These counselors seemed to feel that the private placement program was relatively non-ideological compared with the workshop agency.

In the late 1960's, the placement program, which, as has been noted, was a private company which aimed at making a profit, had obtained a contract to place county welfare clients in competitive jobs. It was not until the mid 1970's that it became active in placing VR agency

clients. The company got into the placement business because its parent corporation manufactured educational aids , i.e., projectors and audio cassettes, and it was felt that these devices could be adapted to evaluate readiness for employment. This was accomplished by employing these aids to present a battery of tasks to clients and then assessing how well they did. If a client showed an aptitude for work in one or more areas, he was deemed a suitable candidate for placement, and he was immediately forwarded to a placement specialist who personally worked with him in searching for a job.

The placement program also had an educational area chiefly designed to improve client math and reading skills, and it conducted "groups" to teach interview and "job survival" skills. These activities would seem to indicate that an educational ideology pervaded the placement program, but in practice they functioned largely to give clients something to do during the up to five months they might be in placement. The parent corporation's expertise in educational aids was the route through which the placement program got into the placement business, but once established in this area, its selling point with its clients was that it got people jobs. The

private placement program, the local state VR agency office, and the individual VR counselors all concurred that the placement program was 80% successful in obtaining jobs for clients who truly wanted to work, e.g., as judged by who stayed in program and who went out job hunting. A better than average placement rate (though less than 50%, to judge from my caseload) even seemed to hold true for the psychiatric clients.

This was a remarkable record, and brought the company the business it desired. It was also a record which fed upon itself, for state VR agency counselors referred the placement program the clients they felt to be most job ready, i.e., those they expected to actively engage in a job hunt, and whose overt behavior was socially acceptable enough to suppose that they might be capable of holding competitive employment. These clients were often the "cream" of the counselors' caseloads, and needed little counseling to begin with. For its part, the placement program did not advertise itself as rehabilitating clients, and it did not attempt to alter bizarre client behaviors or to teach specific job skills, but if it successfully placed a client, the state VR agency counted this as a rehabilitation.

At no point in its history was the private placement program a social agency, and few of its personnel had such aspirations. Much of its staff was young and had worked no place else; some had worked for the state labor department; none were social workers, or psychologists, or "professional" counselors. Their attitude was pragmatic, and their methods flexible. While occasionally they made moralistic statements, e.g., about client hygiene, for the most part they listened to clients, to VR counselors, and to personnel directors, and they adjusted. Thus in one instance a program admission counselor called to tell me that she was terribly upset because she had discovered that a newly referred client of mine had been in their program several years before and at that time he had been very disruptive. She expressed a fear of a repeat performance. After a few words from me, however, to explain why I had referred him, she calmed down and agreed to give him another chance. As it turned out, this client subsequently moved on to placement and then a job, and at no point in this process was he confronted with moralizing about his past failure.

Ideologically, the placement program operated neither

on medical, educational, moral nor psycho-social models. Rather, its structure, tone and methods were "pragmatic". Its ideology, if it had one, could be called a "placement" or "personnel" ideology. It did what worked, and it did what it was in the business of doing, namely, placing people in jobs. Neither its personnel, nor its paperwork were much interested in medical diagnoses. There was little concern for "training" anyone, nor for the moral benefits of work, nor for the intricacies of psycho-dynamics. The questions asked were, "Can the client work?" and "How can we get him a job?" For the placement program and its staff, employment contacts were more important than ideological justifications.

Chapter IV

COUNSELOR IDEOLOGIES

Staff Ideologies

Up to this point, we have chiefly been concerned with ideologies current in some of the major institutions in the psychiatric vocational rehabilitation field in Northern City. Our interest has been in how these organizations reflect in their histories and their structures the five clusters of ideologies which have been outlined. Now we turn to explore how individuals within these organizations come to hold and apply rehabilitation ideologies. It will soon become apparent that staff members do not always share the perspectives of the organizations for which they work.

First, within a given agency, different personnel

may, and in fact do, tend to hold different views. Some of these differences are personal, but many are connected with their different occupational roles. Counselors do not have the same tasks to perform as administrators; nor do administrators perform the same jobs as doctors. It should, therefore, be no surprise that they have different perspectives on rehabilitation, and that they emphasize different ideologies. Because they do different jobs, they tend to define their "problems" and preferred "solutions" in ways that meet their separate needs.

Second, there is a difference between the formal and informal aspects of organization. Thus while the state VR agency had statuses and procedures which officially specified how clients were to be worked with, the counselors who had to deal with these clients faced demands and pressures not always envisioned in the official rules. The status system reflected an orderly application of medical and educational models, while the counselors charged with implementing it often found themselves confronted with non-orderly clients who, for example, were not always able to set up realistic vocational goals prior to referral to a training status, and who often were best understood and worked with using

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psycho-social models. Since the official structures of organizations can never fully reflect all of the interactions going on within them, members always find a need to improvise some normative, and in the VR case, ideological expedients which reflect them more clearly.

Furthermore, staff members are individuals. They come to their jobs with different backgrounds and goals, and they understand the world and their parts within it differently from one another, and differently from their employing agencies. They bring their own private demands to bear upon institutional policy, and in the final analysis often perform their jobs by their own lights. Personal moral ideologies, for example, often decide how counselors will do psychiatric vocational counseling, and given the very personal and private nature of counseling this is an outcome which organizations such as the state VR agency find it virtually impossible to preclude.

One of the more salient features of the psychiatric VR field is the exceedingly fine division of labor within it. Very many occupational roles have been distinguished, though many of these encompass very similar tasks. Thus VR counselors, social workers, psychologists,

psychiatrists, recreation counselors, occupational therapists, and education specialists all do some vocational counseling with clients. This division of labor, to some extent, seems to be an historical artifact, and to reflect the division of labor of the various disciplines which over the past century have come to work with psychiatric patients, rather than to reflect the tasks individual counselors and others perform today. Therefore, instead of specifying the ideologies of all of these specialties, the analysis which follows will combine similar roles into over-arching categories and will take note of sub-group ideologies only when they show significant deviation from the norm. The larger occupational categories with which we will be concerned are: 1) counselors, 2) psychiatrists (and attendant medical personnel, e.g., nurses), and 3) administrators. Our analysis will begin with the counselors, and within this group special emphasis will be put on the ideologies of state VR agency counselors. Also of special concern will be the ideologies of rehabilitation counselors employed by the state psychiatric hospital. Both of these sub-groups, it should be observed, have extensive client contact, and have specific responsibility for facilitating vocational change and development in their clients.

Counselor Professionalism and Ideology

Marvin Sussman (1965) in his sociological analysis of the rehabilitation field has concluded that "the counselor role is the crucial operating one in the rehabilitation system" and that "counseling around vocational goals is the predominant activity of the rehabilitation counselor." He observes that though VR counseling might be expected to be professional work, it apparently is not. Rehabilitation counselors are typically salaried employees and not private practitioners. Moreover, theirs, he states, is an occupation which is not based on a body of "systematized knowledge". Sussman is thus not sure that professionalism is possible for rehabilitation counselors, or even that counselors would find professionalism desirable.

Sussman's study was done almost twenty years ago and since that time the VR counseling field has burgeoned. The National Rehabilitation Association (NRA) has attempted to establish itself as a professional organization, and several graduate schools have instituted

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programs designed to teach professional VR counseling. In reaching for professionalism, these organizations have sought to develop a body of specialized knowledge, and in this have relied upon what I have called "rehabilitation ideologies".

At the state VR agency, this movement has been reflected in the educational requirements which have been established for hiring (the equivalent of a Master's degree) and in the proliferation of special "in-service" training programs whose avowed purpose is the increased professionalism of counseling staff. The agency operated its own training unit, and periodically brought counselors to the state capital for one to three day sessions on specific topics. It also encouraged local VR offices to run monthly training sessions, and so in Northern City all local counselors gathered one afternoon a month at the local central office to be instructed on some locally chosen and arranged topic. There were also federally funded training sessions for which counselors could volunteer and which were conducted under the auspices of a regional university's VR graduate school

All of these in-service providers featured several

different types of training topics, the most important of which may conveniently be identified as: 1) medical information, 2) counseling techniques, and 3) caseload management. Of these, the first embraced medical ideologies, the second, educational and psycho-social models, and the third, technological rather than ideological paradigms.

Medical sessions typically identified a disease, provided basic physiological information about it, discussed its medical treatment, and concluded by examining the rehabilitation ramifications of the disease process and its treatment. In the case of heart disease, for instance, this would entail a discussion of the mechanisms of myocardial infarctions, would include a description of heart by-pass operations, patient medication and exercise regimens, and would conclude with a recitation of the vocational limitations imposed by these various factors.

Counseling oriented sessions tended to follow less predictable patterns. Thus the university in-service program featured separate offerings in "goal planning", "micro-counseling", "professional burn out" and "VR

counseling practice". All of these professed to help counselors to counsel better, and in order to do so provided counselors with both "theoretical" and "practical" training. Different sessions tended to be based on different counseling theories, e.g., "cognitive", "stress management", or "client-centered" theories, and then various exercises might be used to inculcate the skills being taught. These exercises might entail the use of video feedback, or the drawing up of preference lists, or active role playing. The usual idea was to get people involved so that they could learn by doing.

Caseload management sessions tended to focus on the bureaucratic mechanics of being a VR counselor. Their emphasis was on how to meet the strictly organizational demands made of counselors. They taught strategies for the effective use of time, methods of case recording, and required documentation practices. One session sponsored by the regional university aimed to provide "secretarial-counselor team training" and promised to cover topics such as "improved communications, resolution of conflicts, and defining job roles".

Medically oriented in service training sessions

typically accepted medical models without reservation. Most of these sessions dealt with physiological disabilities, and hence dealt more with medical practice than with ideology. Those sessions devoted to psychiatric disabilities were fewer in number (during my four year tenure as a VR counselor, neither the regional university, nor the capital city in-service unit provided any such sessions) and usually began with a medical doctor defining a "mental illness" (e.g., "schizophrenia" or "manic depressive illness") in strictly medical terms. These definitions were not questioned either by the presenter or by his counselor audience. In this regard, counselor professionalism defined itself through the acceptance of medical definitions of rehabilitation problem areas. It professed no unique body of knowledge for making such decisions.

Counseling training on the other hand actively sought to develop a unique VR counselor role. It did profess specialized knowledge, and presenters often stressed the need for professionalism in counseling. The counseling techniques offered were not based on medical models, but on educational and psycho-social ones. Of the counseling theories taught, "client-centered" ones were easily the

most prominent. They were endorsed by both regional university and state agency presenters, and were both educational and psycho-social in nature.

Client-centered theories, as taught to VR counselors (both at in-services and in graduate schools), were derived largely from the works of Rogers (1951, 1961), Carkhuff (1969, 1977), and Ivey (1978). It was assumed that counselors worked largely by "reflecting" client's thoughts and feelings back upon them and thus helping them to reach their own conclusions about how to solve the problems which brought them into counseling. Reflection was to be accomplished by active listening, by paraphrasing and summarizing client remarks, by interpreting clients' statements, and by occasionally confronting clients with their own contradictions (Ivey, 1978; CEPR2, 1980). All of these techniques, and others, were considered learnable skills, and were believed to be the core of VR counseling's specialized knowledge. It must be noted that the counselor's human qualities were also stressed, for it was felt that being "non-judgmental", "genuine", and "caring" (Carkhuff, 1969) were important factors in developing the interpersonal trust which made reflection work. In this case, it was

the use of experimental techniques to verify this fact which purportedly gave counseling its professional status.

Client-centered counseling had both educational and psycho-social roots. Its theorists were almost all attached to universities. The subjects of their ministrations were largely college students having adjustment problems. The counseling they offered promised better role adjustment and easier decision making. It was thus psycho-social in the sense that it focused on role change, but it was also educational in the sense that it was part of a larger educational context and often saw itself as providing a kind of self education. Not surprisingly, these theories have been most enthusiastically embraced by school counselors charged with solving student adjustment problems.

The client-centered theories as initially elaborated were never designed with the aim of rehabilitating the psychiatrically disabled. Counselors who attended rehabilitation graduate programs told me that they were taught that the counseling skills they were acquiring had universal application. They assumed, and their teachers assumed, that psychiatric patients would respond to

reflection techniques and to genuine human compassion. These counselors reported with some bitterness that this was not true. College students, they said, responded well to paraphrasing and interpretations, etc., but psychiatric clients did not. College students would talk and figure things out, while many psychiatric clients would sit back and virtually dare the counselor to help them. Without a subject who was actively talking and actively engaged in problem solving, these counselors found that their techniques led nowhere.

In response to this problem, and to the burgeoning number of psychiatric clients seen by VR counselors, a modified rehabilitation counseling theory has achieved recent prominence. Its chief proponent, William Anthony (1980), has argued that the major functions of rehabilitation counselors are: 1) diagnosing vocational limitations, and 2) building client skills. He puts less emphasis on talking to psychiatric clients in a therapeutic way, and more on deciding what to change and then accomplishing this through skill training. Anthony provides long tables of vocational skills and possible vocational limitations in order to facilitate the diagnostic process. He talks of "physical, emotional and

intellectual" skills operating within "living, learning and working" environments. A sample of some examples he gives is as follows: "being well groomed, losing weight, being punctual, listening, making friends, controlling one's temper, lifting heavy things, climbing stairs, asking for a raise, giving a speech...." As can be seen, these skills are very specific and potentially very numerous. According to Anthony, the counselor's professionalism is to be demonstrated in his ability to select relevant skill deficiencies and to provide ways to compensate for them (e.g., through classes in grooming, or workshops for discipline training, and the like.).

Anthony makes it plain that he does not expect vocational rehabilitation to cure psychiatric clients. He doesn't even expect that of psychiatrists. Rather he stoutly endorses the use of skill training to compensate for psychiatric disabilities and in so doing places counseling these clients within the rubric of the educational models. His conception of counseling abandons most of the notions of the client-centered theorists, and with them their psycho-social orientation. He sees psychiatric clients as learning to perform tasks, not as changing social roles.

Anthony has aimed his work specifically at making psychiatric vocational rehabilitation professional, and has attained sufficient recognition within the field to have had an entire issue of the Rehabilitation Counseling Bulletin (1980) devoted to his ideas. Nevertheless, most of the VR counselors with whom I worked were not familiar with his writings, and hence did not consciously use them. In fact, despite his professional stature, only two counselors I encountered indicated that they had read him.

Client-centered counseling and Anthony's educational model are two of the major professional ideologies which have been applied to the psychiatric VR field. Their introduction and dissemination have been part of an attempt to increase the professionalism of VR counselors, yet seventeen years after Sussman's analysis there is still a question about whether professionalism has or can succeed. Attempts at systematized knowledge (and/or ideology) have been made, but their acceptance remains problematic.

First, most VR counselors, to judge from the sample with whom I had contact, were not initially trained in the

VR field. Of the forty state VR counselors in Northern City, and the several score additional counselors I met at in-services and professional meetings, more than twenty told me that they had started their careers in the state job service and that they had switched to VR counseling because they thought it would be less bureaucratic. Two with whom I worked had been in the ministry, but could not find suitable church posts. Some had hoped to be social workers; one had started as a nurse; another's main interest was in English literature. Still others told me that they had simply been looking for a secure job working with people, that they had passed the civil service test for the state VR agency and when they were hired settled in. It is of some interest that none of the counselors with whom I worked reported that they had ever intended to work with the psychiatrically disabled. None reported having received any training to do so. Most who were assigned psychiatric caseloads got them when they started working for the state agency because other counselors with greater seniority had opted for working with other types of clients.

Second, professional ideologies were little used on the job (see chapter 9). Neither client-centered

counseling, nor detailed skill diagnoses were much performed by state agency counselors. Some state psychiatric hospital VR counselors did diagnostics and training, but almost no one referred to the professional ideologies when doing this work. There were few on the job discussions of how to improve counseling techniques, and though in private counselors frequently criticized absent colleagues for a lack of professionalism, few suggestions were made as to how counselors could become more professional.

Third, professional identification was in general weak. Few counselors read the professional literature, and meetings of the local NRA chapter were always sparsely attended. Pride in personal professionalism hardly ever manifested itself and I can recall but two occasions in four years when counselors asserted that they wanted to do a good job "in a professional manner". Once when a CMHC therapist asserted her professional rights by pointedly referring to herself as the "primary" therapist of a shared client, a senior counselor privately responded that in that case state agency counselors should start referring to themselves as "primary" VR counselors. Yet this burst of professional pride had no further

reverberations, for his suggestion was never mentioned again.

There were some exceptions to the non-professional orientation of most counselors, but counselors with professional VR training and/or a deep professional commitment were in the minority. One such, who by all accounts had spent his whole career advocating client's rights, was himself severely physically disabled by arthritis. His was a lifelong quest to improve his situation and that of people like him. He made it plain to me that he was passionately committed to client-centered counseling, but confided that no one else in the office was interested in such things and so he felt it prudent not to say too much about it. This counselor ultimately became physically incapable of working and retired. Subsequently he had an operation which dramatically improved his health and he asked to be reinstated. This request was denied, and he was told that one of the reasons for this was that he had always been "too client oriented", i.e., that he had worked too much for client goals rather than agency goals.

Another counselor with a professional orientation had

worked out-stationed at the state psychiatric hospital for five years and associated little with other state agency VR counselors. Ultimately, he decided to leave the agency and obtained a Ph.D. in VR counseling. He was well versed in the professional literature and often talked to select hospital personnel about counseling techniques. When he completed his degree, he got a job working for a local health agency. He told me that he was glad to be out of the state agency; that he considered his old job "paper pushing" and not VR counseling.

Still most VR counselors were not deeply committed to professionalism. Their situation was closer to that described by a long time hospital vocational counselor. She informed me that in her experience most counselors "just fell into their jobs". She believed that most had never intended to be VR counselors; that they had taken their jobs because they "couldn't find other work"; and that they stayed for the same reason. In consequence the ideologies of most of these counselors were little informed by professional ideals. Rather, they were closer to being independent operators with ideas of their own; what may be called "free lance ideologists". (Later, in chapter 9, we will also see that many counselors failed to

use professional ideologies because they had tried them and found that they did not work with psychiatric clients.)

Free Lance Ideologists

The lack of counselor professionalism did not mean that they were non-ideological. It meant instead that they were not strongly influenced by a shared and systematic professional ideology. Counselors had a great many ideologies, some of them passionately held, but all largely of their own choosing. These ideologies were not homogeneous, and varied from the moral models through the medical, the educational and the psycho-social ones. -Some counselors, to be sure, were in fact non-ideological in their approach. After several years with the state VR agency, a fair number of counselors gave up their initial ideological approaches and became very organizationally oriented (see chapter 9). Some, for example, came to devote most of their energies to doing agency paperwork.

The orientations counselors chose depended on a) their personal backgrounds and temperaments, b) who they

interacted with on their jobs, and c) the social constraints placed on these interactions. Thus the counselor who has been described as having a client-centered orientation was strongly influenced by his personal disability. He brought with him a need to offer assistance to people he perceived as suffering from kindred afflictions. Similarly, another counselor had a decided preference for working with mentally retarded (MR) clients, since she had an MR child of her own. Hers was a moral commitment. Yet other counselors came from homes which deeply imbued religious values and this affected their need to help other people. In general, the counselors' "home moralities" determined the moral ideologies they brought to their job. Likewise counselors' family roles, e.g., as the designated "helper" of parents and siblings, often decided how they worked. One counselor whose mother relied on her for emotional support when the counselor's father died often expressed a need to be a "giving" mother to anyone who seemed in need of mothering, while at the same time she felt resentment for being so put upon.

Who counselors interacted with on the job also affected their ideological choices. Most counselors were

deeply influenced by the needs of the clients they served. It has already been remarked that counselors (and therapists) were more attached to psycho-social models than were other personnel. Since they were regularly exposed to clients living problems and demands for change, they sought ways to accomplish role change, and hence sought change techniques beyond those offered by their agency.

Counselor-client relations, however, did not occur in a vacuum. They were subject to constraints brought to bear by the agencies for which the counselors worked, by the laws under which they operated, by the demands made by client relatives, and by social demands in general. It will be remembered that counselors at the Workshop agency, even though they regularly interacted with clients, were very insistent that clients meet "standards". The requirement that these counselors meet production quotas and that they stay within labor department regulations, interacted with their moral aspirations and client contact to produce the very strong work ethic they exhibited.

To some extent counselors could control who they interacted with and hence some of the external constraints

they had to face. Counselors did have some say in choosing their caseloads and where they were out-stationed (e.g., whether at a school, or at a psychiatric or orthopedic hospital, or in a rural community), and they could choose how they would perform their jobs. Thus some counselors favored face to face contact with their clients, while others maximized paperwork or placement activities. In the latter case, a counselor might interact more with employers than with clients, and this in turn would affect his ideological outlook. Thus it was that personal background, social interactions, and social constraints all acted upon one another in determining counselors ultimate ideological choices. This said, it remains to be seen what choices counselors in fact made, and to this we turn next.

The Moral Ideologies of Counselors

If VR counselors are free lance ideologues, then they must surely be accounted free lance moralists as well. For among the ideologies counselors chose, the moral ones were easily pre-eminent. Almost all of 40 VR counselors I worked with in Northern City had some strong moral

commitments which were often held with real passion. Further, these commitments deeply affected their work. Moral ideologies had more impact on how counselors did their work than any other ideologies including the medical and the psycho-social. They determined who counselors worked with, what kind of counseling was done, and often pre-ordained the results of counseling. Nor, I should make it clear, was I immune to these ideologies, and my own periodic moral outrage and entanglements strongly determined the rehabilitation problems I studied and the information I obtained. Emotional and moral neutrality is an ideal which is often put forward by social work and counseling theorists (Rogers, 1951; Turner, 1978). Counselors, social workers and psychologists are urged to be "non-judgmental", i.e., not to let their work be determined by moral models, but this is very far from describing what happens in the VR field. Indeed, it is more accurate to say that VR is awash with morality, some of it overt, some of it covert, and that interdictions against moralizing simply become one more moralizing perspective.

The number and variety of moral models from which counselors choose is enormous. Some of these have evolved

within the VR framework, while others have personal origins and are as it were imported onto the job. Amidst all this variety, there is only moderate counselor consensus, and one result of this is that many moral models are private affairs, while others are widely held. These moral ideologies are views which are acted upon, but not often discussed. They are more visible in action than in pronouncement, and this is part of what makes them ideologies and not mere judgments. Counselor moralities help define client problems, e.g., they point out undesirable personal characteristics, and they encourage the use of moralistic solutions, e.g., the employment of praise, blame and punishment.

Because of the large number of moralities involved, it will be convenient in presenting a sample of them to divide them into two large categories. The first of these are the "work ethics", and these have an intimate relationship with the VR field. In the minds of many counselors, they are the reason why there should be a "vocational" rehabilitation field. The second category may be dubbed the "personal moralities". These are especially diverse, sometimes idiosyncratic, yet in some cases widely shared. Thus "helping" moralities are at

once deeply personal and very pervasive.

"Work ethics" have both individual and organizational support. They include various precepts such as the belief that work confers dignity, i.e., that it is to the personal advantage of clients to work. In practice, however, a more fundamental precept is that "those who can work should work". Here work is seen as a social duty and not as a private boon. It is this sort of view which seems to have led Szasz (1961) to compare hysteria with "malingering".

This latter work ethic is built into parts of the VR system, most particularly into the Social Security system. Many state VR clients are considered so disabled that they are eligible to receive Social Security disability benefits. The Social Security System, however, is always interested in finding out if its beneficiaries are able to work. If they are, they may lose their benefits. To this end, the social security people routinely referred clients to the state VR agency to determine vocational "feasibility", and, if possible, to obtain assistance in job placement. These Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) referrals

were not voluntary. They were based on the maxim, "if you can work, you should". Social security referrals who didn't comply by visiting the state VR counselors to whom they were sent could summarily have their cases closed due to "lack of cooperation". VR counselors were expected to inform Social Security of these non-cooperative clients.

This referral system presented a moral dilemma for many state VR counselors. Some who believed that vocational counseling should serve to build client dignity were adamantly opposed to non-voluntary counseling. They argued that involuntary counseling was not counseling at all, and that in consequence it couldn't work. Nevertheless, they were required to decide whether or not to report clients for non-cooperation, and hence whether or not to be honest. With psychiatric clients these decisions were not always straightforward, because the line between non-cooperation and non-feasibility was a blurred one, and perforce subject to moral judgments. Even some counselors who believed that clients should be forced to work had a difficult time deciding what should be done.

These moral dilemmas were forcefully brought to my

attention early in my job tenure. Just two months after I started work I attended an "in-service" at the state capital where I was urged, albeit somewhat ambivalently, to follow Social Security procedures. Several counselors at the session, however, were incensed. Some vowed that they could not follow the rules as they had been explained. Others, however, found the ensuing controversy to be of little moment. Still others looked away apparently seeking emotional detachment.

A few months later the matter of reports to Social Security also came up in a private discussion I had with my immediate supervisor. It became clear that though he had been with the state agency for ten years he had not resolved the reporting dilemma in his own mind. On the one hand he believed strongly in counseling. He believed it important to follow client wishes as much as possible and to develop "trust relationships" with them. He also believed that rehabilitating the psychiatric client took time, which the forcing of issues often precluded.

-And yet, he mused, "should we be supporting them with our taxes?" There did seem to him to be a duty to work, and why shouldn't VR counselors be required to

enforce it?

Our conversation was a long one, but in the end no conclusions were reached. My supervisor had been using his own version of the work ethic along with his other notions about client rights and counseling techniques to guide his actions in this job area. He had thought about these matters and tried to apply his ideas, but even so, he usually kept these thoughts to himself.

Less ambivalent in their endorsement of work ethics were two therapists who were also counseling clients of mine about vocational issues. In one case, I had referred a client for psychological testing. The purpose was to help him obtain a better understanding of his vocational goals and abilities. A routine part of this assessment was personality testing using projective instruments. When the results of the testing came back from the psychologist, I, as was my custom, shared them with the client. He was very impressed. The psychologist had noted some fears behind the client's usual gruff facade. The client shook his head in agreement and commented, "The man knows me."

Later, unbeknownst to me, the client decided to go to the psychologist for private treatment. Subsequently he explained to me that he had hoped to obtain help in coping with his fears. Instead, he said that from their second session on the psychologist had merely urged him to go to work. The client reported that he was told not to worry about his fears, but to get out there and work "because he could". With this he stopped seeing the psychologist.

The second therapist worked for a CMHC. Our mutual client, a woman in her early thirties, had been in therapy with this therapist for two years, and had a history of hospitalizations dating from her mid-teens. The client at this time was also living in a group home which insisted that its clients have at least twenty hours of program involvement per week. The group home administrators required that their clients be in program because they did not have the manpower for twenty-four hour supervision of residents. They also felt that work and/or school were therapeutic.

The CMHC therapist agreed. Work was therapeutic. Her counseling with the client had stalled, and now the therapist was convinced that the client was malingering.

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She decided to force the issue and demanded that the client go to work. If she did not do so, the therapist informed her, she would stop seeing her. In order to make her fiat stick, the therapist required that the client go on at least ten job interviews a week. I was then requested to verify these interviews. The therapist told her that she was to see me weekly with proof of where she had gone in her job search. When I questioned this procedure, the therapist was adamant. Work, she was certain, was therapeutic, even if it were under duress.

Some counselors, however, were not sure that competitive work was a duty or a therapy. The counselor who supervised the state psychiatric hospital's sheltered workshop thought that too much was often demanded of clients. At one point he came to me and suggested that we write a joint paper advocating the use of "work activity programs" for psychiatric patients. There was no reason, he insisted, why all psychiatric patients should be expected to get out and work at regular jobs, and he was looking for a way to let his hospital superiors know this. Work, he explained to me, could be used to keep people busy and productive. But it did not have to be heavy work; and the hours did not have to be long; nor did a

quick exit to a regular job have to be a universal goal. It was this last he insisted on most, because, as he said, he was being forced to dismiss clients from program solely because they had been in the workshop for what hospital administrators considered to be too long a period. He indicated that he resented the implication that competitive work was somehow morally superior to work activities. He felt he was doing something valuable in giving people a sense of dignity.

Most counselors, certainly state VR agency counselors, faced demands to obtain competitive employment for clients. Some agreed with these demands, while others did not. Some believed that they were performing a service for their clients, while others thought that they were performing a service for society. In any event, these demands were difficult to meet, especially for psychiatric clients, and the consequence was often counselor exasperation. This in turn often led to demands made of clients. These demands usually occurred behind closed doors, but one counselor's attempts to get a client to work were captured on a video tape being prepared for an in-service training program. He had been asked to role-play the counseling of a client who was depressed

over a hand injury. As his partner in this role play began to complain about her situation, he became visibly impatient and told her that she was "always bringing something new up" and that it was time to get down to work. When the director of the taping session stopped him and asked that he try a different counseling approach, he agreed, but when the camera was turned on again, he again told the "client" to stop complaining and get down to business. He felt that work and looking for work were the goals of counseling, and that any other things were diversions. Work goals were a moral commitment of his, and when they were frustrated, his almost automatic response was to demand that clients do what they were supposed to do.

As can be seen, "work ethics" were very pervasive. They had some institutional support, and were held in varying degrees of intensity by many counselors. The "personal moralities" were also pervasive and held with varying degrees of intensity, but they were more diverse and had less organizational support. In order to give a flavor of their enormous range, I will divide them into five sub-categories, namely: 1) sexual moralities, 2) conventional social rules, 3) human dignity issues, 4)

treatment rights, -pro and con, and 5) the "helper" syndrome.

I begin with the sex moralities partly because they were the first to impress themselves upon me. I had been a VR counselor for barely a week when they made themselves known to me. As a part of my orientation to the job, the counselor whose caseload I was taking over was assigned to show me the ropes. This entailed her describing many clients to me. One of these was the young woman who has already been mentioned in conjunction with work ethics. Let me call her L, since I will be alluding to her again.

L, it seems, was perceived as the counselor's most difficult client. She was not cooperative, and she was not getting a job. What was worse still was that she was sexually "lax". L, who was white, had many boyfriends, most of whom were young blacks. The counselor explained to me that this client could not be reasoned with and would not understand that the way she was living was wrong. For the counselor this was a moral issue, and one to be corrected through exhortation. She disapproved of L and how she lived, and was frustrated that she was not able to change her. She expressed some pleasure that this

was now to be my problem and that she could wash her hands of it.

Also worried about sexual matters was a state psychiatric hospital psychologist. Some months after I had begun working with L and after she had been terminated by her primary therapist at the CMHC (for not following directions), L had been admitted to the state hospital and E had become her psychologist. L told E that she was in love with me and E became alarmed. She believed that it was always dangerous for a client to be in love with a counselor; there was no telling where these things might lead. Though E had no reasons to suspect that I'd committed any improprieties (so she later told me), she began encouraging L to stop seeing me. When L insisted on remaining in counseling, E called me and asked me to stop seeing her. She said only that she thought it was a bad idea, this though I suggested that "transference" could be worked with, and often to a client's benefit. She, however, maintained that it was wrong, and when I asked her what I should do, she suggested I stop seeing L professionally and start seeing her personally. She seemed to feel that a real romance was somehow more honorable than permitting a client to have a fantasy one.

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The dangers of sexual transference were very much a preoccupation of E's, and I learned that she had warned several other male counselors and therapists not to get involved with female patients whom she had found capable of developing crushes on male authority figures.

This fear of sexual misconduct by professionals was very widespread in Northern City's VR community. About a year after my conversation with E, a fellow state VR agency counselor told me that she had gotten in trouble at the CMHC where she was out-stationed. It seemed that a client of hers had accused her of giving him sexual encouragement. Both the director of the CMHC and the local state VR agency office director had then, without making further inquiries, told her to "behave" herself. According to her, when she tried to defend herself, the VR office director informed her that "transference" was very rare; that it almost never happened that agency clients fell in love with their counselors; and that consequently she must have had some responsibility for it. I subsequently canvassed a dozen agency VR counselors about their "transference" experiences and all reported that some clients had fallen in love with them. When told of the director's remark, most laughed. One then explained

that she was not surprised; that the director's reaction was the very reason why she always kept these matters to herself.

A second area of personal morality which serves an ideological function is "conventional social rules". These excite far less passion than do sexual rules. Nevertheless, their innocuousness and apparent "common sense" make them widely accepted, and almost invisible in their action. Most counselors were of the opinion that there were just some correct ways of living and that it was their job to encourage these. One almost universal example of these was grooming codes. Ill dressed and ill washed clients could count on being told to clean themselves up, whether at the hospital, or at the private placement program, or in a workshop. In one instance, a client was referred to me because a hospital counselor had visited her home and found it extremely dirty. After talking to the client, I determined that neither she nor her husband had any interest in her obtaining employment. Nor was either of them dissatisfied with her homemaking. When I called the counselor and told her what I'd found, she requested that I still do something. A home "shouldn't be that way", she complained.

Very common also were referrals from counselors who wanted clients to go to work because that was the "normal" thing to do. Theirs was not a work ethic which proclaimed that work was a duty or a potential source of personal pride. Rather their feeling was that that's just what people do: they work. To them, a normal life consisted of a routine which included getting up and going to work each day.

A third sort of personal morality, one which also ignited personal passion, was the "human rights issues". Here the typical issue was the dignity of the client. Many counselors very strongly believed that clients were entitled to be accorded "respect"; that they were worthy of being listened to; and worthy of making personal choices. Often these counselors were prepared to fight for their client's rights in this area.

One state agency VR counselor who was out-stationed at the state psychiatric hospital with me went to visit a client at a group home. This client had been having difficulties with a roommate and had requested the counselor's help in getting the group home staff to

adjudicate the problem. When the counselor got back to her office, she was seething. It seemed that instead of hearing out the client's complaint, the group home staff had persisted in pointing up the client's deficiencies, and the issue remained unresolved. The counselor was so angry at the way her client had been treated that she stomped into my office muttering, "they don't listen; they just don't listen." She then asked me if I could think of some way to force the group home staff to treat her client with more respect.

I was sympathetic with this counselor's feelings, for, as she knew, I too had been incensed by the way the group home had treated one of my clients. In my instance, I had attended a conference ostensibly called to determine whether the client should be moved from one residence to another. When I arrived I discovered that the move was a foregone conclusion, and that the meeting was to be used to get the client to commit herself to some vocational goals. Since the client would not willingly do this, pressure was brought to bear on her. She was told that work was good for her and that she needed "structure". When the client again balked, she was urged not to be "defensive" and was told that things were being done "for

your own good".

I then intervened to suggest that I had some reservations about the vocational plans being developed, and this was followed by what I judged to be an attempt by the client's therapist to prove to me that the chosen plan was correct. This was done by eliciting the client's psychotic symptoms, i.e., by making some contradictory demands of her followed by a request to hear about her "voices". My reaction to this was utter outrage. Though I tried to restrain myself, I believed (whether rightly or wrongly) that the client's dignity was being stripped from her, and that she was being made to "look bad" just so that a point could be made with me. My moral anger at what I perceived to be an assault on someone's basic human rights was so great that it took me an hour of walking the streets to calm down. I discovered that I too had a moral agenda, one which engaged the core of my personal being.

Yet moral anger was not my prerogative alone. The other side of the coin is that the therapist and the group home staff were fairly angry too. Both the client and I were perceived as being irresponsibly obstructive. We were seen as violating basic moral principles, namely the

work ethic and the duty of people to allow themselves to be helped.

It is hard to overestimate the energies tapped by moral concerns, and human rights issues seem to have the power to stir the strongest feelings. Two other cases which illustrate this involve psychiatric hospital personnel. In one instance, an educational counselor visited his client on a ward and literally found her being yelled at and physically pushed around. When he returned to his office down the hall from mine, he was so agitated that he could not sit still. He walked up and down the corridor button-holing people he knew and telling them about what had happened. He kept shaking his head and repeating, "they treat people like dirt... like dirt."

In the other case, a recreation counselor who had been assigned vocational duties attended a hospital meeting regarding one of her clients. She came back dismayed that the client's hospital job was being reassigned to meet the hospital's needs, not the client's. This counselor had spent a considerable amount of time trying to determine what kind of job would be suitable for the client, and then some weeks in fighting for the

client's "rights". After the conference decision went against her, she broke down in tears. "They don't care about people, do they?", she told me.

Morality seems intimately related to the emotions, and particularly to anger. It may be speculated that anger is one of the principal mechanisms used to enforce moral rules, and to defend against the imposition of such rules by others. Further, since some moral commitments are so central to personal identity and self-esteem, the levels of anger generated in moral disputes can be very considerable, and when one loses a particular moral clashe, the corresponding pain and sorrow can be equally intense.

The fourth sub-category of personal morality, "treatment rights", has to do with questions of who should be helped by VR services. Many counselors felt that some clients were deserving of services, while others were not. Clients who helped themselves, or who were perceived as victims of a bad break, elicited sympathy and were felt to merit extra counselor effort. Similarly, a client whose disability aroused a counselor's personal concerns might expect better treatment. Thus the counselor whose

caseload I took over cared deeply about mentally retarded clients, and though they were but a small fraction of her clientele, she spent disproportionately large amounts of time with them. She felt they needed and deserved her help.

Other clients were perceived as not having a right to assistance. One hospital VR counselor flatly refused to work with a client because he had killed his wife. She did not want to see or talk to him, and said that his crime was so terrible that she didn't care what happened to him.

Among state agency VR counselors there were in general some misgivings about psychiatric disabilities. During one local office in-service, the origins and treatment of depression were being discussed. Two cases were being considered. In one the client was depressed because he had recently become paraplegic, and in the other the depression was the result of a childhood loss. A counselor rose to point out that the paraplegic had something "legitimate" to grieve about, but the other person did not merit sympathy because he should have gotten over his problem years ago. As she talked, several

other counselors shook their heads in agreement. The first client had a clear disability, and he was deemed eligible for services, while the second's problem was thought to be of his own doing, and really he should take care of it himself.

The fifth type of personal morality, the "helper syndrome", seems to be very common in what are sometimes dubbed "the helping professions". Many VR counselors, social workers, nurses, and psychologists felt that they had an obligation to help the unfortunate and if need be to make sacrifices for them. Some believed that at the very least clients needed "love". These counselors and therapists felt that they must be "good" people and that helping others was a necessary component of virtue. This was especially true of the newer counselors. One young hospital counselor told me how hurt she was that a client she was trying to help had not returned to see her. She explained that they had both come from the same rural part of the state and that therefore this client should have been amenable to help. "She should know I understand and that all I want to do is help." After saying this she then asked me, "What did I do wrong?" She believed that she was being denied the right to help and that therefore

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the problem must be some fault of her own. This was especially painful, she explained, because it "felt so good" to help.

Some older hands at the counseling business believed that they'd learned that being helpful was not always possible, but feared that it was a seductive goal nevertheless. A hospital VR counselor with fifteen years of experience had a huge poster on his wall which warned him against trying to be a "rescuer". He believed that it was too easy to want to "save" people.

Many counselors persisted in trying to be helpful even if they didn't feel like it. There was a great deal of solicitousness, of asking clients how they felt, of reassuring them "things will get better". A client of mine responded to this by telling me that he felt there was a lot of "phoney love" in the hospital. "People tell you they care, but once you're gone they don't give a damn."

Among state VR agency counselors the helper syndrome took a special form. Since one of the major functions of the agency was to fund client programs, getting more money

for clients was often equated with being helpful. During my first year with the agency, before budget constraints became a matter of concern, it seemed that at every local office meeting someone would stand up to complain that there was not enough money for client transportation, or client maintenance, or college programs. "How can we help our clients under these circumstances?", was a question repeatedly asked. "Doesn't central office know our clients have heavy expenses?" Counter-arguments, e.g., in terms of budget constraints, were viewed as showing a lack of concern.

The moral models which counselors adopt thus may be seen to have quite a range and to have a deep impact on the kinds of jobs counselors try to do. Yet the moral commitments of counselors do not always result in the consequences they intend. They have many unintended "side effects". Among these are: a) excessive blame of clients, b) client degradation, c) counselor rigidity, d) client appeasement, e) avoidance of issues, problems and people, f) interpersonal conflict, and g) failure (both personal and organizational).

- a) Excessive blame of clients. Morality entails the

use of blame, but this technique can be used in amounts beyond those intended. Ineffectual blame tends to escalate to unwanted levels. One of the purposes of blame seems to be to change other people's behaviors and/or beliefs. When this change does not occur, a normal reaction seems to be to increase the amount of blame. This in turn may inspire greater resistance to change and hence more frustration on the part of the change agent and hence more blame and more resistance and ultimately stalemate.

This seems to be what happened with L when her counselor tried to dissuade her from sexual "misconduct", and also when she was pressured to go to work. L simply balked. She became full of excuses about why she couldn't go to work, and indeed even refused to see her counselor. She began complaining about back pains, and made it abundantly evident that she disliked her counselor and hated being accused of wrong doing whenever they met. The result was an impasse, and both were happy when their counseling relationship ended.

L had also been blamed for intransigence by her therapist, and the latter's attempt to enforce a job

hunting regimen ultimately led to a rupture in their relationship. Before it ended, however, the therapist had begun accusing L of being "manipulative" and "passive-aggressive". Given the context of their relationship, these were not mere descriptions of L's behavior, but instances of blame. L in response denied that she was manipulative or passive-aggressive, and in turn accused her therapist of being manipulative.

Blame not only can spiral out of control, but it can occur when it is unintended. The counselor who during the in-service taping session became exasperated with his role play partner for not getting down to work blamed her for "always bringing something new up". When asked not to do this, he repeated the pattern in a second taping. He later explained that he could not help himself; that that kind of client always elicited that kind of reaction in him.

b) Client degradation. Moral injunctions and moral certitude often result in the lowering of a client's status. Sometimes this is intended, but often it is not. When a counselor feels he knows what's best for a client, there is a strong impulse to make that happen, and

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frequently the handiest way to do this entails discounting the client's own judgment or wishes. Sometimes what happens is that the client is not listened to. At many case conferences clients were present, but literally ignored when the time for decision making arrived. Often they were treated as if they were non-persons. At one case conference I attended for L, her therapist and a group home counselor were talking about what her goals should be. L tried to break into their conversation, but soon found herself sputtering "but, but, but..." She was unable to draw even a glance from them. At a different case conference, a state psychiatric hospital social worker was trying to arrange for the discharge of a patient and ostensibly trying to involve the patient in this planning. In fact, what she did was only to invite the patient's concurrence. She would for example ask, "And don't you find that medication helps?" or "You agree, don't you?", while the patient provided only diffident confirmation. The patient knew that her in-put was expected to follow the social worker's agenda, and so she comported herself like a little girl agreeing with her elders.

At many conferences where clients were not present,

counselors made jokes about them. More common was the practice of enumerating a client's character flaws. It was especially common to label clients as "manipulative" and/or "passive-aggressive". Both of these were considered unacceptable methods of attaining an end, so that if a client mutely insisted on his own way, or deviously tried to maneuver his counselor into giving him something he wanted, the client's end as well as his means was likely to be discounted. In the four years I worked as a VR counselor, I can recall but once hearing -"the client is trying to manipulate me, but I think we should do it his way anyway". The general rule was that character "flaws" became part of an argumentum ad hominum, i.e., the client's arguments were ignored and he was condemned for being what he was. This was especially true for psychiatric clients, for their illness was used as prima facie proof that their "judgment" was impaired. Diagnoses of "paranoia" or "thought disorder" were often ipso facto interpreted to mean that what the client wanted was wrong.

If all else failed, some counselors found it acceptable to physically thwart a client's desires. When a hospital VR counselor got into a dispute with a client

about who should care for the counselor's cat (this was personal business between them), the counselor told the client she would not talk to her unless she calmed down. The client, however, persisted in telling the counselor she was wrong, which led to the counselor loudly telling the client that if she didn't stop talking she would be barred from the workshop. The client replied that the counselor couldn't do that, that it would be wrong, whereupon the counselor called hospital security and informed them that the client was to be ejected from the building and, if necessary, physically prevented from re-entry for the next three days. The client, it must be added, was crippled in an arm and a leg, and was not physically dangerous to anyone.

Such scenes as the above can only bring visions of the disciplining of small children. They discount the client's anger, judgment and desires, and treat them as moral inferiors. In short, they are "de"-grading.

One of the surprises I had when I began working with psychiatric clients is that most of them seemed sane most of the time. They could easily have been treated as moral equals. But to do so would mean subjecting oneself to the

moral influence of the clients. Human beings take seriously what their equals ask or say. With psychiatric patients, this influence might not be based on "rational" judgment. Since it is frequently difficult to separate the rational from the irrational, discounting most of what clients say, i.e., degrading them as people, becomes a common strategy. This seems to be the purpose of degradation, and why it attains special importance where moral models prevail.

c) Counselor rigidity. Moral models often generate so much commitment that many counselors find it difficult to entertain solutions and conclusions other than the ones they already hold. Counselors often feel that they are right and others wrong. They feel this toward fellow professionals with alternate ideas, and, a fortiori, toward clients with ideas of their own. Moral models become more than hypotheses about rehabilitation; they often form an important part of counselors' self identities. Counselors see themselves as good and helpful people; as people trained to make decisions which other people, especially clients, should be willing to accept; and indeed have the moral sense to accept with gratitude. Counselors rarely see themselves as rigid, but rather as

simply standing up for what's right.

At the group home conference discussed earlier, the ostensible purpose was to decide on whether the client should change residences. What occurred, however, was that the group home counselors were so sure that their prior decision was correct that the subject of moving the client never arose. Similarly, at a Workshop agency conference called to decide what sort of program a client was ready for, the workshop counselor came in with his mind made up. The client in question had just finished a workshop evaluation at the agency, and the counselor was to recommend what he thought was the appropriate next step. Theoretically, the client, the workshop staff and I were then supposed to thrash out a satisfactory plan. In fact, what happened was that when I asked the client what he felt ready for, the workshop counselor interrupted to say that the client's opinion wouldn't matter in this case because the workshop (namely himself) had "decided it had no appropriate programs" for him. This decision was presented with an air of finality. The counselor "knew" he was right. On several other occasions he had let me know that he felt well trained for his job and perfectly qualified to make such decisions.

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For my part, I was equally ready to assume the correctness, and all too often, the infallibility, of my views. When I became infuriated at the group home conference for L, I "knew" that a terrible injustice was being committed. I "knew" that I was a person dedicated to fighting injustice. Whatever views one may hold of my convictions or judgment, these were a part of me that I was not about to change lightly. I clung to them ferociously because they were a part of my very identity. I needed to view myself as a "good person".

But then so did the workshop counselor, and the group home staff, and the therapist. All felt themselves to be good people, and all made rigid, moralistic decisions based on convictions central to their self identities. The result of all this is that impasses were frequently reached in the development and execution of rehabilitation plans, and it was difficult to negotiate new strategies.

d) Client appeasement. Since so many counselors felt a need to "be" good, they felt a complementary need to "do" good. All too often, however, their hopes were frustrated. Clients complained that they were not being

helped, or they began functioning more "bizarrely", or they were dropped from programs, or they had to be refused something they had requested. Counselors needed a way to cope with this without sacrificing their self images as helpful people. Appeasement was a tactic which allowed them to do this.

In order to allay client frustrations, and in the process allay their own, counselors often told clients that things were "okay" when they weren't; or that they would be okay even when there was little reason to think so. (Among hospital therapists this was often called "supportive therapy".) At the state psychiatric hospital, counselors of all stripes were likely to tell a client that a change in medication would make things better. Sometimes the prospect of going home would serve this function, and in the case of counselors making referrals to the state VR agency, getting a job was often promised as a way of solving the client's problems. The important thing was not whether the changed program or medication would work, but whether at the moment the client was willing to accept the possibility that it might work, and hence be appeased.

A classic example of this occurred with a client of mine who was being dropped from a vocational program for the mentally retarded (MR). The client had been at the MR agency for a year, mostly in workshop training. During the year several conferences had been held to plan for his continued programming. It had been decided that he was likely to be a long term client, and that if he were to improve, he would need the security of knowing that he was in a program committed to keeping him there. The MR agency counselors said they were willing to make such a commitment. Despite this, however, as the year ended and the state VR agency funding was about to run out, the MR agency decided it could no longer keep this client in workshop. It felt that he was not making progress fast enough.

An MR agency counselor was assigned to get the client into another program. She then, without consulting me, or talking with the client, began a referral to the state psychiatric hospital's work program. When she was assured that this could be arranged, she spoke to the client. She told him that he had done well at the MR workshop, but that things would go even better at the state hospital's work program; that the change was being planned as an

improvement.

It was only now that she informed me of the impending change. I was told that the client had been a failure in program; that there was no choice but to terminate him; and that the psychiatric hospital referral was being made because she could think of no other alternative. She explained to me that she was trying to ease the client's transition, and reiterated what she had told him. When I suggested that the client deserved some honesty about the situation; that it might help him to cope better; she assured me that she knew that, and that she had been fully honest with him. While telling me this, the MR counselor wore a very sweet smile and spoke in her most lilting voice. Not only was the client to be made to feel good; so was I. We all, including the MR counselor herself, needed to be assured that what was being done was good and right, and would have positive consequences. The client, in fact, was quite aware of what the MR counselor was trying to do. He later told me, "She just wants to make me feel good."

Most instances of VR counselor appeasement were less complex or sustained than the above. More usually a

counselor simply tried to persuade a client that a planned program was a good idea. The use of phrases like "don't worry, it will work out" was standard. So were assurances that the place the client was being referred was an excellent program, one well suited to his needs.

It must be noted that "appeasement" is a word with negative connotations, and is, in a sense, itself a moralistic word. Perhaps, it might be suggested, that a word like "pacification" would serve better for it carries with it the positive implication that calming clients and giving them reason for optimism are good tactics. Appeasement, however, has been our word of choice because it is the unintended side effects of moral ideologies which are being examined. Calming clients and facilitating positive change are presumably quite intended. Appeasement, however, does more than calm; it denies what is actually happening and so often impedes change. It often unintentionally permits a status quo to continue. One of the problems faced by the client of the MR agency was that he had regularly been transferred from program to program. An important factor in the earlier conclusion that he needed a program that would make a commitment to him was that he had ceased trusting programs

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and in consequence was not about to apply himself to what he felt was going to be another let down. The MR counselor probably did not intend to give him more reason to be distrustful, but her less than honest attempt at reassurance may well have had precisely that effect. Her use of appeasement left his referral and re-referral history intact, and the problem this caused unaddressed.

As it turned out, after the client was transferred to the psychiatric hospital's work program, he was very relieved. He now had reason to believe that he was in a program that would last, and he had been assigned to a hospital VR counselor who did not automatically assure him that all was well.

e) Avoidance of issues, problems and people. Another unintended side effect of the ubiquity and intensity of moral ideologies among counselors is the avoidance of issues, problems and people. Degradation of clients, counselor rigidity, and client appeasement are all forms of avoidance, but there occurs a straightforward kind of avoidance too, one that consists of simply not dealing with some issues, problems or people. Whether from fear of disagreement, or failure, or conflict, or just a

distaste for the unpleasantness of the difficult or ambiguous, there is much that many counselors would rather not confront. The moralizing of issues, etc., serves to exacerbate this tendency, for morality and moral ideologies are salient to people. They are important to one's self and to others, and this very importance intensifies the cause for avoidance.

Of the issues avoided, the efficacy of counseling technique ranks as a prominent one. The few serious discussions I was able to have about this were with my initial supervisor and with one of the counselors out-stationed with me. It's not that other counselors weren't interested; it was apparently that they found the subject a dangerous one. When the local state VR agency's in-service polled the VR counselors to see what subjects they would like more training in, "counseling techniques" headed the list. Yet counselors did not talk much among themselves about how to do counseling. My impression was that counseling ability was just too important to counselors' self images and to their status within the office.

Counselors did sometimes talk about how well they

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were counseling, but they rarely gave details. They rarely said what methods they were using, or gave descriptions of the results these were having with clients beyond merely indicating that they were getting "rehab". There was usually a light, indeed a self deprecating tone, to claims of good counseling. It was as if counselors were embarrassed to say that their counseling was good, and were signaling with their embarrassment that no questions were to be asked about details. Modesty forbade it. But then so did the possibility of being found wanting. I can recall one counselor, who after telling me how well his counseling was going, smiling, shrugging his shoulders, and then saying, "Well, you know how it is", before quickly changing the subject.

Nor did VR counselors talk much about morals per se. There were many negative judgments made about others, and pronouncements about what was right, but no talk I can remember about how one's own moral commitments affected one's counseling. Morality was not seen as an ideological perspective. Rather, it was a given; something to be taken for granted and not examined. This "invisibility" of the moral ideologies strikes me as being of utmost import and its ramifications will be discussed in further

detail in chapter 10.

Also avoided were client problems. There was little delving into what clients were doing and why. One VR counselor described herself as just "sizing people up" and then referring them "where I think they'll fit". She was not concerned about client dynamics or personal histories, just about getting a gut feeling of what people should be doing and then referring them someplace. At most conferences about clients, I was never asked what I knew about a client's background, and many times when I offered this information it received but perfunctory notice. My interpretation of this, in part, was that client problems were invariably complex, and that looking at the complexity only confused morally based judgments. Better then to avoid the confusion and make the judgment.

Avoidance of people was a more clear cut affair. Counselors avoided other professionals or clients with whom they had serious disagreements, especially moral ones. With fellow professionals, they literally did not call one another, did not attend conferences, did not drop by for small talk, and, if possible, ceased making referrals to programs where there had been confrontations.

Thus after my unpleasant experience at the group home, I rarely ventured back; nor was I invited to come back. Similarly, when I had a serious moral disagreement with L's therapist, we mutually stopped talking to one another. And lest it be thought that I was being atypically unsocial in my reaction, it should be noted that many counselors remarked to me about the "isolation" that they felt their jobs entailed. One of the state VR agency counselors out-stationed at the psychiatric teaching hospital told me that he had been there for five years and still didn't know anyone (i.e., hospital counselors or therapists). Another VR counselor out-stationed at the Workshop agency told me that she usually stayed in her office to avoid the "craziness" of the workshop staff; and that she rarely ventured to the downtown state VR agency office because she also disliked the craziness of the VR staff. And when counselors complained about others, they typically did so behind closed doors. When my fellow VR counselor at the state psychiatric hospital told me of her despair with the group home staff, she was careful to close the door of my office so that no one else might hear and carry tales.

When counselors had disputes with their clients, it

was not unusual for them to avoid them too. This was commonly done indirectly, for example, by not following through on a promised referral or letter. Or more directly, it could be done by scheduling fewer sessions with the client, or by referring him to some other counselor or program for the purpose of getting the client "off my hands". An importunate client who knocked at a counselor's door too often might be told to come back another day because the counselor was "busy" -whether or not this was true. Many a counselor expressed relief when a troublesome client failed to return for a scheduled appointment.

Some of this avoidance was probably necessary for counseling efficiency and counselor sanity. Much of it, and there was a great deal of it, stemmed from the intensity of the moralism current in the rehabilitation field, and which was especially active among the counselors and therapists. Avoidance may be counted as an unintended side effect of moralism, because it was not sought. Most counselors found the isolation it entailed very unpleasant. Nor, for the most part, did this avoidance facilitate the coordination of VR programing. Counselors would like to have worked with one another; it

would have made their jobs easier; but the moral friction endemic in the field made avoidance the more comfortable option.

f) Interpersonal conflict. By now it should be abundantly evident that interpersonal conflict was common among VR counselors, and that indeed there was considerable interorganizational conflict too. Conflict was, in fact, so ubiquitous, and at times so virulent, that it deserves, and will get, a chapter of its own (chapter 8). For the moment, we will only mark its existence, and present the details later.

First, moral conflict existed between virtually all of the participants in the VR field, i.e., between counselor and counselor; counselor and client; doctor and client; doctor and counselor; the public and the counselor; etc., in all possible permutations. (The same applies to the permutations between organizations, e.g., the state VR agency vs. the state psychiatric hospital; the state VR agency vs. the Workshop agency; etc., though some such as the private placement program avoided most of the strife.) Second, the conflicts were intense. While there was little physical violence, the amount of

emotional violence, both overt and covert, was large. People felt they were fighting for goodness in general, and their own goodness in particular. The latter was very important to counselors' identities, and, just as importantly, to their professional and personal status. Being "good", and "being good at being good" (i.e., being a good counselor), or at least appearing to be, were important to counselors' professional reputations.

Interpersonal conflict may be considered a "master" side effect of the moral ideologies endemic in the rehabilitation field. It was both a cause and consequence of all the other side effects thus far enumerated, i.e., of excessive blame, of client degradation, of counselor rigidity, of client appeasement, of avoidance, and of failure. Without an awareness of its on-going, pervasive conflicts, or the mechanisms used to try to contain them, no picture of the vocational rehabilitation field can be complete.

g) Failure (both personal and organizational). Like conflict, failure may be considered a "master" side effect. It too was a cause and consequence of all the other side effects. The concept of "failure" is being

used here as defined by the various participants in the rehabilitation field; i.e., the counselors, the clients, the rehabilitation organizations, etc. These various participants, to be sure, did not always share the same conceptions of rehabilitation failure, e.g., rehabilitation success was defined differently by all of the ideological clusters we have identified, and there were some non-ideological, that is, specifically organizational definitions as well (e.g., "rehab" rates - see chapter 6). The failure we are considering was both personal and social. It includes clients failing to achieve their rehabilitation goals, and the inability of society and/or its agents to achieve their aims. Clients, counselors, and rehabilitation organizations all confront significant frustration in the attempted rehabilitation of psychiatric disabilities.

This frustration and failure derives from moral ideologies in two main ways. 1) The side effects of moralism make the planning and execution of rehabilitation difficult. Factors such as counselor rigidity make for poor planning, and this in turn increases the chance of failure. 2) It is in the nature of moral models to advocate controlling people, and in the psychiatric field

this easily spills over into "over-control". Over-control then leads to resistance by clients and other professionals, and again the result is an increased chance of failure.

Counseling tyros typically enter the rehabilitation field unaware of the pressures toward failure. They have usually heard about and been taught about successes, not failures, and so are unprepared for what they find. This lack of realistic preparation itself militates toward failure, and the result is that many counselors "burn out". In the face of the real problems they encounter, some become cynical, some withdraw into retreatism, and others opt out of the field. The exhaustion they experience might well be called "moral burn out", for it is counselors' moral identities which are most affected. It may also be added that rehabilitation agencies offer little practical help in counter-acting this phenomenon.

The above is but a scant outline of the nature of psychiatric rehabilitation failure. As with conflict, failure is so important and pervasive that it will later be dealt with more extensively (in chapter 9). It will figure prominently in our later discussion of counselor

socialization.

The Psycho-Social Ideologies of Counselors

The psycho-social models are not as widespread or as passionately held as are the moral models. They too tend to be free lance, and they too depend more upon counselor choice than institutional mandate. Indeed, there was little organizational support for the psycho-social models at the rehabilitation agencies. Since counselors were on their own in this, there was a great variety of psycho-social models simultaneously represented in the community. While client-centered models probably held the honor of greatest representation due to their prominence in counselor training, they by no means displaced other models.

Counselors who used psycho-social models did so independently and largely in private. Furthermore, their commitments to these models tended to be shallow and to change often. Counselors seemed to follow professional trends in these matters. Apparently the counselors' situation of working intimately with clients created a

need for a better understanding of clients and for better tools for helping them. Because of these needs, counselors seemed to cast about in their professional contacts, and in the popular literature, for some ideology which would help them. They then attempted to apply this ideology; sometimes they proselytized for it; and most usually they wound up dropping it. The primary reason for this latter seem to have been that as independent operators counselors had a difficult time making psycho-social models work for them, i.e., they didn't provide the help anticipated. Counselors also had a great deal of difficulty in interesting their colleagues in the models they themselves had adopted. Without success in the counseling relationship, or professional support from fellow counselors, there was little incentive to retain a particular psycho-social model, and so they were usually replaced with something else; sometimes another psycho-social model; sometimes something outside of the rehabilitation field entirely.

Client-centered models. I have indicated earlier that counselors rarely spoke about counseling techniques, but an exception to this was a counselor who was out-stationed with me for about a year. I first learned

of his interest in client-centered counseling when he approached me after I had made some remark during an in-service training session on the need to respect client's rights. He asked me if I had ever read Carkhuff, and approvingly commented that it sounded as if my ideas had been derived from his. He then explained his understanding of Carkhuff's views to me, and spoke warmly of the training he had received in these at a regional university.

We did not have much occasion to speak about these matters again until he was transferred to the state psychiatric hospital. After a while it became apparent that his real interest was not in client-centered counseling, but with clients per se. He said that he had flown the banner of client-centered counseling because he had found it the best way to advocate for clients' rights. As he began to work with the psychiatrically disabled (his previous caseload had been primarily with the physically disabled), he confessed some disillusionment. He no longer felt, if he ever really had, that Carkhuff's ideas could be directly translated into the psychiatric arena.

Another colleague out-stationed with me for awhile

also declared a preference for client-centered techniques. She was just completing a master's program in mental health counseling which featured a client-centered orientation. Though she was an ex-nurse, she was very anti-medical, and occasionally referred to the counseling she was learning as much preferable. A year after obtaining her degree, she hardly ever mentioned counseling techniques when we met, but instead spoke bitterly, and in very moral terms, about the hospital and school colleagues she was now working with.

Rational-Emotive Therapy. Probably the most strongly held psycho-social model I encountered was held by a vocational counselor at the state psychiatric hospital. She believed that Albert Ellis's Rational-Emotive Therapy (RET)(Ellis, 1977) was the way to counsel and the way to live. In order to improve her skills in this technique (which emphasized changing client's cognitions and methods of reasoning), she financed courses for herself at Ellis's school in New York. In order to have some freedom to practice what she had learned, she attempted to set up a private counseling service during her evening hours. Throughout the three years I observed her, she consistently applied her views when working with clients

(e.g., at client conferences).

During this period she also began trying to persuade other counselors of the merits of RET. In this she met with out-right rejection. Several other counselors tried to persuade her that life, and in particular, patient problems, were more complex than RET admitted. She was personally castigated for being unemotional and insensitive to the emotions of her clients. This she vehemently denied. After a time, RET ceased to be a topic of discussion between her and other hospital counselors. People knew where they stood, and attempts at persuasion ended.

Transactional Analysis. A state VR agency counselor out-stationed at a rural psychiatric hospital helped organize an in-service training session during my first year of tenure at the state VR agency. At his behest, half an afternoon was devoted to introducing state agency counselors to Eric Berne's Transactional Analysis (1961). He himself acted as instructor for this training segment. His expressed hope was to introduce the staff to a counseling technique which he said he had found helpful and "valid", and which he was sure others would find the

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same. This counselor had not had formal training in counseling or transactional analysis (TA), but had picked up what he had learned by reading books such as "I'm O.K.; You're O.K.", by attending some introductory sessions on TA, and by personally undergoing transactional analysis. During his presentation, the counselor audience made jokes about the films he showed, and generally indicated that they saw little value in the materials he presented. "We've seen this before", and "That's just a way of classifying people, not helping them", were some of their comments. Several times he was asked if he were serious about what he was saying.

Two years later this counselor was no longer talking about TA. If asked about professional matters, he would talk about how he had learned to turn out some quick, easy "rehab". He much preferred, however, to talk about the audio business he was starting up on the side.

Stress and Relaxation Therapy. The state VR agency counselor out-stationed at the psychiatric teaching hospital had for several years been interested in family counseling. He had attempted to start a small private practice in this specialty, but it fizzled. Gradually his

interest turned to stress as a cause of psychiatric impairment. At the hospital where he worked, "stress" was a topic which was "in the air". He had done some reading about it, and even started teaching an evening course on it at a local college. His presentation featured an emphasis on relaxation techniques and exercises. Once at a professional meeting, he told me that he found these techniques useful for calming himself down, and recommended them to me. He never made a point of discussing these with state VR agency counselors, however, and in time his interest in stress began to wane. Instead, he started to devote his energies to a part-time job he took working for a local manufacturer. He even started seriously contemplating the idea of leaving the state VR agency and going to work full time for the manufacturer.

Gestalt Therapy. A state psychiatric hospital vocational counselor, whose background was in social work, indicated, when he started working at the hospital, that he thought that gestalt therapy was a "terrific" counseling tool. When the hospital showed a film on it, he recommended that everyone go see it. "It's the greatest", he said. He also advised reading Fritz Perls'

books on the subject. At the same time he took a young occupational therapy aide who was functioning as a vocational counselor under his wing and started to introduce her to the virtues of gestalt. Occasionally he recommended "paradoxical intervention" as beneficial too.

After a while, he barely mentioned these techniques to anyone, and then one week he came to work touting an esoteric language therapy. He had attended a workshop on it over the weekend, and he assured people that it was "the greatest" and "terrific stuff". A month later, one heard little about it.

Ego Psychology. The most serious student of psycho-social models I encountered among rehabilitation counselors was the ex-state VR agency counselor who had once been out-stationed at the state psychiatric hospital. He had returned to graduate school to obtain a Ph.D. in rehabilitation counseling so that he could operate at what he felt to be a professional level. Among other things, he had read Anthony's books and articles, and after an initial flirtation with these ideas had rejected the educational model as "too shallow". He had found that he could not apply Anthony's system at the transitional work

program where he was now employed.

Instead, he embraced "ego psychology". His views on this were eclectic, and he called them his "philosophy of rehabilitation". He believed that clients needed to experience work and to integrate it into their egos. During an in-service training session at the state VR agency he recommended a four stage process toward this end. His four stages were: 1) emotional support of clients, 2) cognitive feedback, 3) structure (e.g., explicit work rules), and 4) gradual re-entry to work (as the client's psycho-social crises were mastered).

Psychoanalysis. If there was a psycho-social model which was not in vogue among VR counselors, it was psychoanalysis. No counselor whom I met expounded it, and many whom I met took pains to denigrate Freud. On several occasions, I heard counselors dismissing psychoanalysis as "too deep". Representative of this line of thought was a state VR agency senior counselor who airily said of psychoanalysts in general, "those folks are crazy". During several downtown meetings, he went out of his way to mock psychoanalysis by joking with fellow counselors that he wanted them to lie down on a nearby couch so that

he could analyze them.

The Medical Ideologies of Counselors

The medical models were not of central importance to VR counselors with psychiatric caseloads. They were not a direct part of most of the work they did. Medical diagnoses were important to only two of the tasks these counselors performed, namely establishing eligibility for state VR agency services, and referring psychiatric clients to "medical" services such as "psychotherapy" with medical personnel. Otherwise they only concerned VR counselors because they sometimes concerned some of the other professionals with whom they had to interact, chiefly psychiatric hospital and CMHC personnel.

Nevertheless, many VR counselors had strong opinions about medical models. Some of these were pro, and some were con. During my first week at the state psychiatric hospital, the other state VR counselors stationed there took me aside and forcefully told me that Northern City was "medical model city", and that at the state hospital the medical model was the official one. They said this as

a warning, but they also said it with great disdain. "You can't change these people... You can't reason with them", I was told.

Some VR counselors, however, did believe in the medical models. When during an in-service session a psychiatrist questioned the value of certain psycho-active medications, one counselor became upset. She felt that he was saying that psychiatric disabilities were not the result of a chemical imbalance in the brain, and she wanted him to know that that was not what she had been taught, nor what she believed.

The free-lance orientation which applied to the moral and the psycho-social ideologies also applied to the medical models. State VR counselors were free to choose whether or not to accept medical models and in what degree. This freedom of choice, however, occurred in relative ignorance. Most of the counselors with whom I interacted knew little about the putative medical aspects of psychiatric disabilities. Like the counselor described above, they were often content to consider "mental illnesses" as due to "a chemical imbalance" without further understanding what this chemistry was supposed to

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be, or what evidence there was to support it. The phrase "a chemical imbalance" was the very one most doctors used in explaining mental illness to their patients. And there it was used more to quiet patients' questions than to explain to them the underlying nature of their "disorder".

Nor were most VR counselors very familiar with the diagnostic procedures employed by M.D.'s. State VR agency counselors developed a good working knowledge of the diagnostic categories doctors used because of their involvement in determining eligibility for agency services. They also had a good feel for major psychiatric symptoms, for these client behaviors (e.g., paranoia) often made their presence felt during counseling sessions or in vocational programs. Nevertheless, few counselors had an understanding of the dynamics of psychiatric conditions, or of the range of criteria used in developing a psychiatric diagnosis. This was apparent during in-service training sessions devoted to psychiatric conditions. Counselors asked elementary questions, and settled for elementary answers. In a session on schizophrenia, for example, they would ask a question such as, "What is the general course of the disease?", rather than indicating that they had an idea about the course of

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schizophrenia, and now needed clarification about some aspect of it.

Moreover, most of the VR counselors were made very anxious by talk of psychiatric illness, especially schizophrenia. Unlike other in-service training sessions, those on schizophrenia invariably began with nervous laughter filtering through the room, and with jokes about craziness being exchanged and repeated. Once these sessions began, however, especially if they were given by an M.D., there was rapt attention, and deeper quiet than at any other sessions. Even clerical staff would attend psychiatrically oriented sessions; something they never ordinarily did in other cases.

The ignorance and discomfort many VR counselors felt when confronted with "psychiatric illness" was also manifest in their referral habits. If a client began behaving very bizarrely, or became too difficult to be managed in counseling or in program, there was a tendency to refer the client to a medically oriented therapist; either an M.D. or a therapist associated with a psychiatric hospital or a CMHC. (Alternatives such as family services or pastoral counseling were not used. Nor

was intensive counseling by the VR counselor himself considered.) The attitude in doing this was, "let the therapist take care of the problem, and I'll pick up with the client when he is more ready for vocational programming".

If the client were already seeing a medically oriented therapist, the attitude would be, "well, why isn't the therapist doing his job?" or "what is the therapist doing anyway?" I attended many conferences on clients where these questions were asked verbatim. In these cases, the counselors wanted results, and they cared little about how medical people were to achieve them. Medicine was treated like a black box into which one put a client and from which one expected an improved client to emerge. This attitude was virtually identical to that which laymen expressed toward psychiatric hospitals. Medicine was accorded the status of a beneficent mystery, and per force, so often were medical models.

The local state VR agency office director (an ex-VR counselor), once suggested to me that it was the state psychiatric hospital's job to "cure" clients, and that he did not care how they did it. When I argued that we

needed to know what was happening with a client in order to counsel him effectively, he demurred. Nor was he impressed with my statements that the psychiatric hospital was not doing a very good job of "curing" our clients. Instead, he compared the psychiatric client with accident victims. You send them to the hospital to get patched up, and when they're substantially healed, that's when you do VR work with them. The healing, that was a medical job, and hence no concern of ours.

Most counselors, on the other hand, found it difficult to distinguish between therapy and counseling; that is to say where healing ended and rehabilitation began. Presumably, "therapy" was a medical specialty, but counseling was widely acknowledged to have therapeutic aspects. No one knew where to draw the line between the two, or indeed if such a thing was possible. Some were quite explicit in believing that it was not. The result was that counselors who liked to do counseling. i.e., who liked to interact with clients, tended to view counseling as a therapeutic enterprise, while counselors who preferred referring clients were happy to regard therapy as the province of medicine.

Whether or not counselors were for or against medical models, there was frequently a very moralistic flavor in their attitude toward them. Those who called Northern City "medical model city", felt that the medical treatment of clients was "de-humanizing". They were upset that, as they perceived it, client feelings were being ignored in favor of controlling them chemically. Proponents of medical models, however, were in agreement with Dr. Ausubel's previously quoted view (1967) that "recognizing" that psychiatric patients have a "disease" was "the most significant and perhaps only real advance" mankind had made in dealing with insanity. These counselors virtually equated the medical models with modern civilization.

State psychiatric hospital vocational rehabilitation counselors could be found pro and con on the medical models too, but because of their position as hospital employees, they found it difficult and professionally dangerous to publicly express objections to them. When I mentioned to one of them that this seemed to be the case, she laughed loudly and said, "You're not kidding. The doctors wouldn't like that." A consequence of this was that whatever their private feelings about medications, hospital vocational counselors, more than state VR agency

counselors, tended to tout medications to their clients. Doing so was safe. If other staff members should find out that they were advising clients that they should take their medications as prescribed, or that medications would help them, there would be no bad consequences for the counselors. But if medications were talked down, and clients, as they were wont to do, informed others of this, there might be negative comments, or reproachful looks, or perhaps worse. I never discovered how severe censure of hospital counselors might get, because I never encountered an instance of a hospital counselor speaking negatively of medications to clients. I only know that they avoided doing so. They might, and did, question the efficacy of medications to me, but not to clients.

Some hospital counselors (and therapists) believed strongly in the use of medications and of chemo-therapeutic regimens, and through exhortations and/or ultimatums were prepared to enforce their beliefs. I was initially less inhibited in expressing some of my doubts about medications than some of my hospital colleagues, and so some of my views became widely known. In one instance, a client of mine went to a hospital therapist and told her that she was feeling bad. She also

told her that she had stopped taking her medications. The therapist immediately assumed, mistakenly in fact, that I had advised the client not to take her medications, and without ever contacting me, she went to her superior who sent a letter of complaint to my superiors asking that they investigate the matter. This my superiors did. Though no action was taken against me, for I had no part in the client's attitude toward medications, the effect was chilling. I learned that going against medical models at the state psychiatric hospital would indeed be sanctioned, and that the hospital and some of its people were prepared to sanction even personnel who were not on their staff.

As with the moral models, the medical models had side effects, i.e., unintended consequences. Many of these will be elaborated upon later when we review psychiatric ideologies, professional conflict, and rehabilitation failure (chapters 5, 8 and 9). Let it be remarked for the moment, that medical models did not work well for rehabilitation counselors and their clients, i.e., that the rehabilitation of psychiatric clients did not typically proceed smoothly, and that placing reliance on medications did not seem to change this. Rather, treating

medicine and medical personnel as authorities beyond examination, likely foreclosed the possibility of doing some kinds of productive work (see chapter 5). The rigid acceptance of medical models seemed to foster in some counselors a contentment with their own ignorance, and in some medically associated personnel, with their own superiority. The results were often impassivity, intransigence and avoidance.

The Educational Ideologies of Counselors

Educational ideologies have been an important part in the development of vocational rehabilitation, and they are built into the very structure of rehabilitation agencies, but they are only of marginal importance to VR counselors. VR counselors are not educators; at least state VR agency counselors are not. They do not run workshops or classrooms; they only refer people to these. Vocational skills are an end product for them, but not one they help inculcate directly. VR counselors think education important, and believe that it helps clients to get and hold jobs, but it is not a central part of their daily tasks, certainly not if they are working with psychiatric

clients. Hence educational ideologies are not very salient for them, and educational models not much talked about. The major exception to this is that VR counselors often do decide what sort of vocational skill might be appropriate for a particular client, and so counselors do talk about what kind of school and/or program might be suitable in a given case and why.

One further exception, is the fact that VR counselors do coach clients in such skills as job hunting. With psychiatric clients they also give advice on how to "live", and especially tips on how to get along with bosses and co-workers. This is sometimes conceived of as education in life skills, but it also has a moral flavor about it, i.e., some counselors feel that they are teaching clients how they "should" live.

Counselors attached to workshops, however, are much more likely to see themselves as teachers. Since they instruct people on how to do particular jobs, they see themselves as teaching job skills and/or job discipline. As a part of their job, these counselors also sometimes organize classes in "job hunting techniques" and "job survival skills", and these can have all the academic

trappings, including classrooms, syllabi, and lessons. For these counselors, education is the essence of rehabilitation.

The Religious Ideologies of Counselors

In the whole of the time I spent as a rehabilitation counselor, I encountered no colleagues for whom religious ideologies were important on the job. One VR counselor I met was an ordained minister, one was an ex-minister, and another had her graduate degree from a seminary, but, so far as I could determine, neither they, nor any other counselors, therapists or social workers, used religion to try to understand vocational rehabilitation, or to decide what kind of work to do with clients.

Non-Ideological Orientations of Counselors

Many counselors were fairly non-ideological in their approach to their jobs. Their goals and techniques were not based on moral or psycho-social or medical super-structures, but were tied to the immediate (usually

organizational) tasks at hand. The private placement agency has already been described as basically non-ideological and oriented toward getting clients jobs. Some state VR agency counselors also had a placement orientation; others conceived of themselves as coordinators of services for clients; and others acted as if they were just bureaucratic functionaries whose job was to get the paperwork done. The longer a counselor stayed with the state VR agency, the less likely he was to see himself as a "counselor", and the less likely he was to be committed to educational, or psycho-social, or medical models (see chapter 9).

Placement-oriented counselors often started their careers with the state labor department. They enjoyed establishing contacts with employers, and developing "job orders". Some of Northern City's VR counselors were constantly evolving schemes to open up new areas of employment for their clients, and through such mechanisms as in-service training sessions were urging their colleagues to do the same. Most placement-oriented counselors did not have psychiatric caseloads, and those who did, regularly complained that psychiatric clients were hard to place, and even harder to keep placed.

Counselors with a coordinator outlook took pleasure in referring clients to program, and then acting as a mediator between the program, the client, and the original referral source. These counselors appeared to enjoy going to conferences and meetings. They were oriented toward performing this aspect of their job well. Training and counseling they were prepared to delegate to others as much as possible.

The bureaucratically oriented counselors did not much seem to enjoy their job. Many of them seemed classic cases of burn-out. They felt there was little they could accomplish as counselors, so why try. Their main job, they believed, was to get the paperwork done, so that's what they did. The goal they aimed to achieve was job survival. There was an especially large proportion of this sort of counselor at the state psychiatric hospital, and their colleagues often referred to them as merely "sitting and taking up space". For the most part, they remained unobtrusive and little seen.

Counselor Ideology and Agency Position

Counselors bring many commitments with them to their jobs, especially moral commitments. As has been suggested, these moral commitments have an enormous impact on the kind of job VR counselors perform. These commitments also play a role in determining what agency a counselor will work for, and what sort of caseload he (or she) will have within that agency. Thus it was more likely for a counselor with commitments to the mentally retarded to work for an MR agency; or if with a generalist agency like the state VR agency to have an MR caseload. The agency and caseload of a counselor then further helped determine the kind of work he would do and the kind of ideological identification he would make. Thus compared with state VR agency counselors, state psychiatric hospital counselors tended to be more psycho-social, more medical and more educationally oriented. They were especially likely to be more educationally oriented if they were attached to a workshop. State VR agency counselors frequently started with a placement orientation (e.g., those coming from job services), and this was often increased by the agency accent on "rehab", and their own negative experiences with moral and psycho-social orientations. Places like the Workshop agency, with its

social service aspirations, seemed to encourage the moralistic inclinations of its staff, and they became notorious within the VR community for their rigidity and moral certitude. Client contact increased the chances of a counselor at least trying to employ psycho-social models, and attachment to an organization with a medical identity insured that a counselor would at least give lip service to medical models. VR counselors, therefore, while in many ways free lance ideologists, were also subject, in their orientation and actions, to a great deal of social constraint.

Chapter V

PSYCHIATRIC IDEOLOGIES

Authorities

The Northern City office of the state VR agency had one psychiatrist working for it, and he functioned in the role of a part time consultant. Nevertheless, most of the agency's psychiatric clients had had, or continued to have, contact with some psychiatrist. It was, after all, a psychiatric diagnosis which usually made these clients eligible for the agency's services. Most of my clients had their psychiatric contact at the state psychiatric hospital where I was out-stationed, and so it is primarily the ideologies of these doctors which will now be examined. The medical people at the state hospital were not completely representative of those in Northern City; most of the doctors, for example, were of foreign origin;

but they did share a core of ideological concerns with their colleagues at other city hospitals.

The single most important ideological fact about these psychiatrists was that they functioned as "institutional symbols" of medical models. The state psychiatric hospital was a "hospital" because it presumably offered medical treatment, and this medical treatment was "medical" because it was supervised by M.D.s, i.e., by "psychiatrists". As signs of their central role in the institution, doctors received high pay, they received social deference from their lower ranking colleagues, and they occupied positions in which they could exercise authority.

The hospital administration, and most staff members, treated psychiatrists as authorities. They were supposed to know what was wrong with patients, and what ought to be done to help them. Many M.D.s were not personally respected by the nurses and therapists who worked under them, e.g., they were often disparaged as incompetents and fools, but when a question arose about what plan to follow in working with a client, all deferred, at least publicly, to the M.D.'s expressed wishes. Doctors were often

influenced by nurses and therapists who usually had closer contact with patients than they did themselves, and, in fact, frequently rubber stamped medication recommendations made by these staff members, but it was the doctor's say-so which made treatment decisions official.

At many case conferences one could see an almost fawning quality in the demeanor of junior staffers toward the physicians. Questions such as, "And what do you think, doctor?", might be asked, when one knew from private discussion that the question asker had little confidence in the psychiatrist's judgment. Whatever other staffers thought of them personally, doctors were accorded the trappings of authority. Nevertheless, some doctors functioned as very real authorities. They were believed to have mastered the mysteries of "mental illness", and to be able to provide answers.

One such figure was a psychiatrist who had been chairman of the department of psychiatry at the local teaching hospital. He had a national reputation, and a bearing which was visibly intelligent and impressive. It was his practice to come to the state psychiatric hospital on a monthly basis to review cases and to make

recommendations. Before his coming there was always a buzz of anticipation, especially among therapists whose patients were to be presented. After he left, his judgments were often cited by those charged with implementing patient treatment plans. He was believed to be a genuine authority, and if he made a recommendation, it was assumed that he probably did know better than others on the "treatment team". In my own experience, however, I did not find his observations substantially more helpful than those of other doctors.

Not only were the psychiatrists regarded as authorities, but they acted as the institution's spokesmen for the medical models. Both inside the hospital and outside of it, it was usually doctors who verbalized the medical rationale for what was being done with patients. At case conferences, it was they who summed up the medical situation, and they who made sure that the medical perspective was included in the decision making process. It was they who were called upon to talk about the medical aspects of psychiatric conditions at in-service training sessions within the hospital, and they who were invited to explain mental illness to groups outside the hospital. The state VR agency, for instance, quite consciously

requested M.D.s to explain schizophrenia and manic-depressive illness to its counselors rather than have psychologists, or social workers, or rehabilitation counselors do it.

The Medical Ideologies of Psychiatrists

As organizational symbols of medicine, medical models were not unexpectedly of foremost importance to most hospital and CMHC psychiatrists. Most used medical models to define the problems they faced, and to choose the solutions they believed appropriate. Thus "insanity" was defined as a "disease", or at least a "disorder". Patients were classified as having some diagnostic entity, and this entity was understood as having some physio-chemical and/or genetic etiology. These diagnostic, and putatively physiological, aspects of patient difficulties were stressed. Patients and staff members were habitually told that depression was the result of a lack of a chemical transmitter in the brain, and that schizophrenia was probably an inherited condition which had to be accepted as such.

But firstly, and most importantly, doctors considered it beyond question that patients had disease "entities", i.e., that something medical was wrong inside them; and that it was the doctor's job to identify this. One of the psychiatrists' primary tasks at the state hospital was "diagnosis", i.e., identifying what a patient "had". When a psychiatrist was called in to examine a person, it was often to give an expert opinion on what clinical label best fit the person in question. M.D.s were not averse to this role, and at more than one case conference I witnessed them spontaneously introducing the subject of diagnosis, and then elaborating upon the "symptoms" which indicated one "disease" entity as opposed to another. Sometimes diagnostic criteria were discussed for their own sake, without even an allusion being made to a particular patient.

At the state psychiatric hospital, doctors were almost unanimous in emphasizing the physical aspects of disease. Other explanatory devices tended to be discounted. Thus at an in-service given on "affective" diseases, e.g., depression, one doctor explained that there were some people who believed that depression was the result of emotional "loss", but that he was sure the

evidence proved inherited chemical processes to be at fault. He spent almost no time explaining the loss theory, but elaborated at length on chemical mechanisms which he speculated might be responsible. Similarly, a psychologist told me that he had given a course on psychotherapy at the local teaching hospital, but that his M.D. students were forever telling him that they did not want to hear about psycho-dynamics; rather, they wanted something they could "use in practice", i.e., something which might help them in understanding the pharmacology of mental illness.

For the doctors whom I observed, the medical models were much more than scientific hypotheses; they were a very real "faith". Their chemical and/or genetic explanations of disease entities were not treated as "could be's", but as facts; facts with fuzzy details, but facts nevertheless. Doubts might briefly be entertained, but they were habitually set aside so that doctors might proceed with the "medical" tasks at hand. Two examples of this occurred during in-service training sessions given by psychiatrists for the state VR agency counseling staff. In the first instance, the doctor was explaining the nature of manic-depressive illness. He began by telling

the counselors that in his opinion this was a chemical disorder. He said he was not sure what chemicals were involved, because the evidence was conflicting. He also admitted that he could not understand how the lack of a single chemical (e.g., nor-epinephrine) could be responsible for opposite manifestations, i.e., depression and mania, but that there must be some mechanism. He then went on to advocate the use of chemo-therapy; because, after all, the disease was chemical.

In the second case, an M.D. from the teaching hospital was talking to the VR counselors about the nature of schizophrenia. He spent much of his time describing the "typical course" of the disorder, e.g., the "pre-morbid" personality, the "prodromal" symptoms, acute psychotic episodes, and other presumably regular features of the disease. From this and other materials (e.g., twin studies), he drew the conclusion that schizophrenia had a large genetic component. And yet, he confessed, there was something strange about this disease. It almost always seemed to have "social" manifestations. He said he did not know why this was so, but then he did not pursue the question. His attitude seemed to be that if schizophrenics typically had difficulties dealing with

other human beings, that there must ultimately be some physiological reason for this. Neither he, nor his colleague who discussed the affective disorders, publicly considered the possibility of social determinants of social phenomena. Rather, their commitment was to physio-chemical processes and "medical" treatments.

Doctors not only emphasized the biological aspects of patient conditions when called upon, as at in-services, to explain mental illness; they often did so during casual conversation. At one case conference, while some hospital counselors, the patient's psychiatrist and I were waiting for the patient to arrive, the psychiatrist, apropos of nothing in particular, began talking about recent research on brain metabolism which was done using CAT-scans. He was very excited that differences had been found between the metabolisms of schizophrenics, manic-depressives, and normal persons. He explained that at last a concrete physical basis was being found for the differentiation of disease processes.

Even when physio-chemical processes were not a direct issue, doctors paid special attention to diagnosis. Schizophrenia and manic-depression were treated not merely

as classificatory categories, but as underlying conditions which needed to be correctly ascertained. Thus it was that at case conferences doctors often spent a great deal of time in trying to decide what sort of schizophrenia a patient had. It is of interest that these distinctions were often made apparently for their own sake, i.e., they were made without specific regard for treatment consequences. On more than one occasion, I observed the question of diagnosis being raised by an M.D. only after it had been decided that the staff did not know what to do with a patient. In this sort of case the doctors' attitude seemed to be that at least the diagnosis ought to be correct. If tentative agreement on a diagnosis was then reached, there was frequently no follow-up question about the implications of this diagnosis for treatment.

Getting the diagnosis right was a psychiatric concern which even survived a major change in the hospital's diagnostic decision making machinery. During my tenure as a VR counselor, the American Psychiatric Association introduced the Diagnostic and Statistical Manual III (DSMIII). It profoundly altered the official categories of mental illness, and the criteria for assigning diagnoses. As the DSMIII was adopted at the state

psychiatric hospital, the new labels began appearing on the referral forms I received from M.D.s. And though during this process the putative disease entities changed, getting the new ones correct was accorded the same importance as getting the old ones right had.

Since most psychiatrists understood the problems which they faced as physio-chemical entities which were to be identified (i.e., diagnosed) largely from patient "symptoms", they tended as well to perceive the solutions to patient problems as grounded in physio-chemical manipulations. Though they endorsed other forms of intervention as well, the more medically concrete the treatment employed, the more secure doctors appeared to be. This was true whether the treatment used was considered "therapy" or "rehabilitation".

In order to facilitate the examination of the medical model solutions favored by doctors, I will divide them into five categories; namely: 1) diagnosis, 2) dedication, 3) prescription of patient behavior, 4) prescription of professional behavior, and 5) medical authority. While these categories overlap, and are not intended to be exhaustive, they should still provide a good over-view of

how the medical ideologies of psychiatrists affected their own work, and how they interacted with the rehabilitation efforts made on behalf of psychiatric clients.

1) Diagnosis. For many doctors, getting the diagnosis right was not only a matter of correctly understanding what was wrong with patients, but it was more; it was itself an important therapeutic tool. Theoretically, a correct diagnosis enabled a doctor to prescribe a correct treatment. For example, if a patient had a specific chemical imbalance, then this would presumably indicate that his condition could be improved by restoring him to the correct chemical balance, e.g., through medication. In practice, the diagnosis alone was also treated as having beneficial consequences.

The most important gains attributed to diagnosis per se were attributed to patient "acceptance" of "mental illness". Patients were told they were "sick"; they were told they had a chemical imbalance; and once they came to believe this, they were deemed to be on the road to improvement. They were then described as having acquired "insight" into their condition. The psychiatrist who explained the affective disorders to the state VR agency's

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counselors was very clear about this. As he put it, the first thing a doctor must do with a patient is tell him, "You have a mental illness". One then hoped that the patient would come to agree. If he did, he was ready for other forms of treatment. Acceptance of a diagnosis was considered an indicator of a good prognosis. Knowing that one had an illness, and often knowing what kind it was, helped the patient to change his behavior and to develop healthier ways of living. Doctors thus not only believed that mental illness could be controlled chemically, they also accepted the psychological effects of diagnosis as a form of medical treatment.

Even if patients were recalcitrant, however, and even if a specific clinic's policy explicitly forbade sharing specific diagnoses with patients (as some did), correct diagnosis was deemed beneficial. Much emphasis was put on the benefits of correct record keeping. One of the major tasks of doctors at the state psychiatric hospital, and of the state VR agency, was to "certify" client disease. Chart notes and referral forms signed by M.D.s were taken as making a person's disease official. The diagnoses assigned on these records then tended to remain unchanged throughout a person's psychiatric and rehabilitation

career. Presumably staff members new to a client's case would be able to tell by consulting the files what a client "had", and hence adjust their actions to meet the person's needs. In fact, part of what seemed to happen was that the diagnostic labels made staff members more comfortable with new patients. I often saw hospital staff members thumb through a patient's chart, and then look up and say something like, "Oh yes, he's a paranoid schiz", as if they suddenly understood the patient. Diagnosis at least gave the feeling that one was dealing with a known, a familiar entity, and for this effect alone it seemed to be considered a valuable aspect of psychiatric treatment.

2) Medication. At the very heart of medical treatment as practiced by doctors at the state psychiatric hospital was patient medication with psychotropic drugs. Most of the psychiatrists with whom I had contact conceived of themselves as trying to correct chemical defects in the brains of their patients. To do this, they had at their disposal a large number of anti-psychotic agents, anti-depressants, anti-convulsants, and other varieties of psycho-active drug. They also had at their disposal many drugs whose purpose was to counteract the numerous, and often very serious, negative side effects of

the primary psycho-active drugs. Utilizing this armamentum, doctors tried to discover the correct medication, or combination of medications, for a given patient. Indeed, fine tuning medications was probably the primary job of hospital physicians.

Typical of psychiatrists' use of drugs was a doctor at the state hospital's out-patient unit. For most of his business day, he sat in his office to be available to patients' therapists who would come to him for prescriptions for their clients. Occasionally he briefly interviewed patients. More often he depended upon therapists' descriptions of patients in deciding what medications were appropriate. To an outsider (namely this observer), these decisions seemed to have a hit-or-miss quality. Thus if a client was behaving in a manner acceptable to the therapist, the odds were that the patient's medication would automatically be renewed. If the patients behavior and/or the physiological side effects of his medication (e.g., muscular stiffness), were outside of acceptable limits, the medications would be changed. What they were changed to seemed to depend upon the physician's guess as to what might work. If the new drug did not "improve" the situation, another change in

medications might be expected. Despite psychiatric emphasis on diagnoses and on physio-chemical etiologies, these were rarely used as explicit rationales for specific medication changes. One was much more likely to hear from an M.D. as he changed a prescription, "well, let's try this one and see what happens".

Indeed, it was often medication success which affected diagnosis, instead of vice versa. Thus a patient diagnosed as schizophrenic, but not responding to the major tranquilizers, might be given a trial period on lithium carbonate, a medication usually viewed as a specific for mania. If he responded, the patients diagnosis might officially be changed to manic-depressive illness.

Most of the doctors I met at the state hospital strongly believed in the efficacy of medications. In fact, so strong was this belief, that virtually all hospital patients were medicated. This occurred whether or not a chemical defect could be demonstrated (actually chemical defects were never demonstrated, for as far as I know tests of brain chemistry were never given), and whether or not medication appreciably changed a patient's

behavior for the better. Usually patients' behaviors did alter with medication; sometimes dramatically. Among the effects most sought were a diminution of patient violence, a decrease in "hallucinations" and "delusions", and an improved propensity to communicate intelligibly with staff. If these changes occurred, i.e., if a patient's behaviors were controlled in desired ways, then the medications were considered effective, and the patient was described as responding favorably to chemo-therapy. This did not mean that what was achieved was what would be described by most people as "normality". Normality per se was not a goal of medication, and many patients deemed to have responded favorably gave the impression of being "doped up", e.g., of being lethargic, or slow thinking, or slow moving.

Medications were considered so important within the psychiatric community, that enforcing their use was a major preoccupation. The doctor who instructed the state agency VR counselors about affective disorders and their treatment, as has mentioned, informed them that the first thing he told his patients was that they were sick, but he emphasized that the second thing he stressed with them was that they had to take their medications. He insisted that

if patients did not take their medications, that they would not be accessible to other forms of help.

Doctors solemnly told patients, counselors, parents, and group home staffers, that it was vital for patients to take their drugs as prescribed. There were constant reminders about this, and constant questions about whether a given patient was still on his medical regimen. Since patients often disliked the effects of the drugs they were taking, there was a tendency for them to stop taking them. Frequently clients complained to me of feeling dizzy or uncoordinated. Often I was told by a client, "I can't think", and as often some vowed to me that they would not allow the doctors and nurses to force them to take drugs any longer. Many times I was told stories about how they were regularly badgered into taking their medications.

If a patient's behavior deteriorated in any way, the first question doctors and other medical personnel asked was, "Is he still taking his medications?" Questions about the effects of family fights or vocational pressures might be asked by doctors or other staffers, but they had a much lower priority. The medical attitude seemed to be that there was probably little which could be done about a

patient's social circumstances, but that medications could be manipulated easily, and that they could achieve the effect of suppressing unwanted patient behaviors. This often led to a situation such as a patient doing well in the hospital, returning home to a family in turmoil, then stopping his medications and becoming as violent as he had been before his initial hospitalization. He would then be sent back to the hospital where his medication would be changed to a longer lasting injected form which it was hoped it would be harder for him to discontinue using. Often this allowed the patient to remain relatively calm even when once again returned to his family. In such a case, the change in medication would be described as a therapeutic success.

The belief that psychiatric illness had physio-chemical causes (e.g., brain damage), and that stopping the medications believed to control these was responsible for most patient difficulties was regularly reinforced in the monthly newsletter distributed by the state department of mental health to hospital employees. Thus, in one issue (This Month in Mental Health, Dec.1981), a state psychiatric hospital psychiatrist was interviewed about drug treatment. When asked why so many

schizophrenic patients "relapsed" so quickly, his reply was, "I would bet that they've simply stopped taking their medicine." The one article I found in three years of newsletter issues (1979-1982) which suggested that perhaps schizophrenia might have social causes and social treatments was entitled, "Schizophrenia: an alternate view" (N. Lehrman, Sept.1979), and its psychiatrist author affirmed that his was a "minority view".

One of the two psychiatrists I met who openly expressed serious reservations about psycho-tropic agents was the psychiatric consultant to Northern City's office of the state VR agency. He told counselors that in his opinion most psycho-active drugs were merely sedatives; that they put people to sleep, but little more. "Sure they control behavior", he explained, "they just make patients too tired to get angry or to fight back."

He also felt that medications got credit for things they never did. At one VR agency in-service, he related his experience while working as a physician at a psychiatric hospital. He noted that before psycho-active drugs came into widespread use, that if a patient was violent in in-take when he was sent up to a ward a

psychiatrist was often called to calm him down. When the psychiatrist arrived, he often found that the patient who had been very angry while in admitting had already become much more tractable as the immediate trauma of hospitalization subsided. Nowadays, he said, the same thing happens only the patient is given a drug while he's in admitting and when he gets upstairs in a calmer condition the drug is given the credit.

3) Prescription of patient behavior. Telling a patient what to do, i.e., how he should act, was another major treatment modality favored by doctors. The psychiatrist who instructed the VR counselors about affective disorders was very clear that first a) you tell the patient he's ill, then b) you make sure he gets medicated, and finally c) you tell him how he should straighten up his life. His example of this was a "manic" man who had been yelling at his wife. If you first tell him that he must be nice to her, he won't listen to you. "He'll tell you to mind your own business." But if you get him to accept the fact that he's ill, and get him medicated, then he'll listen.

Most of the psychiatrists with whom I interacted were

not hesitant in prescribing to patients what they should do. These doctors provided more than advice, they told their patients how to act. They seemed to believe that they knew what sorts of life styles were "healthy", and that it was their job to get patients to live them. Thus I often heard M.D.s tell their patients to "be active", or to "take your wife out to dinner". They did this as if these injunctions were but another form of medical prescription, rather like "take two pills before you go to bed."

Of special interest for the vocational rehabilitation of psychiatric clients was that class of prescriptions called referrals. Many times doctors believed that their patients needed to work , and that work would be therapeutic for them. These patients were therefore "told" to see a VR counselor.

4) Prescription of professional behavior. For doctors, psychiatric treatment included not only telling patients what to do, but also frequently telling other professionals how they should be working with patients. An example of this was provided by the physician who gave the state VR counselors their in-service on schizophrenic clients. I had been given the responsibility of arranging

for his talk with the counselors and, as per my instructions, I told him that the agency wanted someone who could explain the nature of schizophrenia to the counselors. He agreed to do this, but only after he made an important proviso, namely that he be allowed to devote most of his presentation to letting the counselors know how they should be rehabilitating schizophrenic clients. And indeed, when he gave his talk, this was precisely what he did.

The predominant physio-chemical orientation of the psychiatrists made itself very much felt in the sort of prescriptions M.D.s gave to rehabilitation people. The prevailing medical attitude was that because patients had an underlying physical defect, that given current knowledge, they could not be "cured"; and that hence the best that could be hoped for was to maintain patients' levels of social functioning and perhaps in some ways compensate for their limited vocational potential. This certainly was the opinion of the doctor who gave the in-service on schizophrenia. He repeatedly cautioned the counselors not to expect too much of schizophrenic clients, and not to aim for goals which were very high. He recommended low level, repetitive jobs, e.g., in a

sheltered workshop; and he drew a diagram on the blackboard to indicate the general, but erratic, downward course of functioning which might be anticipated for schizophrenic clients. He specifically cautioned against using rehabilitation techniques to try to raise the level of patient functioning, or to try to achieve some of the higher level goals which patients often asked for.

Most of the psychiatrists I encountered were not so detailed in their recommendations for the rehabilitation of psychiatric clients. Many just asked the state VR agency to "train" their clients for work, but beyond that had no idea of how such education was to be accomplished. Furthermore, though doctors often told VR counselors what they wanted done, they rarely followed through on their referrals. They rarely called to ask how a patient was doing, and rarely inquired about how the rehabilitation was being conducted. They generally confined themselves to initial definite, but vague, prescriptions.

My experience was that though psychiatrists might easily make recommendations, their knowledge of vocational rehabilitation was usually limited. A case in point of this was provided by a psychiatrist who had been hired as

a consultant by the central office of the state VR agency. He was asked by the director of the agency to find out why so many psychiatric clients were unsuccessful in obtaining competitive employment. In order to ascertain this information, he reviewed fifty of the agency's case records, and then submitted written and video tape reports on how he thought VR counseling should be conducted. Most of the counselors who subsequently saw his video tape were visibly upset. Though they agreed with some of his conclusions, for example, that counselors and clients ought to agree on program goals, they were upset with others, which though definite in statement, seemed not to evidence an understanding of how rehabilitation was conducted. Thus he advised against using college courses as a way of assessing client interests and motivation, though most counselors found this a convenient, inexpensive, and useful procedure. He said he feared the effects of failure experiences on clients, though many counselors believed that failure was often as instructive as success to their clients. His lack of awareness of rehabilitation practice, however, was best exemplified by his statement that he could not understand why the agency was not working with patients who were over sixty-five years of age. He expounded upon this at some length, and

suggested that it was something the agency should study. It apparently had not occurred to him that sixty-five was the usual age of retirement, and that therefore, for the most part, the "vocational" rehabilitation of these people was neither sought nor appreciated.

5) Medical authority. Implicit in the four medically oriented treatment modalities already discussed was the idea that psychiatrists ought legitimately be regarded as authorities, and that authority, per se, had medical efficacy. In diagnosing patients, in writing medical prescriptions, and in telling both patients and professionals how they should act, it was assumed that doctors should be treated as if their judgments were, if not quite, then almost, infallible. For many, medical pronouncements had a magical and mysterious quality about them; one which many doctors believed enhanced their powers as physicians. They anticipated a kind of "placebo effect" based upon patients' willingness to grant a special authority to their statements. Certainly many patients did grant psychiatrists this authority. It was not unusual for a client to preface a statement to me with the words "my doctor said", as if that alone put what followed beyond question. As has already been reported,

many VR counselors were also prepared to give doctors a special status in the handling of "therapeutic" matters. They did not understand the medical aspects of psychiatric conditions, nor did they feel secure working with "psychiatric" clients, so that the doctors' willingness to assume authority relieved them of responsibilities they did not feel confident enough to shoulder.

As with most of the other ideologies we have and will examine, the medical models of psychiatric conditions had unintended side effects. Among these were: a) over medication, b) extensive control of patients, c) patient degradation and d) the exclusion of alternative solutions.

a) Over medication. The medical faith in the physio-chemical underpinnings of "psychiatric" conditions fostered a very strong bias toward the use of medications in dealing with almost all patient problems. At the state psychiatric hospital, the use of medications was stressed almost to the point of excluding other forms of treatment. The use of medicines was considered the quintessential medical treatment, while treatments such as those which used moral prescriptions, though extensively used, were considered somewhat less legitimate, and probably less

objective and scientific as well.

Almost all clients referred to me by the state psychiatric hospital were on some form of medication and some seemed more disabled by the medications they were pressured into taking than they were by their putative psychiatric conditions. One, a young man in his mid-twenties, suffered from periodic bouts of bizarre thought. In order to control these, he was given large doses of a major tranquilizer. When he appeared at my office for an appointment one day, he was so stiff he could barely move. There were tears in his eyes as he repeatedly sobbed, "They're killing me. These drugs are killing me." He lamented that he couldn't work the way he was, and asked me why the hospital wasn't willing to help him in some other way. "Why are they doing this?", he implored.

In part, it seemed to me, that the reason hospital staff members were treating him as they were was that they were deeply committed to making chemo-therapy work. In consequence, there was a strong likelihood of their using medications -including very large doses of medications-, even if other types of interventions (e.g., the

psycho-social therapies) might have been more effective. Certainly the heavy dependence on psychotropic medications often made patients look like zombies with frozen faces and lifeless eyes. This appearance then militated against the patients being accepted by potential employers or by ordinary citizens. Indeed the negative consequences that medications had on employment opportunities was one of the main factors which did occasion a change or reduction in patient medications. On several occasions when I pointed out to doctors that a client's trembling or stiffness might make it unlikely that an employer would hire him, the doctor promptly changed the clients prescription. Despite the fact that doctors claimed authority regarding psychiatric conditions, and often did not hesitate to make recommendations concerning the rehabilitation of their patients, when confronted with a counter opinion from a rehabilitation professional, they often acknowledged a lack of expertise about vocational matters and ultimately accepted the counselors judgment.

The untoward side effects of large doses of drugs used for protracted periods of time was for most physicians a very unwanted consequence of their reliance on medicines. Despite their commitment to the use of

chemicals to affect patient behavior, some doctors had strong misgivings about their use, at least in specific situations. Especially feared were conditions such as tardive dyskinesia. This last was a condition which became most manifest in the uncontrolled and unattractive movements of a victim's tongue. These movements were believed to be the result of brain damage caused by large doses of the major tranquilizers, and was deemed irreversible.

When an adolescent client of mine began to show these movements, her psychiatrist immediately removed her from all medications, and in the course of changing her prescription was reported by the client's social worker as saying, "Oh my God, what have I done? I've ruined this young girl." Once the medications were stopped, the patient quickly snapped back to apparent normality. Her tongue movements stopped. Her sluggish, bovine appearance was replaced by a girlish enthusiasm. Within a month she was able to leave the hospital and enter a vocational program. Within a year she was married and running her own home. And while her improvement when medications were discontinued was the most dramatic I witnessed, hers was not an isolated case.

o) Extensive control of patients. Some twenty years ago, Erving Goffman published his famous work on mental hospitals: "Asylums" (1961). He described them as "total institutions" which controlled the lives of their inmates in minute detail. Today little has apparently changed. The state psychiatric hospital where I worked was very much a total institution; though perhaps it was a bit more humane than it had been in former years. Nevertheless, it still prescribed when patients got up, when they ate, where they should be, and what they should be doing. While I was stationed at the hospital, there was still much use of punishment to enforce hospital rules. In one case, a woman who, because she had been unable to sleep one night had gone to her ward's "day" room to sit and think, was forced to go into a "seclusion" room (a punishment cell) when she refused to return to her own. Attempts at "deinstitutionalization" have apparently done little to change the amount of control exercised over patients, for many clients remained under institutional control even after they left the hospital. Several counselors who acted as liaisons with the group homes to which clients were referred told me that these were really "mini-hospitals"; that in them patients were also told

when to rise, when to eat, when to go to program, and so on.

The medical models accepted and promoted by psychiatrists in many ways helped to perpetuate institutional controls. By casting the doctor, and by extension, the hospital, in the role of the unquestioned authority, they provided a rationale for control, and often over-control. The mysteries of medical prescriptions made it difficult for patients to oppose psychiatric impositions, and indeed, at times actually helped them find comfort in this sort of control. In so doing, the independence of patients was directly, and indirectly, discouraged, while hospital routine was made easier and more predictable.

Though some patients welcomed the enforcement of medically decided goals, others found them an onerous burden. Many psychiatric patients came to the hospital after living lives virtually dictated by parental demands. They had been closely controlled all of their lives despite their best efforts at opposition. They were vulnerable to external control, but instead of being taught how to develop their internal resources, were

merely asked to accede to a different set of goals urged upon them by a different set of authorities.

This was the circumstance of a young man who had come to the hospital diagnosed as suffering from catatonic schizophrenia. He grew up in his minister father's home and was required by both of his parents to be a moral model for the sake of the parishioners. He related to me that he was subject to so many controlling demands from his parents that he retreated into mutism in his late teens in order to protect himself. As he emerged from his self imposed silence, he made it plain that he anticipated being punished if he dared make decisions on his own. During one counseling session with me, he confided that he feared doing well in a food service course he was taking because he believed that cooking was really womens work and that if he did well in it, it would be like beating his mother in her area of expertise. She, or some other woman, e.g., his teacher, would be sure to punish him for this. He simultaneously feared that if he tried to change his college major, his friends would face retaliation from his female college teacher.

This young man dreaded control by others, though he

had many unrealistic ideas about where it might come from and how he might successfully oppose it. Nevertheless, he was quite correct in his feeling that he continued to live in an atmosphere of strict controls. Over a three year period, I observed him trying to cope with the imposition of goals by staff members at the state psychiatric hospital, by a private psychiatrist, by counselors at the group home where he lived, and by supervisors at his work program. At one hospital conference I sat in on, I saw him struggle to find an answer for a hospital vocational counselor who asked him to enumerate his vocational goals in the hospital job to which he had been assigned. He answered by explaining his social goals, i.e., by explaining how he hoped to get along better with people. The vocational counselor was not happy with this answer, however. She later told me that she felt the medical staff of the hospital required explicit, observable, vocationally oriented goals, and that hence it was her duty to solicit these from the client. In consequence she pressed him for a different answer until he became flustered. He did not know what was expected of him. Nor did his inquisition end until he was virtually told what goals would be acceptable (in this case learning work discipline), and then verbally adopted them.

This client was disoriented by overt attempts at control, and ill prepared to cope with them. But instead of being taught how to develop his own goals, he was once more required to accept other people's goals. In part, this seemed to be the result of the medical models of the psychiatric hospital and its satellite institutions which asupported, and often demanded, controls over patients. (Of course, it derived from moral models too, but more of these shortly.) "Medical" success was defined by the production of well behaved, well "functioning" patients. The object was to reduce bizarre and unacceptable behavior, whether through medication or verbal prescription, and this put stress on patient conformity, not on independent patient development.

Some doctors would have argued that the controls they fostered were not excessive, but a necessary and proper amount of control given the magnitude of the task they confronted. This may well have been so. Certainly it was often true, if it is allowed that patient control is an appropriate goal of psychiatric medicine. Nevertheless, the heavy reliance on control techniques which existed at the state psychiatric hospital did interfere with the

development of some patients abilities which were also presumably doctor goals, e.g., increased patient self-esteem and independence. This frequent by-product of large doses of control was an unintended side effect, even if medically encouraged controls were otherwise deemed appropriate. In fact, many hospital personnel, including psychiatrists, were dismayed by the negative consequences hospital procedure had on patient independence, but felt they had no choice.

c) Patient degradation. Almost a corollary of the over-control of patients was their inadvertent moral degradation by medical models. These models virtually demanded that patients acknowledge their "illness". In so doing they stripped patients of responsibility for their own behavior. Ostensibly, patients were sick, and sick people were not accountable for actions they could not control. Many doctors were explicit in their expectation that this would protect patients from unreasonable and unwarranted punishment. In fact, the "sick role" of the psychiatric patient was a kind of "super" sick role. Mental patients were deemed to be so sick that not even their judgments were to be accorded respect. Their moral, as well as their physical, abilities were held suspect,

and hence they actually found themselves facing extreme demands and extreme punishment. By the large-scale lowering of the value accorded patients' judgments, and by replacing them with medical judgments, the moral status of patients was effectively de-graded, and they were made vulnerable to the judgments and often painful decisions of others.

Patients who were given large doses of medicines, despite their own protests, were often put in physical and emotional pain by being medicated. Certainly their self-esteem was negatively affected. The patient who complained to me that the drugs he was given were "killing" him, also said, "Look at me; do I look normal?", while he sat at my desk and cried. Another client of mine was, on the advice of her doctor, placed on a behavior modification schedule. In order to get her to stop making rocking movements when she sat in the day room, it was decided to reward her for not rocking. To do this, a "positive reinforcement" was considered necessary, and since she very much liked listening to her radio, it was decided to take this away from her and to let her use it only when she controlled her body movements. Her doctor and her psychologist spoke of this as "rewarding" her.

They did not seem to notice that the initial taking away of her radio was for her a very painful form of punishment. This young girl had apparently been so de-graded by being made the object of medical ministrations, that others on the staff also felt they had the right to manipulate her life circumstances without being obliged to consider her feelings or, what in other circumstances, would be considered her basic social rights.

The medical degradation of patients, the conversion of them into objects to be changed from the outside (e.g., by drugs or social manipulation), discouraged patients from trying to change themselves. The message they received that they were not morally worthy, that they were not responsible human agents, may have been sent in the belief that it protected patients and was for their own good, but it carried with it the implication that patients had not the power to improve their own circumstances or the potential to make viable decisions on their own behalf. The result was to encourage a sullen passivity, sometimes referred to as an "institutionalization syndrome". The girl whose radio was taken away from her decided that she would do nothing but sit in the day room,

even though her radio was being offered to her as a reward for doing otherwise. In this way, patient degradation grossly interfered with the presumptive medical goal of returning patients to their communities to function as normal, productive citizens.

The lowering of patient status, and the concomitant raising of medical status, seemed to introduce into psychiatry and rehabilitation a kind of insidious "moralism". When patients failed to live up to medical (and often rehabilitation) expectations, they were not called "bad", but "sick". This "sickness", however, was not treated like an infection they would soon get over and would leave few lasting consequences. Rather, it was treated as a species of "super" badness; one which was built into the physio-chemistry of the patient. Patients behaved badly. They broke very basic social rules (see chapter 7). They were inappropriately angry, or very irresponsible, or intractably depressed, or hopelessly confusing in their thought and communication patterns; all of which they were not supposed to be. And what is worse, they either didn't change their ways, or changed them with maddening slowness. To medical personnel there seemed to be no other reason why mental patients resisted change

than that they had bad brain chemistry or bad genes; with the emphasis on "bad". It was as if patients were born bad, irrevocably bad, and that this is what justified large doses of control and the large scale discounting of patient judgments and desires.

Medical personnel were often exasperated with their psychiatric charges and from this exasperation grew their moralistic degradation of patients. Far more than once, I saw whining clients ridiculed, or verbally incoherent patients treated with great disdain. Far more than once, I saw doctors or nurses talk past their psychotic patients, or ignore their wishes during planning sessions. Of even more consequence, however, was the fact that because bad chemistry was considered the fault, the history of the patient's difficulties was rarely explored. Patients suffered the indignity of hardly ever being asked how they felt, or about what had happened to them in their families before they came to the hospital. If they were asked about these things, they were asked in such a way that the patients believed medical personnel didn't really care about them. Certainly, literally scores of my clients told me that their doctors and nurses had never really talked to them about the things that were bothering

them. Some asked me, "How come?", while others complained that a system which so ignored their feelings was "a rotten system". More common than blaming the system, however, was a kind of self blame; a feeling that if I am treated with disdain, if I am ignored, it must be because of something about me; I must somehow be a bad and unworthy person who deserves such treatment. It must be observed that this is no mere inference on my part, for dozens of my clients asked me what it was about them which caused others to treat them so badly. Many were convinced that it must be because they were "evil".

This quasi medical moralism which patients experienced was almost surely unintended, and indeed would not have been recognized as moralism by medical staff. Yet the way patients were treated functioned as a species of moralism. "Moralism", as opposed to "morality" or "moral models", implies a righteousness, a belief that one's own judgments are beyond question, while the rejected beliefs of others are beyond redemption. Moralism implies an almost absolute right to tell others what to do, and hence it is that the "medical" treatment patients received is being compared to moralism. By telling patients what to do when they were in the

hospital, or when they were free to go out into the community, or what medications they must take, or how to treat their families or, -with regard to rehabilitation-, that the time had come for them to seek employment, while simultaneously ignoring their desire to be heard and understood, patients were given the message that they were "bad" and that their views and feelings were not worthy of consideration. By their actions, doctors implied that "righteousness" was on their side. They acted as if only they were right, and that because patients had an unredeemable physiological malady, they must almost invariably be wrong. Hence the strong belief that it was medical personnel's prerogative to prescribe behavior to hopelessly "sick" patients operated as a functional equivalent of moralism. Patients felt condemned, or at least "judged", even if their doctors only thought of themselves as practicing scientific medicine in their patients behalf.

In fact, many psychiatrists firmly believed that their prescriptiveness was a humane defense of their patients' moral rights. Certainly many of them did talk about patients' rights, and genuinely did intend to enhance patient dignity. Patient rights were often talked

about at case conferences and at in-service training sessions. Indeed, the very process of "deinstitutionalization" (i.e., the referring of patients out of the hospital, mostly into small group homes) was supposed to be an exercise in restoring patients' rights. Its presumed benefits were frequently compared with the moral horrors of the long-term "warehousing" of patients which was said to have occurred in the past. The doctors with whom I talked considered themselves to be humane people, and not moralizers. That some of their concurrent medical beliefs encouraged an authoritative prescriptiveness which functioned as a form of moralism to degrade and de-value patients, must therefore be accounted a side effect of medical ideologies.

d) The exclusion of alternative solutions. The medical models, especially as employed by most of the psychiatrists at the state psychiatric hospital, tended not only to favor physio-chemical solutions to patient problems, but to discourage the use of other solutions; specifically those involving "role change". Their bio-physical orientations encouraged doctors in the belief that most psychiatric conditions had no real "cure", and that therefore the pursuit of substantive psycho-social

change was a chimera. This meant encouraging the maintenance of patient "functioning" as long as the patient could get by in the community without too much trouble.

Many psycho-social ideologues (e.g., the psychoanalysts) have maintained that many clients need to "regress", i.e., exhibit some unwanted, often infantile, forms of behavior, before they can begin making substantive progress toward change. Re-experiencing old traumas is thought by some Freudians to lead to "corrective emotional experiences" (Alexander, 1948), which though unpleasant to live with or to live through, make for increased emotional strength. To state psychiatric hospital doctors, however, this point of view was anathema. Regression, however introduced and for whatever purpose, was viewed as unwelcome. It interfered with straightforward, measurable progress toward the inducement of socially acceptable behavior in patients. Thus while some psycho-social ideologists might have argued that the adolescent girl who wanted to rock back and forth in the dayroom might have benefited from the comfort she was giving herself, the consensus at the state psychiatric hospital was that rocking was "unhealthy"

behavior, and hence to be firmly discouraged. Other perspectives were regarded as "fanciful". When I mentioned at a case conference that some in the literature recommended that patients be allowed to "work through" their feelings, including the use of rocking if necessary, I was told that this view of patients was "unrealistic", and it was never seriously considered as a potential treatment modality.

In another instance, a client had made a mess while doing some cooking at a group home. His rehabilitation counselor from the psychiatric hospital was not upset by this, and indeed viewed it as a positive sign. She believed that because the client had had feeding difficulties as a child that it was not surprising he should be attempting to evolve techniques for coping with food and food preparation. Her view, however, was adamantly rejected by the group home staff and the client's psychiatrist. They instituted a new medication regimen and a rule forbidding him to cook at night. Discussion of alternative strategies simply did not occur.

Why those with medication-oriented medical models were so intolerant of other perspectives cannot be given a

definitive answer here, but several possible explanations do present themselves. First, physio-chemically oriented models were viewed as "scientific". In an age of scientific ascendancy, alternatives may have been regarded as vague, imprecise and unscientific. Second, a related possibility is that medicine itself is ascendant in our century. It has performed miracles in keeping people alive and well, so that any approach promising to eclipse medicine may have been viewed as thwarting progress. A third possible reason for the exclusivity of medical models is the reliance they place on medical authority. Medical ideologists may have feared that if other perspectives were allowed equal legitimacy, these would have robbed medicine of its authority, and, in consequence, of part of its potential benefits.

A fourth explanation, one which also has to do with authority, relates to psychiatrists' personal aspirations. Doctors occupy a very high status in our society and they may be expected to want to preserve it. Since doctors, by law, have ultimate control of medications and so can use the prescription of medicines as a major prop for their status, any ideological perspectives which foster an alternative to the use of medications may be expected to

meet with medical opposition. A fifth possible reason why medical models might be used to discourage other views is that the use of medications has apparently established itself as a relatively inexpensive and fairly effective method of controlling large numbers of socially disruptive people. Psycho-social models might have had a better chance of being viewed with favor but for the fact that these techniques are often costly, time consuming and emotionally painful. Hospitalization and chemo-therapy, on the other hand, have the advantage of relatively easy implementation, and because of their historic application also have the advantage of existing public acceptance. Finally, because medical models are viewed as moral, they may have been regarded as a bulwark against the return of barbaric treatment methods for the insane. Alternatives, whatever their rationale, carry with them the possibility of destroying a perspective many believe to be one of their ultimate social protections.

Though many of the reasons favoring the exclusivity of medical models may have merit, they nevertheless impede the implementation of other solutions which might also benefit psychiatric patients and/or society. Medicine has long represented itself as a champion of human progress,

but the possibility exists that it may also be slowing certain forms of progress.

The Moral Ideologies of Psychiatrists

In many ways, this section on the moral models current among psychiatrists must duplicate materials already presented above. The primary reason for this is that the chief moral system used by doctors in guiding their rehabilitation related work was the medical model of psychiatric problems. In discussing physicians' medical ideologies, it has been strongly asserted that these functioned as moral, and often "moralistic", perspectives. Doctors often presented their medical views as a branch of science, but in fact in the psychiatric arena their physio-chemical views seemed as much a faith as a science. Views about the specific nature of the chemical and genetic substrates of psychiatric "illness" changed regularly (see Sarbin and Mancuso, 1980), but a belief in the necessary existence of "some" substrate persisted nevertheless. In fact, medical definitions and scientific theories served to disguise the ever-present moral aspects of most of the work psychiatrists actually did with

patients. It must be recalled that patients faced strict controls; that they were blamed and punished, and relegated to a position of reduced moral responsibility. These were all moral acts, and, what is more, were justified as being for the patients' own "good".

When potential patients came to the state psychiatric hospital, they did not complain of chemical imbalances, but usually spoke of problems having to do with families or neighbors or the police. They protested bitterly about the injustices perpetrated against them, and asked for help in correcting these. The problems of which most of them spoke were undoubtedly moral in nature, i.e., they had to do with attributions of rightness and wrongness, and good and bad. And it was moral assistance which most of them sought. They wanted to feel that they weren't guilty, or that others were basically at fault, or, at least, that their own badness might be expiated. Once in the hospital, this moral context did not evaporate, and patients found themselves surrounded by people regularly passing moral judgments upon them. Staff members, including psychiatrists, labeled them "bizarre" or "paranoid" or "passive-aggressive" or just plain "sick". Not only were these moral judgments, but most of them were

negative moral judgments. As has been pointed out by psychologist Ernest Seigel (personal communication, 1981), if you think well of someone and they persist in a job they are doing you describe them as exhibiting "perseverance"; if, however, you do not think well of them, the very same behavior will be described as "perseveration". Hospital patients were likely to find themselves judged as "perseverating".

Within the active moral arena of the hospital, the doctors' medical status acquired important moral aspects. He (or she) served as a figure of authority, mystery, and ultimate justice. He was supposed to be able to cure people, whether or not this was his avowed aim. His role as leader of the medical team made him a symbol of the virtues of medicine as it sought to rationalize and humanize the treatment of the insane. No doctor I met proclaimed himself a symbol of medical virtue, but the acceptance of authority, indeed the assertion of authority, within what was a highly charged moral context, can, I think, be fairly construed as tacit acceptance of this symbolic moral function.

If it is correct to say that in employing medical

models as they did, psychiatrists were simultaneously invoking a disguised moral model, then it must be observed that this disguise itself had moral consequences. By assuming a scientific, physio-chemical mantle, and by clothing themselves in the authority of medical expertise, doctors made their position difficult to challenge. Others with a more overtly moral perspective might well feel themselves to be challenging objective facts, not subjective moral judgments. In short, the medicalization of the psychiatrists' role was itself part of a larger moral enterprise; a moral gambit whose success hinged upon convincing potential adversaries that it was not a moral act at all. In fairness, it must also be indicated that most doctors honestly believed that their role was more scientific than moral, whatever its moral effects might be.

Beyond the moral aspects of the medical model, and the symbolic role that psychiatrists occupied within this, doctors shared many of the moral perspectives of other hospital and rehabilitation personnel. Doctors, as well as counselors believed in the work ethic. At case conferences, they spoke both of the dignity of work and the duty to work. On numerous occasions I was told by

doctors, "It would be a good thing if we could get X to work", or "I think a job would straighten Y out". Physicians also had many personal moral commitments. They too endorsed conventional moral rules, and advocated human dignity, and patient rights. A major difference between them and counselors in this area was that physicians were more likely to describe behavior they advocated as "healthy". Thus certain kinds of family relations, e.g., those where "warm" and "supportive" feelings were shared and where communications were "direct", would be described as indicating mental health, while others, e.g., those with endemic patterns of fighting, would be labeled "pathological". Oddly enough, no doctors I encountered talked about the sexual morality of clients or staff members the way some counselors did. In their sexual attitudes they seemed to be fairly non-judgmental; perhaps because of their medical training; perhaps because of the influence of Freudian ideas.

At the state psychiatric hospital, many of the psychiatrists were of foreign origin, and one got the feeling that their personal moral beliefs were not always the same as their subordinates', but their personal views were rarely shared in casual conversation. There existed

a kind of moral distance between M.D.s and the rest of the staff. My impression was that since doctors held a morally superior position in the hospital, i.e., since they exercised an acknowledged right to make judgments regarding patient behaviors, this made them, at least, the symbols of moral wisdom, and that a prohibition on the easy communication of moral attitudes between doctors and those of lower status functioned to preserve the former's mystery and authority. In any event, I did not learn much about psychiatrists personal moral views beyond what was implied in their actions toward clients and staff, because these were not matters they talked much about in my presence; -nor, I gathered in the presence of other rehabilitation counselors.

The moral models used by psychiatrists did have side effects, but as far as I could determine, these were the same as those already enumerated in our discussion of the moral ideologies of counselors and the medical ideologies of psychiatrists, and hence will not be repeated here.

The Psycho-Social Ideologies of Psychiatrists

Psycho-social models were in little evidence amongst the doctors at the state psychiatric hospital or at the community mental health center where I was briefly out-stationed. If anything, there was a decided bias against these ideologies. Whenever talk of treatment arose, it was diagnoses and possible medications which occupied psychiatrists. My experience was that doctors were far less likely to discuss patient psycho-dynamics than were counselors, and counselors did not much talk about dynamics. If role change were mentioned at a conference, it was not a topic psychiatrists pursued. Very often they explicitly dismissed it. What was called "therapy" by them was the kind of behavioral prescription which has already been described. They did, of course, have some belief in the value of psychological causation as was implied by their belief that patients' acceptance of their illness led to improved outcomes. This kind of acceptance was often called "insight", but a deep understanding by patients of their own psycho-dynamics was rarely what was meant.

Some counselors and social workers told me that at the local teaching hospital there were some psychiatrists who did believe in "psychotherapy". These counselors also

made a point of relating that these doctors were in the minority, and that, moreover, their skills and commitments varied widely.

The Educational Ideologies of Psychiatrists

Psychiatrists, like state agency VR counselors, were not educators; nor did they perceive themselves to be rehabilitators. The psychiatrists' major roles in the rehabilitation process were certifying disabilities and referring patients for rehabilitation services. Nevertheless, despite the emphasis doctors placed on medical models, in making referrals, they often did recommend training, either to teach a specific vocational skill, or to have a patient obtain a particular educational degree. How this training was to be conducted was not an area with which most doctors concerned themselves. While they did not distinguish these prescriptions from medical ones, they generally acknowledged that "training" was not their area of expertise. Indeed, it seemed that many doctors recommended education because it was a conventional social value. Everyone "knew" that schooling was necessary if

people were to obtain "good" jobs. When I pointed out to one psychiatrist that for his patient this might not be true, he acted genuinely surprised, and then admitted he really didn't know. After all, he said, it was I who was the vocational rehabilitation counselor. Similarly at an in-service on learning disabilities, the psychiatrist presenter made a persuasive appeal to the VR counselors to provide more education for these clients, but when one counselor arose to ask how this was to be done, he replied that he did not know, that it was the counselors who were the experts on training.

One exception to the above attitude (out of the perhaps forty or so psychiatrists with whom I interacted in one way or another) was exhibited by the psychiatrist who was called upon by the state VR agency's central office to give advice on how to work with psychiatric clients. He made recommendations on how to use, or more accurately, not to use, college programs. But his views, too, seemed more grounded in conventional wisdom than in an educational ideology. Thus his views seemed to have more to do with morality than with a developed model of how skill training might best be employed with the psychiatrically disabled.

The Ideologies of Nurses

Nurses, like doctors, had their primary identification with medical ideologies. The role of "nurse" has historically been a medical one. Within psychiatric hospitals, including the state psychiatric hospital, the chief functions of nurses have been the dispensing of medications and the regulation of patients' ward behavior. In recent years, many nurses have revolted against the more custodial aspects of their jobs, and their professional organizations have lobbied hard to put nurses in a more "therapeutic" role. This has resulted in many nurses beginning to function as counselors and therapists. At the state psychiatric hospital, some ward nurses were designated as the primary therapists for a few patients, and some nurses were assigned to the out-patient unit where they functioned as full fledged therapists.

Despite this recent movement into counseling oriented tasks, nurses, at least those at the state psychiatric hospital, retained the most medically oriented philosophies of all staff members, with only the possible

exception of doctors. Nurses believed very strongly in medical authority and in the efficacy of chemo-therapy. Traditionally, nurses have been the "hand-maidens" of doctors, and many identified their chief role as the careful regulator of medications. When given therapeutic responsibility, as in the out-patient department, they tended to concentrate on observing and adjusting the effects of medications on their clients.

Because of their intimate relations with patients, nurse-therapists were exposed to the hurly-burly of moral interaction. Like counselors, their own personal moralities came to the fore. The moral rules they emphasized, however, seemed more conventional and more work oriented than those of most counselors. Many of the nurses with whom I interacted seemed pre-occupied with issues of cleanliness, a traditional nursing task. They were also the most moralistic of those who functioned as therapists. Thus many of my out-patients told me that whenever they went for medications their nurses would ask them what they had been doing in their private lives. If these nurses disapproved of the way the patients were conducting their love lives or their other personal relationships, they did not hesitate to comment. Many of

my clients told me that they deeply resented such judgments, and this was a reason they gave for not going to medication clinic.

In terms of vocational rehabilitation, nurses were easily the most concerned with getting patients competitive employment. In personal conversations I had with nurses, they often commented that particular clients "needed" work. Often I was told that "it isn't right for X to be sitting home doing nothing". Frequently this would be followed by a statement such as, "It's not normal". I also received proportionally far more referrals for vocational services from nurse-therapists than from the psychologists or social workers of the hospital out-patient unit. (The ratio was at least 3 to 1.) These nurses seemed to favor clear-cut and routine solutions to their patients' problems. Thus they seemed more comfortable with the act of making a referral than with the process of engaging in a talk therapy, and with the idea of getting someone a job rather than the subtleties of altering relationships. In consequence, they were little involved with psycho-social ideologies. If talk at a conference did turn to psycho-dynamics, the nurses present were the first to fall silent.

All of these factors give a strong indication of how the historic development of the nurses' role affected their current ideological commitments. Traditionally, nursing has been a profession where roles are clear-cut, where authority flows in established patterns, and where dealing with moral ambiguity is not an advertised part of the job. Over the years nursing schools have developed more and more technologically oriented programs, and it seems likely that these factors influenced the state hospital nurses who functioned as therapists in their preference for technical precision when working with their patients.

All in all, it seems that medical personnel, both doctors and nurses, were relatively unaware of how big a part moral models played in the treatment of psychiatric clients. Both groups tended to think of themselves as engaged in the objective practice of medicine, while in their daily tasks they relied heavily on moral beliefs and influence techniques. It is also probably fair to say that they not only used morality, but "moralism". There existed a kind of medical righteousness which few psychiatric personnel seemed to notice in themselves.

Chapter VI

THE IDEOLOGIES OF VR ADMINISTRATORS

Non-Ideological Ideologists

The concept of "ideology", as we have been employing it, includes two major components, namely: 1) a "conceptual framework" used to understand some part of the world, and 2) an "organization for action" which is used to guide some of the activities of those who hold the ideology. In terms of psychiatric rehabilitation, this has meant that ideologies define what "disabilities" are, and what kind of "treatments" may best be used to remedy them. Medical, moral, educational and psycho-social models have all been used to specify what rehabilitation problems are and how they may best be solved.

When one analyses VR administrator ideologies, one

encounters a group which, though it used ideologies fairly extensively, did not basically seem to have strong ideological commitments. VR administrators may perhaps be best characterized as "non-ideological ideologists". At the state VR agency where I was employed, the top administrators did not use ideology to determine what rehabilitation was or how it should be conducted. Rather, they used it for organizational and personal purposes. Ideologies were primarily employed to protect and enhance the VR agency, and to advance the administrators' own positions within it. They were not employed to define or guide the kind of work done with clients. As will shortly be seen, administrators were not very concerned with helping counselors develop viable counseling techniques. For administrators, ideologies were primarily political tools, and not a "conceptual framework" or an "organization for action" actually used in determining the daily work of the agency. For them, ideology had more a symbolic purpose than an operational one.

The men who ran the state VR agency, especially the dozen or so top administrators at the state central office, i.e., the regional directors, the policy planners, and the liaisons with other agencies, had a very limited

understanding of the ideologies used by VR counselors or psychiatrists. In fact, the man at the top of the agency hierarchy and many of his chief appointments had little or no background in vocational rehabilitation. The director of the agency himself was an administrative specialist who before his VR appointment had run the state department of motor vehicles. The man he designated to head agency operations in the region of the state where I worked had been an executive with a civil rights group. His chief qualification for his new job seemed to be that in his former one he had often criticized the racial practices of the state education department. Neither of these administrators had ever worked with VR clients, and neither had counseling backgrounds. Moreover, while in their jobs they made little effort to gain such expertise. It was not part of their perceived role. They set agency policy; they did not work with agency clients. For them, the ideologies used by counselors and psychiatrists were largely irrelevant.

Counseling ideologies were surely deemed irrelevant by the regional operations director. During a week both of us spent at an orientation session for counselors, he never asked a question about counseling, nor did he appear

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to listen when the subject came up. Instead he devoted his energies to asking questions about agency procedures. He wanted to know about the status system, and fiscal interactions with other agencies, and not about the work done directly with rehabilitation clients.

While the top administrators of the state VR agency did not seem to know or care much about rehabilitation ideologies, their subordinates, the directors of the local VR offices, did have some familiarity with these ideologies. These administrators had all once been VR counselors and all had regular on-going contact with counselors. Nevertheless, it is important to note that they rose to their current positions by dint of having passed civil service examinations which tested their knowledge of the medical aspects of rehabilitation, of some general counseling theory, and of accepted administrative practices, and not because of any practically demonstrated expertise in counseling or commitment to counseling excellence. For the most part, they appear to have been counselors who abandoned counseling ideologies in favor of non-ideological organizational orientations. As such, their personal ideological commitments were not very strong and were very

vulnerable to organizational influences. Thus the director of Northern City's VR agency office assured me when we first met that he was committed to psychiatric rehabilitation. He told me that it was an exciting field, and that he expected to upgrade its practice within his office. Two years later, however, when psychiatric rehabilitation was no longer a priority of the state central office, he too had lost his interest in it and was talking about phasing it out.

For the most part, administrators seemed to use rehabilitation ideologies for politically inspired public relations purposes. A large part of their job consisted of interacting with groups outside of the agency. Often they gave talks on the importance of vocational rehabilitation, and in this could be quite eloquent. As part of this effort, VR ideologies were used as instruments of persuasion. The state director was especially adept at employing moral ideologies to appeal for increased services in behalf of the disabled. He could describe very convincingly the plight of the disabled as social outsiders who only required a helping hand from his agency in order to make it into the ranks of the "hard-working" employed. According to other

administrators, these same ideological ploys were used in inter-agency budget battles. Agency administrators were described as arguing that the moral and instrumental needs of VR clients entitled the VR agency to a larger share of available state resources. Disabilities were portrayed as potentially temporary roadblocks which could easily be removed if only there existed the political will to do the right thing in behalf of the handicapped.

These administrative invocations of ideology were, however, basically for non-ideological purposes. They were not used to guide rehabilitation practices or to understand client needs. Rather their main purpose was to advance agency interests per se. The primary goals sought were organizational growth and stability; and, not incidentally, the administrators' personal advancement within government. Running an expanding, politically successful organization was believed to bring improved career prospects. All of the administrators thus far mentioned were very explicit in their statements that they wanted the state VR agency to "look good", and to get more tax monies allocated to it. Many were equally candid about their desires to impress their own superiors so that they could move on to more responsible and prestigious

jobs. When some counselors objected to some of the administrators' non-client-oriented practices, e.g., emphasizing numbers of statistical "rehab" rather than less tangible client advances, one of them argued that preserving and expanding the VR agency was more important and, in fact, was also in the clients' best interests. As he explained it, only by protecting the agency's interests first did it become possible for counselors to continue providing valid client services.

Because agency administrators existed within a highly ideological arena, they also found themselves in the role of quasi-ideological mediators. Their governmental superiors, other agencies, clients, counselors, and public pressure groups all made demands about how rehabilitation should be conducted, and many of these demands were couched in ideological terms. Willy-nilly, administrators were confronted with the task of reconciling competing, often conflicting, ideas about what should be done to or for various client populations.

The administrators whom I observed (i.e., the ten in Northern City and approximately the same number in the Capital City central office) did not perceive themselves

as mediators. They did not consciously seem to be trying to arrange compromises between competing factions. Nevertheless, they had to placate many very different and very vocal interests. In this, they functioned as "political appeasers". They had at least to give the appearance of satisfying conflicting ideological goals. In order to accomplish this, they made many ideologically grounded promises; for example, to teach clients skills, or to provide them with the dignity of work, and so on. (The account of a Learning Disability conference presented later in this chapter contains many graphic examples of this sort of promise.) They also made claims about the rehabilitation success they achieved or expected to achieve, and provided statistical evidence to "prove" this (e.g., numbers of "rehab" - the meaning of "rehab" will be more fully explained shortly). Different groups were told what they wanted to hear, and this had the effect of cooling passions and postponing clashes. Administrators did not directly solve many problems; often they just waited for fatigue or cynicism to make issues less pressing. They also used ambiguity, e.g., not specifying how programs would work, as a means of obscuring contradictions between competing groups and ideologies. By using ideological language, but without deep personal

commitments to specific ideologies, administrators were able to function as buffers between groups. By being ambiguous, by not dealing with ideological contradictions in a direct manner, and by both promising and claiming success, administrators served the vital political purpose of at least appearing to solve rehabilitation problems,

The Moral Ideologies of VR Administrators

When I first started exploring the moral ideologies of the VR administrators, they struck me as remarkably "amoral" men. I was looking at them through the eyes of a counselor, and through the prism of my own admittedly strong moral commitments. To me, it seemed that the administrators did not really "care" about clients or their "rehabilitation", and that they were especially unconcerned about issues involving client dignity. In order to clarify my own thinking about this matter, I asked my immediate supervisor, a "senior counselor", what he thought. What kinds of goals did he think VR administrators had. His answer surprised me, for his initial response was that he thought that their major goals were "moral" ones. He believed that both the local

office director and the agency director were primarily concerned with avoiding "scandal". Later he added that he also thought they were concerned with "appearing to help" people.

The administrative morality to which my supervisor alluded may be characterized as a "public", and more particularly, a "political" morality. It contrasted sharply with the "personal" moralities of the counselors, for it was not a product of individual conscience, but a visible reaction to political demands. In this public morality, appearances counted for more than substance, for it was appearances which most determined (or were believed to determine) voting behavior. I found myself agreeing with my supervisor that the VR administrators' public morality had two major components: 1) the prevention of politically sensitive scandals, and 2) the promotion of "visible" efforts to "help" politically targeted (disadvantaged) groups.

The major types of scandals with which VR administrators were concerned were a) fiscal improprieties and b) sexual malfeasance. A fiscal scandal had in fact precipitated the appointment of the administrative team

which ran the state VR agency while I worked for it. The preceding team had been dismissed for being lax in its accounting procedures. During its tenure there had been a large scandal concerning the misappropriation of client service funds by a VR counselor. The counselor involved had been able to set up dummy clients whose benefit checks he had obtained. He had also arranged for kickbacks from real clients and from real rehabilitation facilities. What made this matter especially embarrassing politically was that while engaged in this scam the counselor had been selected as the state's VR counselor of the year. On paper the number of clients he had served seemed enormous.

When the new administrative team came aboard, its major mandate was to tighten the agency's fiscal controls and to make it more businesslike in its procedures. The new agency director was selected precisely because of the administrative controls he had instituted while at the motor vehicle department, and he took these responsibilities seriously. He quickly designed forms and reporting procedures which were designed for auditing, not rehabilitation purposes.

Also taken seriously was the prospect of sexual

scandals. Many clients complained of being taken advantage of sexually by VR counselors, and the possibility of these accusations going public, e.g., being taken to the newspapers, haunted administrators. In Northern City it appeared that at least one counselor had slept with some clients. Several of his clients accused him of having done so, and the office gossip was that he had. In an effort to both protect himself and the agency, the local office director began compiling a dossier on the counselor and at one point unsuccessfully brought him up on charges of sexual misconduct. After this incident the director continued to be sensitive to the prospect of public sexual embarrassment. This was one reason why he was uncomfortable with cases of sexual transference (see chapter 4). He correctly perceived that others might threaten a public disclosure of these occurrences. In point of fact, one state hospital "team leader" did proclaim that he would make a "cause celebre" of a transference situation to which I was a party (see chapter 8).

The second major component of the administrators' politically oriented morality was promoting the appearance of helping target populations. For VR agency

administrators, this meant obtaining "rehab". "Rehabs" are not to be confused with lay notions of "rehabilitation". "Rehabs" had a very specific statistical definition within the state VR agency. A client was counted as a "rehab" if he obtained competitive employment and held it for a period of at least two months. If the client then lost his job, he could still be counted as a "rehab", and could reapply for agency assistance and be "rehabed" again. Thus a psychiatric client whose vocational problem was an inability to hold a job might be "rehabed" several times without his underlying problem ever being addressed. Or if a psychiatric client had a regular job which was interrupted by hospitalization, when he returned to work he could be counted as a "rehab" even if no agency service was necessary to bring this about. The Northern City VR office director encouraged this sort of "rehab". Indeed he wanted counselors to solicit the referral of clients who it was known would be returning to their old jobs. He specifically told counselors to ask therapists, and nurses, and doctors to send the VR agency patients who would soon be leaving the hospital in order to return to their prior employment. He explained that these clients would provide "quick, easy rehabs" and that this would be

good for the agency. It would "bring the numbers up". He called referrals of this sort "quality" referrals.

Nor was it always necessary for a client to attain competitive employment to count as a "rehab". A client who returned to a home living situation might be described as having become a "homemaker". Or a client who obtained a place in a sheltered workshop, or who was referred from such a workshop and then demonstrated that this was the limit of his vocational capacity, could have his VR cases closed as a successful "rehab". Theoretically the VR agency was supposed to have done something to facilitate these outcomes, but in fact very often little or nothing was actually done. Counselors were repeatedly encouraged by administrators to do some "creative writing" if this was necessary to get a "26 closure" (i.e., a "rehab" closure). Thus if a counselor saw a client one or two times he might be urged to write a "rehabilitation plan" which indicated that that he had done "counseling" with the client, and that this had contributed to the client becoming a "homemaker", or a "sheltered worker". The fact that all involved knew that the client would probably be going home or staying in the workshop with or without "counseling" was usually deemed irrelevant. Sometimes a

device such as buying a client new eyeglasses would be used to document the fact that a tangible VR service had been provided the client.

The use of "rehab" to document successful rehabilitations was commonly known throughout the state VR agency as "the numbers game". The statistics which this measurement system provided were used for public and political consumption. The Northern City office director repeatedly urged counselors to get their numbers up because that's what the people in the state capital and in Washington wanted to see. That's what proved people were being helped. ("Urged" is indeed a very modest word to use in describing what the office director did, for counselors' evaluations were dependent upon their meeting "rehab" quotas.) (see Blau, 1963)

At one counselor meeting, the office director went so far as to say that the goal of the agency was not to "help" people, but to get "rehab". "If you want to do good", he said, "you should be working someplace else." When someone suggested that "rehab" quotas would lead to "artificial" rehabilitations, he readily agreed, but then asked what was wrong with that. He continued that he was

proud of the fact that the Northern City VR office already had the highest percentage of "homemaker rehabs" in the state. For him, the morality of the situation lay in generating the appearance of helping clients. This he perceived as a positive public good. It was an appropriate goal for a political organization, namely a "state" VR agency.

Nor was the numbers game unique to administrators at the state VR agency. Administrators at the state psychiatric hospital were also partial to it. In order to document the volume of work his people were doing with patients, the director of the hospital's rehabilitation unit had his counselors keep elaborate logs of every contact they had with patients, however brief and however casual (e.g., just saying hello to a patient in a hallway could count). He then used the statistics he generated from these to write a report for his superiors which purported to show how vital rehabilitation was for hospital patients. He and other hospital administrators also emphasized the adoption of "measurable" patient goals which they required to be written into patient rehabilitation "plans". "Measurable" goals meant behaviorally oriented goals of limited scope, e.g., "to

improve program attendance", and were considered important because they were supposed to make hospital staff members "accountable" for helping patients. Again, the idea was that the attainment of the "measurable" goals could be made statistically visible and then used to document the fact that "help" had been given the patients. In the hospital context, as well as the state VR agency context, help was not considered help unless it could be "counted" and persuasively presented to outsiders as help.

Another numbers game played by administrators of the state VR agency had to do with providing "timely" rehabilitation services. Shortly after assuming his position, the state agency's director spoke to counselors of a need to deliver VR services more quickly and not to make clients wait for training, or placement. He told counselors in person and through memos that he had been receiving complaints from clients and from pressure groups about this matter, and that he believed these complaints were justified. In order to hold counselors to a time limit, he reorganized the "asterisk system" (see chapter 3). Whereas previously asterisks on counselors' master lists had only indicated that a client had exceeded the average length of time usually spent in a given status,

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they were now to be construed as time limits. He thus introduced deadlines where none had existed before, and by setting the former average time in status as the end point, he effectively cut the time available to counselors in half. The director had told counselors that he wanted "timely" VR services, and then indicated by his actions that he meant measurably quicker services, not services timed to meet client needs. He was later to claim as an agency accomplishment that during his tenure the amount of time required to make clients eligible for agency services had been markedly reduced.

The state VR agency's director had a special responsibility for the agency's "appearing" to help clients. He was the symbol of the agency, and its chief public spokesman. His concern for appearances showed up quite starkly during one of his visits to Northern City. The morning of his visit he spent explaining agency policy to the VR counselors. Almost all of his talk had to do with cuts in agency funding. Because of this, he declared, the agency would have to work with fewer severely disabled clients. Dealing with these clients, he elaborated, was okay from a "humanitarian perspective", but not from a fiscal one. In consequence, the agency

would no longer be responsible for "therapeutically" oriented counseling of psychiatric clients, and would stop giving clients second and third chances to succeed in rehabilitation if it did not seem likely that they would become "rehabs". "We've got to be hard nosed", he asserted.

The same afternoon the agency director acted as the host of an educational conference given for school personnel. Its topic was "The International Year of Disabled Persons -Converting Ideas into Actions". He gave a twenty minute talk of introduction during which he made not a single reference to the state VR agency's funding difficulties. Instead he made an eloquent plea for help for the handicapped. He urged that work with them be expanded and that their "rights" be respected. He pleaded for the civil liberties of rehabilitation clients, and for the need to bring them into the "mainstream" of life. He bemoaned the fact that television commercials did not show the disabled as real people or give them equal representation with the non-disabled, and consequently it was up to rehabilitation counselors and educators to set the record straight. We, the rehabilitation community, had to help. We, the rehabilitation community, were

helping, but needed to do more. At his morning talk with the VR counseling staff, the director said nothing about a need to help; in the afternoon, and in public, it was his primary message.

The moral ideologies subscribed to by rehabilitation administrators seemed always to be designed for public consumption. Thus while administrators could subscribe to many of the moral perspectives adopted by counselors, e.g., work ethics, they used them differently. For the most part they seemed to use moral ideologies to defend their organizations from outside attack. For example, the head of a private rehabilitation program at one point found the director of a CMHC questioning the value of his program. In order to protect his funding from the local community chest, he was forced to argue the merits of his program. He did this, in part, by emphasizing the moral value of his work and the unique contribution he made to the dignity of psychiatric clients by helping them to obtain employment through the use of transitional supports.

The program director of the Workshop Agency also used moral arguments to further his organization's interests.

With VR counselors and VR administrators, he argued vehemently for years that the state VR agency should be putting more psychiatric clients into "extended evaluation" (status 06). He believed that if this were done, clients might be able to remain in the workshop program longer. Psychiatric clients, he explained, needed longer periods of time in order to complete successful rehabilitation. By putting them in extended evaluation, the state VR agency would be respecting their need for time. At no point did he mention, -unless it was brought up by others, -that keeping psychiatric clients in program longer meant more state VR funding for his program. Nor did he voluntarily offer to keep psychiatric clients in program longer by using the Workshop Agency's own funding resources. While the program director genuinely did care about the physically disabled, his moral arguments on behalf of the psychiatrically disabled rang hollow, especially since it was well known that he was very impatient with these clients during his personal contacts with them. Thus it seemed that his moral arguments had more to do with his agency's needs than those of the clients.

The Psycho-Social Ideologies of VR Administrators

When I was hired by the state VR agency, I was interviewed at length by the office director of the Northern City VR office. I advertised myself as being interested in doing "counseling" with psychiatric clients. The director assured me that that was what he was looking for. He said he wanted to improve the quality of counseling done in his office, and hoped I would make a contribution to raising counseling standards. He assured me that he would "back me up" in this endeavor. My impression was that he was an administrator who was interested in supporting psycho-socially oriented counseling.

That, however, was the last support I was to receive for psycho-social counseling from him. Over the course of the next two years I let it be known that I was trying to develop techniques for facilitating "role change" in clients, and even went so far as to give an in-service training session on the subject. One of the few instances of direct feedback I got from the office director on what I was doing occurred during a private meeting I had with him. We were talking about a conflict I had had with some

hospital personnel, and he indicated that he thought I was "too client oriented". He recommended that I do less counseling. When I defended what I was doing, he simply desisted in his comments.

In general, the local office director seemed to tolerate my psycho-social counseling and that of the other VR counselors. He demonstrated his coolness to this orientation, however, by habitually walking out of in-services devoted to psycho-social counseling topics. Initially, he had encouraged in-services of this sort, but for the most part he remained personally indifferent to them. It seemed that his initial interest in this area derived from state central office interest. The capital city training unit went through a period of encouraging client-centered counseling. It urged counselors to attend training sessions on "micro-counseling", and was prepared to fund counseling training at the college level. My impression was that state capital central office interest in psycho-social counseling was in turn ultimately based on federal government support for the upgrading of VR counseling skills; support that Washington was backing with training funds.

For the most part, however, VR administrators had little interest in counseling per se, and a fortiori in psycho-social counseling. They did not do counseling. Most were not trained as counselors. They had no personal psychological or vocational stake in counseling. For them psycho-social ideologies were only a visible mark of staff "professionalism", and as such, when they were in political favor, were a mark of organizational progressiveness. But when funds became short, it was "rehab" and not counseling expertise which counted.

Furthermore, the state VR agency administrators had little personal commitment to alleviating "psychiatric" disabilities. When funds were low, it was the psychiatric population it first proposed to cut. Quick rehabs were required, and there was little administrative acceptance that the psychiatrically disabled might need time to work through their vocationally related problems. Because most psycho-social ideologies stressed a need for time to work out problems, and hence encouraged long term counseling, psycho-social perspectives fell out of favor. One state agency area director went so far as to say that the agency's real job was to pay for client programs provided by rehabilitation facilities, and schools, and so forth,

and not to do direct client counseling. Consequently, he asserted, if the VR agency did not have sufficient case service funds there would be no job for counselors to perform, and he suggested that in such a case they might have to be laid off. He conceived of the counselors' job as one of distributing case service funds and did not believe that counseling per se was a service the agency could or should provide. For him, the psycho-social ideologies were an irrelevant nuisance.

I might speculate that one of the reasons for this apparent anti-counseling bias was that counseling was very difficult for administrators to control. Counseling occurred behind closed doors and so administrators could never be sure that they were getting an accurate or complete report of what happened between counselors and their clients. In fact, they usually did not (see chapter 9). Counselors learned not to inform administrators of interactions which would upset them, e.g., about sexual transference.

Administrative indifference to psycho-social ideologies extended also to the state psychiatric hospital. Thus, while the hospital out-patient unit's

administrators spoke very strongly about their intention of helping patients through appropriate counseling, many of their actions actually discouraged counseling. Among the devices they used presumably to encourage counseling were extensive "treatment plans" with detailed enumerations of patients problems and of methods to be used in addressing these problems. These plans, however, became ends in themselves and often more time was spent in completing them than in working with patients. At one point, the local state VR agency office director and my senior counselor conferred with the out-patient administrators on how they could best coordinate the delivery of rehabilitation services to the psychiatric patients. After the meeting concluded, I was told that most of the talk had been about newly installed hospital report forms. "Boy", my senior commented, "those folks are really proud of their forms. They seem to care more about them than what's going to happen to the patients."

The most psycho-socially oriented administrator I encountered at the state VR agency was my first senior counselor. He had officially been delegated to supervise all counselors with psychiatric caseloads. I was told by counselors who had worked with him when he first attained

this supervisory position that his original emphasis had been on enforcing agency regulations. He wanted the paperwork filled out as per procedures and the counseling sequence to go as blocked out by the status system. He found, however, that with psychiatric clients the course of rehabilitation hardly ever went smoothly, and that establishing a vocational goal was often the most important and difficult part of rehabilitation with these clients and not just the routine opening phase of a training process.

By the time I started working with him, his attitude toward paperwork was relaxed and casual. He was more interested in the counseling, and we talked about this often. His own preference was for "cognitively" oriented techniques, i.e., for clearing up clients "misunderstandings of reality", but he had developed an eclectic and tolerant attitude towards other forms of counseling. He was willing to see what worked for particular clients, and was willing to talk to me about the different circumstances of different clients. As part of his own attempt to find more effective ways of counseling psychiatric clients, he instituted a weekly meeting of all the counselors he supervised during which

counseling problems and potential solutions could be thrashed out. At these sessions particular clients were sometimes discussed, but the more usual topics concerned how to get the proper services for our clients from outside agencies and how to cope with the policies of our own agency. After a year or so, these meetings were discontinued. The senior's reason for calling them to an end was that they had become uniformly pessimistic, and that he had concluded that there was not much that was going to be done which was really appropriate for psychiatric clients. He told us that he thought the rehabilitation facilities and the hospitals would continue their established practices no matter what VR counselors said or did and no matter what the effect on clients. He did not believe that counseling alone could remedy this situation, and so there was no point in talking about things anymore. In light of the repeated failures counselors experienced and the endemic inter-agency conflicts in the field, this was not an unreasonable conclusion. Partly as a result of this pessimism, about six months later he elected to leave the state VR agency entirely. He described himself as "burned out", and averred that he was not sure he wanted to continue in the rehabilitation field.

Shortly before he left he advised me to be careful with whom I talked about the kind of psycho-social counseling I was doing with my clients. He said that though he found the type of counseling I was doing appropriate to the circumstances, he had found it necessary to "protect" me from some of the other administrators at the local office; particularly the office director. These other administrators, he explained, were not likely to understand or be sympathetic with what I was doing. After he was gone, I did in fact find myself under considerable pressure from the local office director regarding the "intensity" of my counseling, and I was urged to stop getting so involved. (see chapter 8)

The Medical Ideologies of VR Administrators

The state VR agency administrators did not have medical ideologies; they used medical ideologies. In a conversation alluded to earlier (see chapter 4), the local office director compared psychiatric clients to accident victims who needed to go to a hospital to be healed. He

neither knew nor cared how this was done. He only wanted to know that after medical "treatment" referrals to our agency would be ready to become successful rehabs. Nor did the office director make any apparent attempts to increase his knowledge of the medical aspects of psychiatric disabilities. Just as with the psycho-socially oriented in-services, he tended to leave the room during psychiatrically oriented sessions. At one point, when I tried to explain to him how psychiatrists at the state hospital were working with patients, he told me that he already knew about the hospital because he had once been out-stationed there himself. I was later to learn that he had indeed been out-stationed there, but as a part-time supervisor, not as a counselor.

The administrators of the agency's central office were likewise indifferent to the niceties of medical models. As long as a psychiatrist certified that a potential client was medically disabled, they were satisfied. These administrators also tended to use psychiatrists as medical consultants, i.e., as experts on how rehabilitation should be performed. Yet their concern was not about how medical models were to be applied to work with psychiatric clients, but about how the

conclusions of the psychiatrists could be applied to the agency's policy needs. Thus, because their statistics had revealed that the agency was getting fewer rehabs per dollar spent from psychiatric clients than from physically disabled clients, they asked a psychiatrist to tell them how they could avoid unsuccessful closures of psychiatric clients (see chapter 5). He made several recommendations, but the message extracted from these by the administrators was simply that psychiatric cases should be closed more quickly and that psychiatric clients should be given fewer chances to succeed in rehabilitation programs. Quick closures and fewer programs meant less money spent, and it was a justification for spending less on psychiatric clients which was sought, not a medical method for increasing the likelihood of rehabilitation success.

This was implicit in the agency director's statements to the VR counselors that they were to avoid "therapeutically" oriented counseling; that "therapeutic care is not a VR responsibility". The implication of this assertion was that even if therapeutically oriented counseling could be successful, it was likely to be long term and expensive, and hence not in the agency's interest to provide. It was not that the agency director was

"anti"-therapeutic; just a few months earlier, before the agency's financial crunch, he had approved changes in the agency's manual which explicitly indicated that counseling with psychiatric clients was likely to have therapeutic overtones. Rather than being "anti"-therapeutic he was "a"-therapeutic and "non"-medical. His goal was "rehab", not rehabilitation based on medical models; or for that matter, on any other particular models.

The Educational Ideologies of VR Administrators

The state VR agency was part of the state education department, and as such its administrators ultimately reported to education administrators. Yet agency administrators did not identify themselves as educators. They neither taught clients, nor supervised people who did. While they did have to sell agency policies to education administrators, this could be done on the basis of "rehab" and not on skills taught. Sometimes VR agency administrators did talk about training clients, but almost invariably this was in the context of the facilities to which agency clients were referred, and not specifically about vocational skills taught or teaching methods

employed. It apparently was assumed that rehabilitation facilities did teach, and no close inspection was made of what the "personal adjustment training" (PAT) they provided actually consisted of. Agency administrators did say that they were "preparing clients to enter the vocational market" and that they were "teaching vocational skills", but this reflected organizational linkages more than active ideology.

Non-Ideological Orientations of VR Administrators

During one staff meeting, the VR agency's Northern City office director asserted that "rehabilitation is what Washington and the State Capital say it is." One of the counselors countered that the agency staff might have to do what Washington and the State Capital told them to do, but that did not automatically make it rehabilitation. Despite this comment, however, the office director stuck to his guns. Rehabilitation, he reaffirmed, was to be defined by what his superiors said it was. It was not to be defined independently by medical, psycho-social, moral, or educational ideologies. For him, rehabilitation was primarily an organizational matter.

Agency administrators, of course, used rehabilitation ideologies, but as the preceding sections have demonstrated, these ideologies were subordinated to organizational purposes, and not the other way around. Their moral ideologies were public and political; geared more toward agency survival and growth than toward assisting clients. Their acceptance of psycho-social ideologies was conditional and followed political trends rather than being determined by the perceived effectiveness of particular rehabilitation techniques. Similarly medical models were used to justify policy decisions arrived at independently and more contingent on financial considerations than ideological ones; and educational ideology though used was simply the language of the parent organization, namely the state education department.

The basic non-ideological orientation of VR administrators may be documented in several ways: first, by noting that the real passions of the administrators were organizational, not ideological; second, by observing the positive disinterest of the administrators in understanding rehabilitation ideologies; third, by

witnessing the lack of commitment of administrators to particular ideological views; and fourth, by being aware of the public relations purposes to which administrators put ideology.

First of all, the concerns for which most VR administrators reserved most of their time and energy, their real obsessions, had to do with administration and not rehabilitation. State VR agency administrators were deeply committed to 1) paperwork, 2) agency re-organization, 3) money, and 4) "rehab".

1) Paperwork consumed much of the attention of VR administrators. Much of their work consisted of writing memos and reports or of reviewing other people's paperwork. It was no accident that the administrators of the psychiatric hospital's out-patient unit were extremely proud of the report forms they had devised. They had spent long hours in formulating them. And when the VR agency administrators and the out patient administrators got together to establish a "working agreement", the form it took was a written document; one which required months to effectuate. Every paragraph had to be examined and honed to make sure that it included no untoward

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implications. Administrators did not work with clients, but with paper. Even senior counselors saw only the paperwork forwarded to them for review and approval by the counselors, and not the clients themselves. It was therefore understandable that administrators cared more about paperwork than most counselors did.

2) When the administration of the state VR agency was changed because of scandal, the new managers were charged with the task of re-organizing the agency. The plan which they devised introduced a new level of administration, i.e., a special level of administrators to supervise counseling. The purpose of this change was ostensibly to tighten controls and to free senior administrators to more closely scrutinize agency operations. A major result of this change, and one suspects not an inadvertent one, was that incumbent administrators, e.g., local office directors, were to be advanced in civil service rank; and this meant more pay and prestige. For over three years, the Northern City administrators, and especially the office director, were pre-occupied with re-organization. At almost every staff meeting counselors would be told of the most recent delay in implementing re-organization. The office director would report in exquisite detail on

the organizational changes made in other offices. The counselors would literally groan as he began his monthly chronicle, and at one point a poll of the counselors found them overwhelmingly in favor of his desisting from sharing these administrative details. For one month he did so, but then he resumed his practice again in the face of continued counselor resistance.

At the state psychiatric hospital, administrators were also involved in a re-organization. Much of this had to do with de-institutionalizing patients and establishing organizational units to serve them in their new circumstances, e.g., an expanded out-patient unit. At one point, the out-patient unit chief tried to place me under his authority. The energies devoted to this were enormous and will be examined in full detail in chapter 8.

3) VR agency administrators were habitually concerned with budgets and funding. Indeed administering money was central to their organizational roles. When money was plentiful, they devised ways to spend it; when it was scarce, they concentrated on ways to conserve it. At all times, they were intent on maximizing the financial resources available to the organization. They considered

this their chief job, and believed it essential to the survival of the agency.

During my first month with the state VR agency I attended an in-service conducted by the director of the agency. Several times during his presentation he was interrupted by underlings seeking his approval on spending decisions. Since this was during a period of rising budgets, he was in an expansive mood. When asked if he wanted to spend several thousand dollars on video training aids, he just waved his hand and said, "Sure, why not. We've got the money, don't we?" Later, with the advent of federal budget cutting, he and his subordinates devoted much of their time to finding services to cut. Thus it was that he proposed working less with psychiatric clients and implemented spending limits on college and other programs. At the same time, one of his operations managers was proposing the virtual elimination of psychological testing services, and maintaining that it was imperative to ration out existing service funds for without money to spend on client services he believed that the agency would have no mission.

Similarly, the point of the "rehab" numbers game was

to persuade funding sources to keep the agency's budget up, and arguments such as "vocational rehabilitation really pays for itself by creating tax payers out of tax users", were employed to dramatize the wisdom of investing in VR agency growth. Administrators of other agencies used a comparable approach when soliciting money from their funding sources, e.g., when the Workshop Agency's program director argued that longer state VR agency supported programs for psychiatric clients improved the chances of these clients being rehabilitated.

4) "Rehabs", as indicated above, were part of the administrators' money generating strategies, but they had a further life of their own. They were a "hard" measure of agency productivity. They were also a palpable demonstration of a job well done. The Northern City office director was extremely proud of having the second highest number of rehabs of any office in the state. This was a fact he never tired of emphasizing. According to several senior counselors, the office director believed that his excellent rehab record would boost his prospects for advancement within the agency. In any event, rehabs were the primary measure he used in assessing counselor effectiveness, and in order to increase their number he

used a ratchet system, i.e. he would set a quota for each counselor, and when it was met, he would set a new, higher quota for the next reporting period.

Most agency staff members simply accepted the inevitability of the rehab numbers game. Some, who generated high numbers, actually liked it. By and large, it was felt that quotas were going to be part of any governmental organization, so one had to learn to live with them. One senior counselor advised me, "Just do it. Get the rehabs. Don't think about it. You get them (the administrators) off your back, and you do your counseling on the side. No one has to know." This senior made it clear that he believed it irrelevant whether "rehabs" were "phony" or not. "I guess they are", he said, "but so what. That's what they want."

Rehabs, money issues, re-organization and paperwork were all organizational concerns, and all were non-ideological. Administrators thus demonstrated their non-ideological orientations by the positive interest they showed in these organizational matters. They also demonstrated it in their lack of interest in rehabilitation ideologies for their own sake. The

simplicity of the administrators' understandings of rehabilitation ideologies was a major indicator of this lack of interest. Psycho-social and medical models in particular, whether valid for rehabilitation or not, required a sophisticated understanding if they were to be applied to work with psychiatric VR clients. No administrator I encountered, however, showed the slightest intention of deepening his knowledge of these ideologies. The Northern City office director habitually left in-services which touched upon them. And when these subjects came up in private conversation, he either drew upon simple analogies between psychiatric disabilities and physical ailments, or simply announced that he knew counseling because after all he had once been a counselor.

The director of the state VR agency was more candid about his lack of knowledge of medicine or counseling. He explicitly stated that he was neither a doctor nor a counselor, and though he was also willing to utilize expert consultants, in making his policy decisions he made minimal use of medical or counseling theory. Thus the lesson he extracted from his psychiatric consultant's report on the agency's failure to obtain many psychiatric rehabs was that less time should be devoted to the attempt

to rehabilitate psychiatric clients; a lesson which did not require much insight into psychiatric ideology.

Similarly, the program director of the Workshop Agency demonstrated an uncomplicated understanding of psycho-social models when he pushed for more program time for psychiatric clients. While he said these clients needed more time for change, he never said why, and he never indicated how the workshop would use the extra time if it got it. His call for "time" adopted a psycho-social catch phrase, not a developed program. His energies, as with those of the state VR agency director and the local VR office director, were not directed toward ideological niceties, but toward the occasional use of ideological symbols to make organizational points.

Not only were administrators' understandings of rehabilitation ideology limited, but a further sign of their non-ideological orientation was that their expressed ideological commitments were very labile. Their ideological statements, and their ideologically related policies, were often a response to external pressures, e.g., to governmental regulations or funding decisions, to public pressure groups, and to other agencies; and as

these pressures changed, so did their ideological allegiances. The Northern City VR office director was unusually candid about this. At a meeting with me during which he de-emphasized the need for counseling clients, I pointed out that he seemed to have changed his mind about this. His response was, "Well, I blow with the wind". This was not said with any ironic overtones, but was offered as a statement of fact. He elaborated by explaining that as conditions changed, he changed. This, he believed, was the best way to survive in the rehabilitation system.

And change he did. When I first arrived at the state VR agency, he was still trying to expand the provision of rehabilitation services for the psychiatrically disabled. Three years later, he was indicating that perhaps these services should be completely discontinued. When I was hired, he offered strong verbal support for counseling; two years later, he was discouraging counseling. Again, when I started, he was trying to persuade the state central office of the virtues of extended evaluations because they allowed more time for rehabilitation; but when the fiscal crunch came, he quietly dropped this campaign. Most of these changes were dictated by changing

fashions at the state capital and by what he rightly or wrongly believed would earn him credit with his superiors. Thus when central office administrators came to value numbers of rehabs per se, the value of work with the psychiatrically disabled decreased in his estimation. Since these clients furnished fewer rehabs than other types of clients, they became less important.

The state VR agency's director had a similar record. During his first year in his position, he repeatedly vowed that he would never play the numbers game with rehabs. Two years later he was playing it actively. In the beginning he urged counselors to deal with more severely disabled clients, but as the funds available to the agency diminished, he decided that counselors were seeing far too many of the severely disabled. When the federal government offered monies for pilot programs in "independent living", he embraced these as his own. When their budgets were cut, they became orphans. Similarly, when the federal government gave priority to psychiatric disabilities, he did too. And when federal priorities were shifted to learning disabilities, he shifted his. He announced that psychiatric caseloads would be weeded out and would be replaced by learning disabled caseloads.

Administrators at the state psychiatric hospital were equally labile in their ideological commitments. Their number one priority at the start of my tenure was deinstitutionalization. They virtually made it into a moral crusade; preaching it both within the hospital and in the community. Administrators went on local television to explain the moral and therapeutic correctness of returning psychiatric patients to the community. Yet when their state central office decided that perhaps the hospital's patient population was falling too low, there was a sudden disinterest in deinstitutionalization; a shift that was literally accomplished within a single week after an administrator from the state capital visited with hospital personnel. Quite suddenly the pressures and the quotas to get people off the wards were gone.

The fourth indicator of the non-ideological orientation of the VR administrators was that one of the chief uses they made of ideology was to improve the agency's public relations. Pamphlets, television spots, and conferences were all used to spread the message that the state VR agency's goal was to help people obtain a successful vocational adjustment. The messages broadcast

were clearly ideological and were used for the ideological purpose of justifying the agency's program. Nevertheless the ideas they represented were not used within the agency to define the nature of rehabilitation problems or to guide rehabilitation solutions. They used ideology as a kind of external window dressing rather than as a set of concepts that the agency attempted to live by.

Moral ideologies, in particular, were publicly enunciated while administrators knew full well that there was little that was being done, or that could be done, to implement many of them. The primary allegiance of the administrators was to the organization and its survival, and not to making the ideologies themselves work. If enunciating moral ideologies furthered organizational aims, then this was all to the good.

As we have seen, the very day the state VR agency's director was informing the agency's counselors that financial considerations required a reduction in agency services, he was urging educators to redouble their efforts to help the disabled and he promised that the state VR agency would do likewise. A month later, one of his subordinates was assuring mothers at a conference on

the learning disabilities that the agency would bend every effort to help their children, even though he was well aware that the agency neither had the funds, nor the expertise, nor the outside resources to do the job. He assured these mothers of his moral concern and of the agency's moral commitment.

In the same vein, at a meeting of the state psychiatric hospital's out patient unit, the Northern City VR office director assured doctors and therapists that the VR agency was very successful in rehabilitating clients. He touted its ability to provide training and to find jobs; this though he was privately talking about phasing out psychiatric caseloads for lack of rehabilitation success. At no time did I ever hear a VR administrator publicly admit an inability of the agency to provide effective rehabilitation. The image they sought to promote was of a committed and competent organization. Organizational enhancement was of paramount import to administrators. If using ideological language could be used to further this aim, then it would certainly be used. And while they might honestly be committed to a public/political morality, other ideologies might be voiced if doing so redounded to the agency's good.

The Learning Disability Conference

The way VR agency administrators used ideology was paradigmatically exemplified at a conference on learning disabilities which all state VR counselors were required to attend. "Learning disabilities", as the agency director had informed counselors, had been mandated by the federal government to receive VR agency services. In the past, in order for the agency to work with learning disabled clients, it had had to classify them under some other category, e.g., under a psychiatric disability code. The announced purpose of the conference, which was jointly arranged by state agency administrators and by a parents association for the learning disabled, was to introduce counselors to the nature of learning disabilities, and to prepare them to begin working with these clients. The VR agency director was emphatic in his expectation of a dramatic increase of agency participation in the rehabilitation of the learning disabled. .

An account of the learning disability conference will be presented below in some detail. This is because it

dramatically exposes parallels between the introduction of learning disabilities into the state VR agency and the earlier introduction of psychiatric disabilities into the system. In both cases, new populations of the disabled had been legislatively mandated to receive rehabilitation services. Also, in both cases, the lack of available resources to serve these clients -specifically time and expertise- was ignored in favor of politically oriented moral appeals.

The first part of the conference was described on its agenda as a "panel discussion" on the topic of learning disabilities. This consisted of talks about the nature of learning disabilities by two medical doctors, by a clinical psychologist, and by a doctor of education. The assembled counselors were told by these gentlemen that what they would be asked to deal with was not a unitary disorder, but really a cluster of related disorders. It was explained that these problems were largely identified "functionally", e.g., "dyslexia" was described as a label which merely indicated an inability to read. In consequence, the counselors were given compendiums of behaviors which could be used to identify learning disabilities. These disabilities were also referred to as

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"medical" problems, and much of the M.D.'s presentations were devoted to portraying them as "real" problems, and not just the misbehavior of children who were trying to avoid learning.

Also presented was a slide show which speculated about the organic causes of these disorders, e.g., brain damage. One of the doctors categorically stated that he believed many different underlying entities were implicated. Thus, in order to help learning disabled clients, rehabilitation counselors would need to make fine distinctions between the often very different medical problems involved in individual cases. Sometimes the problem might be sensory; sometimes it might involve linguistic processing mechanisms; sometimes the culprit might be faulty memory. Providing appropriate services would depend upon accurate diagnosis.

The phrase "learning disability", related one doctor, had been adopted for political reasons. Its purpose was to provide a legal umbrella for channeling federal monies to clients with a cluster of problems which occurred in the educational area. Using a concept such as "learning disability", he continued, was a tactic which had been

borrowed from the "civil rights movement", but which we should not allow to fool us into thinking there was one underlying problem.

Exactly what services VR counselors were to provide LD clients was barely touched upon by the panelists. When asked about what should be done, one of the M.D.s confessed that he was not sure. He declared that he was not an expert on rehabilitation, but since VR counselors had expertise in medicine, in education, and in the job market, it was we who were best placed to make these decisions. Nor did the educator on the panel elaborate upon the services which might successfully be applied in rehabilitation. Instead he dwelt upon the mistakes which had been made with the learning disabled in the past. He noted that he himself was learning disabled, and told a series of anecdotes about his own problems. His major concern was with convincing the counselors of the basic "humanity" of the learning disabled.

This first part of the LD conference was designed to "sell" VR counselors of the need to work with the learning disabled. It also seemed designed by the administrators to demonstrate to federal regulators and to pressure

groups such as the learning disability association that the agency seriously intended to implement legislation mandating aid to this new client population. In order to accomplish these aims, the administrators organizing the conference had employed presenters who used several, at times conflated, ideological orientations. "Learning disabilities" were firstly presented as medical problems, and the weight of medical authority was used to reinforce this. Then the preferred solutions to learning disability problems were indicated to be educational in nature, though the specifics of these were left vague.

Psycho-social ideologies played a minimal role in the panelists' presentations, but it was indicated that long term, one on one, counseling might be appropriate for some of these clients. Running through all of the presentations, however, were moral arguments. The medical label itself was used to persuade counselors that LD clients were not morally unworthy malingerers, but persons with legitimate, probably physical, disorders. The very phrase "learning disabled" was described as of recent political coinage, and as having derived from a morally oriented political movement, namely the civil rights movement. And the educational specialist was most concerned with establishing the "humanity" of learning

disabled clients, and pleaded that they be treated humanely.

The most morally oriented arguments of the day, however, were presented by a mother who was an officer in the learning disability association. She spent an hour telling the counselors the history of her son's struggle with a severe learning disability. It was a horror story which featured indifferent and incompetent professionals who were ultimately to provide little aid to her or her child. She related how at one point some educators, who had little understanding or concern for the learning disabled, had assigned her son to work in a machine shop to see if he could learn a work skill. In doing this, she explained, they simply ignored his history of poor concentration abilities, and, not surprisingly, within a week he had lost two fingers. After he left school, she described how she brought him to a VR agency where the only thing his counselor could figure out to do with him was to refer him to a sheltered workshop. There, because he had difficulty sitting and doing benchwork, he quickly "failed out". The workshop did not want him because he was not "docile" like most of the mentally retarded clients they were used to dealing with. "And so they

blamed my son", she continued, "when it was really the programs and the counselors who didn't have the time or the expertise which he needed.... They could have been more patient."

In the afternoon, the conference broke up into small discussion groups. Most of the participants in these were VR counselors, but they also included some senior counselors, some administrators, and some mothers from the learning disability association. The group I was a part of was chaired by one of the state VR agency's regional directors of operations. He began with a pep talk. He said that he knew that working with LDs would be difficult; that he wasn't sure how it would work out; but that he was confident the agency would do its best. He then asked for counselors who were already working with LD clients to share what they were doing and especially to relate their successes. This several counselors attempted to do, but they indicated that success was hard to come by. In response, one of the mothers in the group made a plea for the counselors not to blame their clients. She told a story of a teacher who did this, when it was really the teacher who was not giving her pupils a chance to learn. The teacher had prejudged her pupils, and the

mother hoped that the counselors would not do the same thing. What was really needed, she continued, was long term, one to one, committed teaching which accepted the fact that progress would be slow and that rehabilitation would be a lifetime endeavor. For rehabilitation to work, she explained, it needed understanding and a readiness to keep working at it.

At this point I interrupted to draw a parallel between the psychiatric and the learning disabilities. I observed that the VR agency was in the process of withdrawing from work with the psychiatrically disabled; that these caseloads were to be drastically reduced. The agency had found that rehabilitating these clients took a lot of time and money, and resulted in a great many failures. LDs too, I noted, were likely to take a great deal of time and money, and to result in few "rehab". Would we then be withdrawing from work with the LDs?

The response to these remarks was a roomfull of vigorously nodding counselors. One rushed in to say that the morning session had been "from a diagnostician's perspective; not from a practitioner's point of view....What are we really expected to do about the

learning disabled?" Another counselor added, "We don't have the expertise to work with the learning disabled,...and the facilities don't have it either. Where can we refer these people?" A third commented, "How can we be expected to work with the learning disabled when our job doesn't even allow us to be counselors?" And a fourth interjected with much disgust, "The agency is schizophrenic. It doesn't know what it wants us to do. It tells us to help people, but it doesn't give us the resources. It doesn't back us up. This is all P.R. (public relations). It's all political."

The counselors were in firm agreement that the VR agency did not have the resources to provide the learning disabled with the services it was promising. The agency's regional operations director agreed. "It's not us," he explained. "It's the federal mandate.... The feds give us a mandate, but no way to do it." At the same time he turned to the mothers present and told them that the agency would do the best it could. "Well, we're going to try", he reaffirmed. "It's the right thing to do."

One of the mothers then implored the counselors to increase the services they provided and not make

"independent employment a criteria of rehabilitation success." With the learning disabled, she argued, that that might be more than could reasonably be expected. The administrator then agreed with her, and then turned and agreed with the counselors that the agency had not the resources to do all that it was asked to do for the learning disabled. Indeed, the session ended with his trying to placate everyone in the room, yet there was basically no resolution of the difficulties discussed. The mothers continued to hope for increased VR services for their children; and the counselors continued to believe they were being asked to provide a service which they did not have the resources to provide.

After the session was over, a local office director who had sat quietly through the discussion sought me out. "You know what your problem is? You're too realistic", he commented sardonically. He made it clear that he agreed with the gravamen of my remarks; that in his view the agency was not geared toward working with problems as difficult as those of the learning disabled. He indicated that he thought the agency's senior administrators were living in a fantasy world. The essence of his subsequent remarks was that they had no idea of how rehabilitation

worked; that they were most concerned with budgets; and that they were prepared to promise anyone anything as long as they thought it would work politically. "Wait till you hear how they want to cut the budget", he concluded.

One may speculate that what was happening with the learning disabled had also happened earlier with the psychiatrically disabled. A law had been passed which mandated that the state VR agency provide services for psychiatric clients. Psychiatric disabilities became "glamorous". Counselors were "out-stationed" at psychiatric hospitals and community mental health centers. The number of psychiatric clients increased dramatically. Yet counselors were provided with no new skills or programs for dealing with this new population. They continued to use a status system constructed for the physically disabled, and continued to refer clients to facilities such as the Workshop Agency which were committed to physical, not psychiatric, disabilities.

Neither counselors, nor facilities, were prepared for the fact that psychiatric clients might take long periods of time to change, and that even if they did get jobs, might be expected to "decompensate" and so require renewed

rehabilitation interventions. What they had been given was a medical label for a new "disability"; an educational rationale for the services to be provided them; and, most of all, moralistic inducements and justifications for helping this new clientele. In short, what they were given was precisely what the learning disability conference gave for its new "disability". Counselors and facilities were provided only with vague ideologies and not tested programs. They were asked to "do good", and given an analogy with physical disabilities with which to understand their new problems. The use of medical labels gave apparent concreteness to the multiple problems they might expect to encounter. And while some of these probably were medical, others were probably social, yet all were submerged and conflated under the rubric of "psychiatric disability". The reasons for doing this were probably as political as those which induced the agency administrators to use ideology to sell the learning disabilities. Then too there were pressure groups (e.g., the Kennedys) and a need for a political label which could be used to construct a legal conduit for providing monies for target populations.

In the afternoon discussion group at the LD

conference, the regional operations director found himself in a difficult position. He was caught in a conflict between the counselors and the mothers. His role demanded of him that he moderate this conflict, while at the same time at least giving the appearance of meeting perhaps contradictory, perhaps unfulfillable, demands. He responded by telling both the mothers and the counselors that he agreed with them, and proclaimed that the agency would do its best to meet their very different demands. Whatever his personal preferences or commitments, he found himself in the role of a political mediator; a buffer between conflicting interests. The way he elected to handle his predicament was through appeasement techniques. His remarks were designed to calm passions and to make all concerned feel that they had some chance of getting some of what they wanted. And while few left the afternoon session feeling that their hopes would be realized, neither did they leave with a determination to cause future disruptions for the agency. They might not be happy, but they were content essentially to allow things to continue as they had been going.

It may also be suggested that the regional operations director's mediation strategy, namely political

appeasement, was not idiosyncratic, but that it was the product of organizational pressures which biased agency administrators toward this sort of strategy.

"Rehabilitation" has already been described as a vague, "elastic" word. "Disability", "learning disability", and "psychiatric disability" all have the same property.

Ambiguity seems to be built into them, and this seems no accident. "Rehabilitation" programs, as seen in chapter 3, have, under government aegis, grown enormously during this century. They have constantly expanded to include new populations and new forms of service. Government has promised more and more help to more and more people. The more that has been promised, however, the less likely it has become that all promises can be kept. And herein lies the advantage of ambiguity and appeasement. Ambiguity makes it more difficult to document failure and easier to build political consensus, even when underlying agreements are marginal. Appeasement helps contain political dissent, and draws heavily upon ambiguities and promises in order to do this.

"Rehabilitation", as practiced by the state VR agency, is a political creation, and the agency administrators are creatures of a political entity. Their

job is to keep political promises, or at least to appear to keep them. If, in fact, their agency was built on ambiguity and appeasement, then agency administrators would be expected to find these expedients virtually built into their jobs; they would be organizational imperatives. Administrators would also find ideologies of many stripes to be of value in their political appeasement tasks. These could be used to tell people what they wanted to hear, and to mobilize political support in many different quarters. Moral ideologies, in particular, might be expected to have this effect, and so it was that for public consumption agency administrators promised to try to "help" the disabled; to be "humanitarian" in their approaches; to promote the human "needs" of their clients; to turn "tax users into tax payers"; to provide more and more people with the "dignity" of employment.

Side Effects of Administrators' Use of Ideology

The stability and growth of the state VR agency as an organization were intimately tied to its political origins and sources of support (especially financial). This put a premium on it and its administrators accomplishing

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political goals. The use of ambiguity, ideological promises, and apparent proofs of success (e.g., "rehab") all furthered these aims. They also, however, impeded the solution of rehabilitation problems as understood by various of the other rehabilitation ideologies on their own terms. Most especially, organizational constraints contributed to: a) a lack of clarity of rehabilitational goals, b) the adoption of ineffectual rehabilitation techniques, and c) extensive frustration among participants in the rehabilitation system.

a) Unclear goals. Rehabilitation was an arena for numerous and often conflicting ideologies. Organizational biases toward ambiguity and appeasement tended to impede the resolution of these differences. Distinctions between different goals tended not to be made, and it was difficult for participants, e.g., counselors and clients, to know what was being aimed at. Sometimes aims were not even elaborated. Thus there was no specific psychiatric rehabilitation ideology. The closest approach to this was made by Anthony (see chapter 4). As will be recalled, he stressed use of the diagnosis of skill deficits of psychiatric clients, but this view derived quite closely from physical rehabilitation ideologies. Furthermore,

even his perspective aroused little enthusiasm within the state VR agency. Specific and clearly adopted ideologies were not a system priority. Even at the level of work ethics, there was no clear distinction between fostering employment as a client "duty" or encouraging it as a means toward client "dignity". Organizationally pronounced goals were vague, e.g., to "help the disabled", and changed often, e.g., from psychiatric rehabilitation to help for the learning disabled; all of which tended to promote confusion about aims.

b) Ineffectual techniques. Without clear goals, it was difficult for rehabilitation staff members or the VR agency to develop or adopt ideological solutions which actually accomplished what was sought. This was probably one reason why there was not a specific psychiatric rehabilitation strategy. Most of the techniques used with psychiatric clients were adopted from physical rehabilitation, e.g., the skill training built into the status system, and they were not overhauled when practice indicated that they might not be applicable. There existed a kind of technological inertia within the system which the political imperatives of the system offered little hope of addressing. Thus built into the system was

a tendency to refer clients to workshop type agencies with little regard for what they actually did for clients. Measuring mechanisms such as the "rehab" system, which was designed to portray success, also served to mask failure, and hence reduced any incentives for improved techniques. Thus workshop agencies could remain physical in their orientations long after the bulk of their clients arrived with psychiatric disabilities, and they would continue to receive state VR agency funds and referrals.

When agency administrators did support technological change, as for example when they made attempts to "up-grade" counselor skills, this was done with little genuine ideological commitment, and hence was subject to rapid change and contradictory injunctions. "Counseling", of course, lost its glamour as quickly as it achieved it, and where at one time counselors were encouraged to get additional training, not much later they were told that counseling was only an incidental part of their job. Needless to say, this inconsistent support did not promote the development of truly effective counseling.

c) Participant frustration. Without clear goals, or effectual rehabilitation techniques, counselor, client,

and even administrator frustrations were virtually inevitable. The prospect of rehabilitation failure, -by any standard, including that of the public moralities -was greatly increased by the political imperatives of the VR agency and its administrators. Psychiatric clients, in particular, responded poorly to the techniques they were offered, and they were referred back to the agency so often after program and vocational failures, that they were described as "revolving door" clients. For these failures counselors tended to blame clients, and administrators to blame counselors, and politicians to blame administrators. This left no one feeling too cheerful, and promoted the endemic and lingering conflicts which will soon be documented in greater detail (see chapter 8). It also led to withdrawal, avoidance, and a pervasive cynicism, sometimes labeled "low morale", sometimes called "burnout". Thus one unsought cost of political success and agency survival was a widespread sense of discontent and failure. The agency perpetuated itself, while at the same time frustrating a large proportion of its members and users.

Chapter VII

THE IDEOLOGIES OF PSYCHIATRIC VR CLIENTS

Idiosyncratic Ideologists

Psychiatric patients are outsiders. Hospitalization marks them as social rejects; as people unable to sustain themselves in ordinary society. As we have seen, both the moral ideologies of counselors and the medical ideologies of psychiatrists degrade patients. They are stripped of moral status, denied a right to make some basic life decisions, and discouraged from taking responsibility for themselves. Psychiatric patients are relatively powerless people. Much of the control of their lives is in the hands of other people. If they have been certified as "patients" or "clients", they have become enmeshed in an organizational system which denies them the prerogatives of "normal" people, and which delegates them precious few

powers within the organizations. They are, as it were, outsiders within a system; objects of action, more than participants in action. Though treatment plans are developed ostensibly to help them, these are largely imposed by doctors, nurses, social workers and VR counselors. It is these professionals who are delegated power by the organizational systems. It is the professionals who have the symbols of power, e.g., offices of their own, and patients are acutely aware of the disparities in their positions. The envy many of my clients felt when they came for appointments at my office was palpable. They often compared my private plant-filled room with the dinginess of the wards where they were forced to live. They often expressed admiration for the fact that I had "made it"; that I had succeeded in life, while they had yet to get started on constructing a successful life of their own. And whatever their age, many feared that they were getting "too old" even to start a life of their own.

Not only do most psychiatric patients feel powerless, they also feel very alone. Many of my clients complained bitterly about feeling alone and lonely. Many cried openly about not having anyone to turn to; anyone they

could trust. This aloneness was most vividly apparent in "catatonic" and "paranoid" clients. Some of them were almost mute, and some were so hostile that they virtually pushed people away from them. These clients not only complained about being alone, they really were alone.

To be sure many clients had friends of sorts. Many would sit in the hospital cafeteria for hours and chat with people whom they introduced as their friends. Yet when they came into my office, these same clients confided that they could not trust their friends. As one put it, "These people are crazy. How can you count on them?" Other hospital patients might be friends today, but they might change by tomorrow. They might get "sick", and friendship might inexplicably turn into anger or betrayal.

If clients turned for friendship to people outside the hospital, they felt at a disadvantage. They felt different, and unsuccessful, and unworthy of acceptance. Most had learned from past experience that people who discovered they were "mentally ill" would feel uneasy with them. They justifiably believed that most people would, in fact, not accept them, and so making real friends would be difficult. One woman in her mid-thirties told me of

how she felt caught between two worlds. She had successfully obtained a competitive job so she didn't have to hang around with her old hospital crowd, but she couldn't confide in her new co-workers either. She was sure that if they knew about her history of hospitalizations they would reject her, so she elected to go it alone.

Nor was it possible for most patients to turn to their families to alleviate their loneliness. Too often it was their families who had precipitated their psychiatric crises. Many clients told me how angry they became whenever they spoke to some of their close relatives. Time and again I was told how little their family understood them, or how "crazy" a mother or a father really was.

The outsider status of my clients was of a special kind. They were alone and powerless not merely by accident, but because they were perceived as "crazy". Their differentness, their "deviance", had a special character. They might not have been able to explain it themselves, but I believe that three major components were invariably involved. These were: 1) that they had

flagrantly broken important social norms, 2) that neither they nor others could really understand why they had broken these rules, and 3) that both they and others found it difficult to get them to change and to live a life which included less rule breaking.

1) Most clients had been labeled "mentally ill", i.e., "crazy", after involuntarily having been brought to a psychiatric hospital. In order for this to have happened, they almost always had to have upset some other people very deeply. Breaking basic social rules, and breaking them with a flourish, is an excellent way of making others upset, and this many of the clients had done. They had yelled and screamed at others; they had been abusive; some had even become violent. Still others had gone in an opposite direction and become quiet to the point of muteness. In so doing, whether they were loud or quiet, basic social rules of communication had been broken. Others who eventually became patients, while continuing to speak in "reasonable" tones, had begun garbling their words so badly that their language was described by third parties as a "fruit salad", and hence they too had broken communication rules.

With some clients, it was not rules of communication which had been broken, but rules of perception and social understanding. These were the patients who were described as having hallucinations and delusions. They did not agree with others about how to describe their shared world. They often thought they heard voices where others heard none, or they felt themselves to be the target of a plot where others judged no conspiracy to exist.

Another class of clients labeled "crazy" had broken rules about the expression of emotion. They were said to have "inappropriate" moods or affect. They cried too much, or they laughed at the wrong time. -Still others had broken with conventional ways of living, and had done so in style. They wore outlandish or ragged clothing. Or they seemed unable to support themselves by holding a job. Or they invaded others personal space by standing too close or by neglecting their personal hygiene.

These examples do not exhaust the kinds of rules which were broken, but are offered only as a sample of the kinds of rules clients did break and of how flagrantly some might be broken. They give some idea of why others might get upset at client actions.

2) Patients, their relatives and friends, and even hospital professionals almost never knew why the patients broke the rules they did. The rule breaking just seemed to happen for no reason, and this confused people. It even confused the patients themselves, for they often complained that they did not know why they did as they did or were as they were. Many did not even know why they were so unhappy.

People who have been labeled "criminal" also have broken important social rules, but people feel they know why criminals break these rules. Criminals are deemed "greedy" or "mean", and these are considered satisfactory explanations of their actions. With "crazy" people, however, there are few immediately apparent satisfactory explanations for their actions. People who are likely to be called "insane" fall into rages or deep depressions without visible reasons for doing so. They just seem to have exploded, or stopped eating, or whatever. It is the inexplicable, unpredictable quality of their actions which makes them seem "strange", or "bizarre", or, more to the point, "crazy".

Why some psychiatric patients' behaviors seem inexplicable can be seen in a story one of my clients told me. He explained to me why he had become mute in his teens. He related how his parents had always tried to control him, and how he tried to gain some measure of freedom by doing what they wanted him to do. He described his father as a very insecure man who would not even allow his son to offer him some verbal support. This rejection of even modest attempts to help left my client utterly frustrated. He felt that he was not being allowed to say anything, not even supportive things, and in that case he might as well say nothing. But he didn't tell anyone why he wasn't saying anything, so his silence seemed to make no sense. It was labeled "muteness", and he was judged to be "crazy".

3) The third major component of patient craziness was the intransigence of their rule breaking. Many of my clients hated doing what they did and how they consequently were perceived, but they couldn't seem to change themselves. As much as they might want to be like others, they could not make it seem to happen. There was a "compulsiveness" to their inexplicable behaviors. Others who tried to get them to change, whether family or

hospital staff members, encountered the same resistance. This frustrated them and left them prepared to reject the clients as "crazy". If, however, change had come easily, if the clients had quickly stopped their rule breaking, it is likely that they would not have been rejected. However inexplicable their initial behaviors, these would have been chalked up as a momentary "lapse", and the clients would have been readmitted to the fold. The "inexplicable" behaviors would have been explained as due to a "bad day" or some such, and the "crazy" label would have been withheld.

Indeed, it took a kind of persistence to acquire a psychiatric diagnosis. In the case of schizophrenia, for example, the DSM III required at least six months of disturbed judgments, or hallucinations, etc., before the label could be affixed. If patients' behaviors changed rapidly, the professional tendency was to attribute the initial rule breaking to "situational stress" and not to some personal characteristic. Reversion to rule keeping, -and the quicker the better, -made the initial transgression appear understandable, and hence less crazy. But persisting in strange behavior, that made no sense, and hence was "crazy".

Many clients agreed. One of mine who seemed to have been making excellent progress, who had obtained a job, and an apartment, and some friends, and most importantly, who had given up drinking, suddenly stopped coming for her appointments with me. When she reappeared some months later, without job or apartment, I asked her what had happened. She replied, "I don't know. I just seem to need to fail. I guess I must be crazy."

The status of "crazy" outsider was a very painful one. No client I worked with, not one of the several hundred who passed by my desk, expressed any pleasure in having a psychiatric condition. For them the idea that madness might (a la the Mysterious Stranger) be blessed relief, would not have been credible. Craziness meant being condemned to aloneness and powerlessness. It meant breaking rules in such a way that others rejected one to the point of shutting one up in a dark, grimy state hospital. It meant wishing to return to the ordinary world, but somehow finding it impossibly difficult to do so.

Thus, craziness brought with it a powerful incentive

to understand why one did as one did, and why one was as one was; and most important, how one could become what one wanted to be. Craziness generated a very strong need for explanations and for action. In short, it generated powerful impulses toward ideology.

But the ideological inclinations of psychiatric clients, precisely because of their aloneness and powerlessness, resulted in them embracing many very "idiosyncratic" explanations and courses of action. Their personal attempts to change things, or at least to understand them, were often so unique and so different from those adopted by other people that they became signs of craziness in themselves. Thrown on their own devices, because of their very isolation they produced "idiosyncratic" ideologies.

The personal ideologies adopted by many of my clients were very diverse, but they typically included an account of their problems and a plan for trying to solve them. Some of these were simple; others very complex. In one case, a middle-aged female client had encountered a period of extreme familial pressures with which she found it difficult to cope. She experienced a great deal of

pressure in her head which she attributed to the literal build up of steam. In order to reduce this pressure, she made a kind of popping noise with her mouth. Her view was that this acted like a valve which allowed the steam to escape, and hence lowered the pressure she felt.

Another client (L) had been hospitalized many times, and had been under the care of many psychiatrists. She had been given many kinds of treatments and many kinds of drugs. Many of these treatments she experienced as attempts to manipulate her, and indeed when she was a patient at the local teaching hospital many of her doctors were learning their trade by working with her. L had very ambivalent feelings toward these psychiatrists. She resented their "experimenting" on her, but also felt a strong need for their protection. When alone, L experienced what were called hallucinations. She heard voices. She called these voices "the watchers", and said they belonged to her doctors who were observing her from a distance and talking amongst themselves about what they should do with her. L's interpretation of the voices gave her an explanation of how she was being treated and why. It also gave her the feeling that her protectors were with her even when she was alone, and so helped her solve the

problem of handling the extreme anxiety she felt when she was by herself. That these explanations were unique to her and rejected by others was experienced by her as a problem, but they answered such important needs that she was reluctant to relinquish them, however much others might call them unreal.

A third client had also undergone a period of hallucinations. When these diminished, she looked back upon them nostalgically. She described how her body had seemed to merge with George Harrison's (a member of the Beatles rock music group), and how this helped her understand why she felt so strange. Also expressed in her vision was the hope that she would reach salvation through art. Music was extremely important to her family, and so the image of physically joining with George Harrison seemed to offer the prospect of sharing his musical success, and, in the process, becoming what her family wanted.

Finally, a fourth client explained his periodic outbursts of violence as being caused by the intervention of the "beast" of biblical prophesy. The awesome power which he attributed to this spectre helped him to

understand why he was so powerless to control his rages. It also enabled him to feel less guilty about behavior which he could believe was really not of his doing. He could also hope that some time in the future God might appear and protect him from the beast.

Some of these client explanations of their situations, and some of the types of action these explanations persuaded them to follow, may not quite seem to be ideologies. They are so far from our common understandings about how the world works that there is a tendency to dismiss them as, -"crazy". Yet structurally they are the same as ideologies. They define problems and solutions; they are constructed of conceptual elements; and they help their subscribers to select preferred courses of action. They are, however, very "different". We are used to ideologies which are widely shared and very familiar and hence almost invisible to us because they seem so "natural". Client ideologies, on the other hand, are very "idiosyncratic". Their very uniqueness reminds us that we expect ideologies to be socially acceptable and socially shared, even if we do not personally subscribe to them.

One of our earliest formulations about ideologies held that they are "integrated systems of assertions, theories and aims". Integration then seemed to mean "conceptual" integration, yet our present difficulty should make us aware that it means "social" integration as well. "Ideology" includes the notions of being socially shared and of being relatively stable. Mutuality and stability, in fact, go together. When conceptions and aims are shared, they become more definable and less subject to rapid or arbitrary change. They become conceptual "frameworks", and "organizations for action", because of their stability; and they become stable because when many people are involved no one person can change them just by saying so. In short, the ideologies with which we are familiar, the ones we recognize as ideologies, are "institutionalized". Indeed, they are often supported by specific organizationally based institutions.

The various ideological orientations of the rehabilitation staff members which we have thus far considered all have institutional supports. The medical ideologies had the support of "medicine" and of particular organizations such as the hospitals. The educational

ideologies were part of an institution we call "education", and were practiced and protected in organizations we call schools, etc. Even the moral ideologies had institutional supports. Ideas about what is right and wrong are widely shared in our society, even if there are disagreements on specific points and emphases. Furthermore, morality becomes stabilized in social "movements" such as the civil rights movement. When the mothers of the learning disabled children banded together in a learning disability association, they legitimized and stabilized their individual beliefs that their children had a "right" to long term rehabilitation and to committed teaching.

The psychiatric clients, however, had a problem with their "ideologies". The idiosyncratic nature of many of their understandings and plans left them isolated and without much support. Indeed, many of their private explanations of the world invited attack and made them vulnerable to rejection. Their personal ideologies may have solved some of their problems, but they also increased their aloneness and powerlessness. What they needed, therefore, were some institutional supports of their own. These many of them found in religious

ideologies and in notions of "normality".

The Religious Ideologies of Psychiatric VR Clients

Religion provided an excellent institutional support for the ideologies of psychiatric clients. Religious beliefs are widely held among individuals in the larger community. They are therefore not easily dismissed as being solely the product of the client's own imaginations. Religion also provides organizational support, specifically from the churches. It can give clients a place to go where fellow human beings will tell them that at least some of their beliefs are correct. Furthermore, religion is supposed to be anchored in the power and community of God. Hence belief in religion can bring a real feeling of mutuality and stability. One can feel an attachment to God, an attachment one can depend upon. And one can rely on God's power, presumably the greatest in the universe, to come to one's assistance.

When we examined the ideologies of other participants in the rehabilitation field, we found that religious ideologies played a negligible role. Counselors, doctors,

and administrators all had secular supports for their views. They functioned as active members of secular institutions and of organizations which provided them with some sense of power and some sense of belonging. Indeed, most of the staff members we have discussed worked for a "state" VR agency or a "state" psychiatric hospital in a society which has injunctions fostering the separation of church and state. Staff members therefore had less need of, and less potential support from, religious ideologies than did clients, and hence were less dependent upon them.

Religious ideologies did, however, offer psychiatric clients a way of understanding the personal and social problems they faced, and they did hold out the prospect of being able to solve these problems. Typical religious ways of understanding psychiatric problems included "possession by devils", the operation of "transcendental spirits", and the intervention of various incarnations of "evil". One of the examples of an idiosyncratic ideology given above included a religious element. The client who was trying to come to grips with his violence attributed his problem to the intervention of the "beast". He used his own interpretation of biblical prophesy to explain his personal dilemma. Another client of mine stated

explicitly that she was "possessed by the devil". She suffered from deep depressions most of her adult life, and she explained them as God's punishment for her always having been an "evil" person.

Some clients did not believe their problems were due to devils within themselves. Some saw others around them operating as instruments of the devil. During our early sessions together, one of my clients questioned me at length about my religious views. After he had determined that I was an agnostic, he periodically interrupted counseling to try to convert me into a believer. He would smile a wary, yet disarming smile, and say, "Come on. Why don't you believe? -Be nice." When he later started to go through a period of deep anxiety, he confided that he felt he was surrounded by devils. Shortly thereafter he told me that he was sure there was a devil in me, and that he therefore wouldn't listen to me any longer. He then put his hands to his ears in order to shut out the sound of my voice.

Yet another client, one who described himself as a "born again Christian", spent an afternoon explaining to me why he had so many troubles in his life and why he was

so depressed. He said that he believed in a "spiritual world", and that spirits were affecting his brain. The way they did this, he elaborated, was through "visions". He told me about two of these, one in which he saw his deceased grandfather, and another in which he saw a "gray arm" before him. Both of these visions, he emphasized, were real, and he offered as proof of this the "fact" that the arm had removed the pain he had been experiencing.

Psychiatric clients used religious ideologies not only to help them understand why they felt bad, but to give them ways of trying to feel better, i.e., to effect solutions to their problems. The last client mentioned was certain that he received some relief from his visions. More typical was relying on prayer or on God's support. Many clients hoped to improve their chances of receiving God's help either by doing good or by holding the right beliefs. Thus one client told me that she went to church almost daily. She said that she found comfort there; a comfort which sustained her. At moments when she felt confused about what she would do with her life, she would pull herself up straight, take a deep breath, and say, "God will lead me. I've got to put myself in his hands."

Some clients took a very active approach to seeking God's help. One of them, who like the client mentioned above felt she was possessed by the devil, was not content to suffer in silence. She wanted the evil removed from her and so she actively sought someone to exorcize her devils. When she heard there was a psychiatrist in the community who had deep religious commitments, she went to see her. Later, she reported to me, that the two of them had gotten to their knees to pray, and that they had prayed that God would use his powers to remove the devils from within her.

Sometimes clients believed that spiritual help just descended upon them. L, who has already been discussed in several other contexts, also had strong religious beliefs. Among other things, she believed that she had special communications with God. One day she informed me that God had elected to make her a "prophetess". When I asked her why, she replied, "I'm a good person. Don't you know that?" She related that God wanted her to bring his message of love to the world so that everyone could be saved. She said that God told her that I was a prophet too, and that my job was also to bring love to the world.

Another client had more apocalyptic views. She described herself as having become a Jehovah's Witness. During one session with me, she bitterly recounted some of the terrible things that had happened to her in her life. First she cried, then she pulled herself together and informed me that her religion taught that the end of the world was coming soon. When that happened, God would redeem her, and her suffering would not have been in vain. "Perhaps I should rejoice at the evil things that have happened," she said. "Maybe it means the end is coming soon."

Many clients put an emphasis on converting others to their religious views. This was a way of doing good and of pleasing God. The more believers there were, the greater the likelihood the world would get better. Thus it was that the client who believed me a devil was also intent on getting me to believe. Clients even tried to convert one another. My Jehovah's Witness client related how a group of born again Christian patients had persuaded her to become one of them, to burn her old copy of the Bible, and to accept a copy of theirs. Later she tearfully recanted this change of allegiance and explained to me how vulnerable she felt to such pressures.

The religious ideologies of psychiatric VR clients were frequently very intense and very individual. Most who accepted them were strongly committed; they deeply believed. This belief gave them a sense of connectedness and hope. It made them feel less alone and less powerless. It gave their often very personal explanations of the world a sense of universality, and, for some, even infallibility. It gave their confused internal lives a sense of order and comforted them in their private pain. Indeed, it seemed to me, that many of those who were in the worst pain ,and the most isolated, found the most comfort in religion. Thus one client told me that when he was feeling most "psychotic", he also felt most in need of religion. He related that when his pain had been most intense, he had spent months reading religious tracts looking for "answers". When he felt better, he said he felt less in need of these answers.

As was the case with the other ideologies we have discussed, the religious ones too had some side effects. Paradoxically, the major one was isolation. Because the essence of many clients' religious ideologies was bound to a particularistic relationship between themselves and God,

many of their religious beliefs were very idiosyncratic. Though religion gave them the feeling of being connected to larger institutional frameworks, the reality seemed to be that many of their religious ideas were generated internally. Indeed, clients' feelings of not being alone often increased their aloneness. Their confidence in divine support encouraged them to hold on to their particular religious ideas and to resist external human pressures. This meant that some of their ideas would seem very strange to others, and that consequently they and their ideologies would be rejected. This rejection, of course, only intensified their isolation, and hence their aloneness and powerlessness.

The Moral Ideologies of Psychiatric VR Clients

Psychiatric VR clients also turned to moral ideologies for institutional support. Morality may perhaps be considered the most widespread institution of society. Moral rules and values form part of most of our daily interactions. Ideas of good and bad, right and wrong, indicate how we should live, and are built into our conceptions of acceptable ways to live. We habitually

judge ourselves and others in moral terms, and it is so much in our nature to do so that often we hardly realize that we do. Subscribing to a society's moral rules, therefore, makes one part of that society. For this reason, believing in our common morality was perceived by psychiatric clients as a way to offset the aloneness they so frequently felt. By subscribing to ordinary morality more determinedly than most people, by being more Catholic than the Pope, psychiatric clients reacted against the isolation of their otherwise idiosyncratic ideological positions. This was especially evident in 1) the value they attached to "normality", and 2) the widespread client belief that they had to be "good", "caring" people.

1) Normality. As has been noted, psychiatric clients needed to understand why they were different, and why they were so often alone, powerless and in pain. They needed explanations of why they were perceived as bad and "crazy". Often this was summed up in the belief that they were "not normal". The chief connotation of being "not normal" was of being "different" in a "bad" way. Implied was the notion that there was something about them, about who and what they were, that was "wrong". Also implied was an ephemeral, probably indefinable, "quality" of

theirs that made them different.

Being "not normal" was contrasted with "normality". This normality was, however, a very idealized version of the normal. It stressed the belief that there were standard, correct ways of living. These were treated almost as immutable, though in fact they were very imperfectly understood. Many psychiatric clients had almost a child's-eye view of the world. Many viewed social roles as constructed from whole cloth, much as a child might view the role of "policeman" as that of the nice man whose job was to protect them, but without having a further understanding of what policemen do day to day. This kind of thinking was well exemplified by a young client of mine who said he wanted to be a lawyer. When I asked him what lawyers did, he said that they went to court and that they defended people. He assured me that he had been to court and seen some lawyers there, and that he liked what he saw. He especially liked their suits. When I asked him what else lawyers did besides going to court, he answered that he really didn't know. I then explained that attorneys often had to do research in law books and that they had to prepare legal briefs, and so on. To this his response was, "Then I better forget about

being a lawyer. I don't like to read." This sort of simplistic understanding of social roles contributed to their apparent immutability, for without an understanding of the details of social roles, it is difficult to conceive of them as changing.

Their lack of awareness of how others really lived, or of the problems with which they wrestled daily, led many psychiatric clients to imagine that "normal" people did not face real difficulties in living. Normal people seemed to know how to live and to be able to manage their problems with barely a ripple. This feeling was expressed by a thirtyish client of mine when she asked me, "Why can't I handle things more easily? -You know, like normal people."

In order to counter their feelings of being "not normal", many psychiatric clients explicitly and energetically pursued normality. "Normal" was what they wanted to be. "Normal" was how they wanted to be treated. Being "normal" would solve their problems, and so they embraced it.

By the same token, they rejected being "not normal".

Many worked hard to avoid being labeled "crazy", or acting "crazy". They wanted to appear normal and so they tried to hide many of their ideas and feelings which they knew others would consider strange. Thus L did not usually go around telling others about "the watchers". When her therapist extracted her feelings about them at the case conference described in chapter 4, she became very agitated. The semblance of normality which she had been trying to portray had been torn from her.

Similarly, clients tried to avoid associations with the psychiatric hospital. Some who were no longer in-patients expressed their discomfort at having to come back to it in order to receive vocational counseling from me. Many refused to take medications because they were a sign of not being normal, and also of being "weak". Some feared that if they didn't stop taking drugs as soon as possible, they might have to continue taking them for a lifetime; something that would surely mark them off as "different", i.e., as "not normal". Most of my clients were very impatient to achieve rehabilitation success. They wanted to become normal before it was too late. Both twenty year olds and fifty years olds told me that if they didn't get a job quickly there might not be any hope for

them. After all, they had already fallen behind their peers in the race for success. Any more wasted time being different might mean that they would never be able to be normal.

Psychiatric clients had many different ways in which they wanted to be, and attempted to be, normal. One client who repeatedly insisted, "I want to be normal. I just want to be treated like everyone else.", demanded help from me in getting a job she considered normal. She did not want to be a sheltered workshop employee; she wanted to be a housekeeper. That's what her mother had been, and that's what she wanted to be. She also wanted to be married; that was part of being normal too. And while she was not able to achieve the former goal, she did fulfill the latter.

In a general way, the major constituents of a normal life singled out by most clients can be seen as elaborations of the two that Freud identified a half century ago: namely work and love. Clients wanted jobs and they wanted human relationships. They wanted college degrees, and girlfriends, and money, and success, and same sex friends, and families. Often the jobs they wanted

were fairly specific, e.g., to be an artist or a businessman; sometimes they were general, e.g., "I just want to work", or "Get me something where I can use my hands." Goals involving love were usually very generalized, and if marriage was desired, it was usually very idealized.

Other constituents of the "normal" life which were desired were: "an apartment of my own", "good clothes", and "respect". A client who had suffered from mutism aspired to the "normal" use of language. The same client also wanted to learn how to cook so that he could be independent like other people. L was especially eager to obtain respect. She envisioned herself as a "leader", and imagined that if she could get other people to accept her in such a role that she would then have the status that she so sorely wanted. If she were only a leader, then she wouldn't have to envy her brothers the houses and jobs and kids they were "so proud of". She would then be normal too.

2) Caring for others. Helping other people was an explicitly moral aspiration of many psychiatric clients. If the problem that they faced was not only that they were

different and alone, but that they were "bad", then the solution that many attempted was to try to do something for someone else; something which would unquestionably be "good"; something which would give them a reason for living; which would give them their place in the world.

Doing for others, was for many psychiatric clients, a substitute for what they really wanted; namely someone to do things for them. Often they were afraid to make overt demands for help for themselves for fear that that would be "selfish". One of my main counseling tactics was to encourage clients to help themselves. Though many were pleased to hear me tell them this, the usual response was, "I can't do that", and then I would be told a story of how if they helped themselves, it would have to be at someone else's expense, and that that they could not do: it would be bad and "selfish". One client used to bring me small gifts on a regular basis, and for months I asked her to give to herself too. She told me she would try, but actually continued to deny herself even the smallest benefits. When I pointed this out to her, she said she had not been raised to care for herself, but to care for others. If she gave to herself, it just made her feel selfish. She did not know why this was so, but she

couldn't change the feeling.

An extremely large proportion of my clients (perhaps as many as half of the several hundred I worked with over the course of four years) expressed a need to help others, and very often specific others. -Alice wanted to help her mother. She had been abandoned as a child, and now felt a need to mother her own mother. These feelings became especially strong the more her mother demanded help and the more strangely she behaved. -Betty felt a moral duty to help her father. He was regularly hospitalized for schizophrenia, and pointedly asked her to stay with him and care for him. She was ambivalent about his demands, but always elected to help him. "What can I do?", she said, "He's my father." -Clara directed her efforts to helping children. She sought out volunteer jobs in schools and churches so that she could give her love to the young. -Dorothy needed to help the old. Though she often complained about their crotchetyness, she felt compelled to do volunteer work at senior citizens agencies, and to listen to the old whenever they wanted to complain to her about their problems. -Evelyn sought out people to help in taverns. She looked for dependent women with lesbian inclinations and encouraged them to look to

her for support. The more physical and emotional problems they had, the more attached she became to them. She gave them money, a place to stay, protection from threats; whatever seemed needed.

Many clients literally wanted to make careers out of helping others. -Frank sought my assistance in getting college training as a recreation therapist. -Gertrude was not so specific about how she wanted to help. She enjoyed working with both children and old people, and so she entered a generalized program in the "human services" which trained people for paraprofessional jobs in the helping professions. -Helen was more ambitious. She wanted to become a social worker, and so she was working toward a B.A. in social work, and hoped eventually to obtain an M.S.W. She wanted to help alcoholics, since her father had been one. -Jane had been a social worker, but felt unable to continue. She had specialized in working with children, but decided she couldn't remain with this kind of work because she didn't even know how to help her own children.

Frequently the kind of help clients wanted to give had very visible roots in their own family histories.

Thus Frank had a father who had been a recreation leader. His father died when he was a young boy and he missed him terribly. Helen came from an alcoholic family. She also had some drinking problems of her own, but had overcome them, and now wanted to share her success with others. Jane told me that she had gone into social work because of her mother. The latter had suffered from asthma and it had been Jane's responsibility to care for her. She had come to feel that it was her responsibility to take care of everyone. And though she protested against this, and protested that she wanted to care for herself too, most conversations with her centered around other peoples problems and what she still felt required to do for them.

After having worked with me awhile, many of these clients were able to admit their guilty secret that they really resented helping others. Betty was able to confide that though she was required to help her father, he never seemed to help her. Was this fair, she wondered? Who was there in the world who really wanted to help her? And when the answer she gave herself was no one, she put her head in her arms and cried bitterly. Jane also felt the inequity of having had to help her mother and her children and her clients. She related that she felt alone in the

world, but also felt a need to hold on to relationships in which she was doing the helping because otherwise she would have no one, and she didn't feel she could face that.

Frequently the emphasis psychiatric clients placed on normality and on helping others had some unintended side effects. Trying to be normal and to help others were envisaged as ways to increase social integration, yet in an important way they often decreased it. Their moral aims often brought clients into conflict with staff members at the vocational rehabilitation agencies and at the psychiatric hospitals, and so increased their isolation. Counselors and therapists often needed to perceive clients as "not normal", e.g., as "ill", and they often felt that it was they who were supposed to be the helpers and not the clients.

One client who insisted on being treated as normal by others found herself being told by her psychiatric hospital vocational counselor that her lack of acceptance of her problems was itself a sign of her illness. She had also repeatedly been told by the state VR counselor who saw her before I did that her vocational aspirations were

"unrealistic", i.e., that she must accept the fact that she was not normal. She was told by almost all of the professionals who worked with her that she must be more "appropriate". When I requested that she be psychologically tested, the results obtained indicated that for all intents and purposes her thinking was "normal", and that her main problem was that years of hospitalization had left her without knowing how to function in normal social roles. Her fighting for "normality", however, had left both her hospital counselor and her state VR counselor peeved with her. Both had told me what a difficult client she was.

Another client who was intent on becoming a helping professional was forever offering to help her friends and relatives. She would put herself out by doing favors for others, and then hoped that they would reciprocate. If they didn't, she became very upset. Her hospital counselor recognized this dilemma, and tried to help her with it. The client, however, did not want to talk about these matters. She insisted on solving her own problems. Help was what she gave others, not what she would allow anyone to give her. This then upset her counselor who felt stymied by a client who would not accept her support.

She used all of her powers of persuasion to get the client to accept her help, and when she failed at this she became very annoyed. The conflict between the counselor and the client over who was to help whom became so intense that after awhile they were not able to continue the counseling relationship.

The Medical Ideologies of Psychiatric VR Clients

Psychiatric VR clients had very diverse attitudes toward medical ideologies. Some were very much in favor of them; some rejected them with equal fervor. Those who accepted them did feel that they were "ill". They accepted the explanations they had been given that they were suffering from a bio-chemical disorder and believed in the need for medications to control their problems. These clients looked to psychiatrists as legitimate authorities, and tended to accept their explanations and prescriptions.

One such client of mine told me how awful her life had been before she realized that she was sick. Now she knew that her depression was an illness, and that if she

continued to take her medications, she would be able to keep going. When I asked her what had led up to her hospitalization, her reply was, "I don't want to think about that." As long as her medication regimen enabled her to keep working, she was satisfied. She admitted she was not happy, but because she believed she was ill, she felt that her life was going as well as she could expect. -Another client with similar feelings repeatedly praised the state psychiatric hospital and its doctors for having "saved" her. "I don't know what I would have done without them", she said time and again.

Some clients used their "illness" as a way of explaining their behavior and of providing a reason why they had behaved as they did. They used a medical rationale for deflecting self blame or the blame of others. One client who had killed his son told me, "It wasn't me; it was my illness." He also used "illness" to explain why he experienced terrible fears. If I asked him why he was afraid, he would reply, "I don't know why. I guess I must be sick."

Clients who rejected medical explanations and solutions were at least as numerous in my caseload as

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those who accepted them. Typically they felt that they were not ill; and they either did not know why they had been hospitalized, or they blamed it upon others for their lack of understanding or their outright rejection. But the most salient element in many psychiatric clients' rejection of medical models was their frequently passionate rejection of medications. They did not feel that they had a physical problem, and they did not feel that medications helped them at all. Often they believed that medications made things much worse. Usually they also had negative feelings toward doctors, and they complained that their psychiatrists never listened to them, and that they imposed unnecessary restrictions and prescribed unnecessary drugs.

Clients often suffered debilitating side effects from their psycho-tropic medications. One, it will be recalled, complained to me that the drugs he was being given were "killing" him. He was not alone in this. Many clients who became stiff, or nauseous, or whose thoughts had become clouded, threatened to sue the hospital and its doctors for having medicated them against their will. Many of them ceased taking medications as soon as they became out-patients; and some of them did this with what

seemed to be good results. The client who complained that his medications were killing him discontinued them once he went home. He immediately became livelier and more smiling. His delusions also seemed to decrease.

Another client gradually decreased her medications once she was out of the hospital. She did not want to rely on psychiatrists or medications to keep her going. Periodically she became frightened and took some tranquilizers to avoid panic. She related that she had become involved with the psychiatric system because she needed social support. She had found that medical professionals would listen to her when others wouldn't, but a price they required was that she take medications. This she was often willing to do, because it was better than being alone.

In a sense, medical models were not ideologies of psychiatric clients; rather they were a set of demands made of them from the outside. They were not a set of explanatory ideas and treatments independently embraced, but ideologies used by others to which they had to adjust; usually by accepting or rejecting them. Therefore clients' understandings of medical ideologies were usually

simple and centered around the main tangible element of the medical models to which they had to react: namely medications.

Perhaps the most important desire that psychiatric clients shared was the hope that the anguish and confusion that they experienced would go away. Medical ideologies seemed to promise that they could accomplish this. If clients put themselves in the hands of doctors and hospitals, and if they took their medications and followed medical prescriptions, then all would be well. The message extracted from this by many clients was that the reward for cooperation with medical systems would be painless change. As a side effect, this discouraged client responsibility, and encouraged clients to come to doctors and VR counselors asking to "be changed", -not for help in changing themselves.

When L came to see me, this was precisely what she asked. In the course of working together, she made it plain that she did not want change to hurt. Her chief complaint about her doctors had been that they promised to make her better, but didn't. Her desire was that I do what they had not. This attitude toward medicine was

comprehensible even though some psychiatrists did make it clear that they expected clients to exercise some self responsibility. It flowed from larger social understandings that medicine and doctors were supposed to make people feel better. The idea was that you go to a doctor, and the doctor cures you.

The Educational Ideologies of Psychiatric VR Clients

Psychiatric clients' understandings of VR educational ideologies were vague at best. A frequent client request upon first meeting me was for "training". If I asked for what, as often as not the answer was "I don't know". As was the case with many other participants in the rehabilitation field, education was simply understood by psychiatric clients as having social value and as somehow leading to good jobs. For many clients it also represented an opportunity to put off having to go to work. Many saw training as an easy kind of work which would enable them to obtain an income without having to exert themselves. They could continue to receive social security payments or they could get a stipend from the training program. Thus a frequent inquiry about training

programs was, "How much does it pay?" If the answer was "nothing", I was usually told, "Well, then forget about it."

While many psychiatric clients recognized that they lacked job skills, many of them hoped that these could be acquired on the job. "I learn better by watching people", was a recurrent comment. Skill deficits were rarely related directly to psychiatric conditions; nor were skills often seen as a way of compensating for psychiatric limitations. If questioned patiently, and, in particular, if not ridiculed, many clients admitted to believing that they had social skill deficits. But these were not understood as open to correction through educational experiences. Patients knew that they had a hard time getting along with people, but this was seen as a personal failing (e.g., "I'm immature.") rather than as due to a lack of knowledge. They did not know how they would learn to get along better, e.g., how to be less angry, but training programs rarely came to mind.

Nor did they realize what was involved in actual "training" programs. It was not until they got into a workshop, for instance, that they fully understood that

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these emphasized the inculcation of work discipline rather than technical skills.

Psycho-social Ideologies of Psychiatric VR Clients

The psycho-social ideologies rarely played an active part in psychiatric VR clients' lives. Most neither sought out treatment based on psycho-social models, nor did they find them offered to them. In my experience with state psychiatric hospital referred clients, it was very rare for a client to understand his problem as stemming from difficulties in role change. In general, my clients viewed psycho-socially inspired techniques as distant and "exotic", and as somehow dangerous. The different kinds of psycho-social models were not distinguished, and most were lumped together as "therapy". "Therapy", in turn, was usually identified with psychoanalysis. Special brands of psycho-social ideologies, such as "client-centered" techniques, were simply not familiar to most clients. The expertise they represented was seen as the property of the professionals, i.e., the therapists and the counselors, who were simply expected to know what to do with their clients.

Some of my clients did ask for "therapy" and wanted to know where to get it or how to choose a therapist. But most wanted to avoid getting involved in something "too deep". They would have agreed with the client who told me in no uncertain terms, "I don't want to be analyzed." While I tried to persuade some of my clients to seek "insight" oriented therapy, e.g., at the local teaching hospital, and though some of them agreed that therapy would be good for them, very few actually followed up on my suggestions and entered upon a productive role change relationship.

In some instances I attempted to engage in psycho-social counseling myself, and with some clients was able to develop long term counseling relationships. I delved into feelings and cognitions with some success, but only with a very few clients, and only after educating them as to what I wanted to do and how I wanted to do it. Most clients, I discovered, reacted to psycho-social techniques as too lengthy, too painful, and too arcane. They just wanted to get better.

One client of mine who had a long history of

hospitalizations began making progress and so was transferred by the state psychiatric hospital to the local teaching hospital. There he was assigned to a hospital resident who wanted to do insight therapy with him. At first, he reluctantly agreed. Then he just stopped going to the hospital except to receive his medications. When I asked him why, he said that the kind of counseling his doctor was trying to do hurt too much. "It makes me remember things I don't want to remember....I just don't want to do it."

Non-Ideological Orientations of Clients

The state VR agency was perceived by many clients as a kind of employment agency. They expected to come to it and immediately be assigned to a job where they could begin earning money right away. Many clients when asked why they had come to see me replied, "I want a job", or "I want to earn some money". Often this was not because they wanted to be "normal" or because they wanted the "dignity" of work, that is because they wanted to pursue some moral aim, but because they wanted some very tangible things in life which they believed a job and money could make

possible, for example, a car or apartment. In this they were very non-ideological.

Many clients had very particular life plans that they wanted to implement. Many of these plans had developed within their families of origin, and many were very persistent. One client had a mother who wanted him to be a business success just as her relatives were. He was bound and determined to fulfill her wish. The fact that he had difficulties in social relationships and even with basic communication skills did not dissuade him. For years VR counselors and therapists tried to persuade him to choose another vocational goal, and periodically he would allow himself to be persuaded. Then after trying the new goal for awhile, and usually after failing at a program aimed at attaining it, he came right back and let it be known that he still wanted to be a businessman.

A client who has previously been described as pursuing normality by trying to become a housekeeper just like her mother had been pursuing this course over a period of thirty years. For her, being a housekeeper meant more than normality, and it was more than an ideology. It was a very particular plan, one which grew

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out of her relationship with her mother, and one which she would not or could not let go. Though she insisted on being normal, she would not allow herself to pursue normality in other ways.

Similarly, another client held on to a house which had been left him by his mother. He constantly protested his need to sell it, but put off doing so for two years. This resulted in his having to remain hospitalized for the whole time, because while he had the house as an asset the welfare system refused to support him, and he could not support himself because he did not have the emotional resources to hold employment. My impression was that holding on to the house was a way of his holding on to his mother and to the security she had provided him, and that he was not about to let go of her whatever the personal cost. This strategy of his was non-ideological for it did not try to explain his life situation, nor was it tied to a comprehensive world view. Neither did it include a generalized problem solving strategy. It was a very particular decision on how he would live. And as with so many other clients, his attachment to it was an impediment to success in other ways.

An Unsolved Problem

Psychiatric VR clients were looking for ways to end their loneliness, their pain, and their powerlessness; and especially for ways to stop being "crazy". One method they used was to adopt idiosyncratic ideologies to help them understand their situation and to direct them to ways out of it. But the very uniqueness of their explanations and plans often contributed to their reputation for being crazy, and so increased their isolation. Religion offered some support, but because of the very personal relationship with God which it permitted, it also facilitated continued isolation. When clients turned to moral ideologies, e.g., to "normality" or to "helping" roles, they often found these aims conflicted with those of their would-be helpers, and so once more they found themselves thwarted. Medical ideologies and medical technologies worked for some. They both explained and controlled many unwanted behaviors, and they did allow clients to be part of a larger community, even if in a subservient role. But many clients found they could not accept solutions imposed from the outside, as in fact many medical solutions were. But if they resisted, they were

once again outsiders, and their problems of aloneness and powerlessness remained unsolved.

Other change ideologies, i.e., the educational and the psycho-social, remained largely tangential to client hopes and aspirations. The psycho-social ideologies were also more painful than most psychiatric clients were ready to accept. Indeed, many saw pain as the problem they most wanted to avoid, and time as something they did not have to spare. Many clients did have non-ideological orientations, which were very much their own, and which they held to tenaciously. Unfortunately for many, their particularistic goals did not come to fruition, or if they did, did not have the expected results. Thus they might want a particular job but not get it, or if they did, it might not make them feel better.

In general, the types of solutions to their problems which psychiatric clients attempted did not work. In particular, the ideologies they embraced were largely ineffectual. Their own preferred ideologies tended to be bound up with their pain and aloneness, and ultimately to perpetuate their isolation and "differentness". In their ideas and actions, many continued to violate basic social

rules, and change to more common standards eluded them.

In consequence, many retained the "crazy" label, and their basic problems remained unsolved. They remained powerless, alone, and in pain.

Chapter VIII

IDEOLOGY AND CONFLICT

Ideology and Justification

Conflicts within the psychiatric rehabilitation community in Northern City were intense and pervasive. Despite regular talk about the need for coordination and cooperation, both individuals and agencies were frequently embroiled in disputes. Charges of incompetence or insensitivity were often being leveled at VR counselors, at therapists, at the psychiatric hospitals, or at the VR agencies. Almost anyone, or any organization, could find himself accused of some reprehensible act at some time; and at such moments the need for self justification became very strong.

In chapter 1, I indicated that the major thrust of my

observations would be toward how ideologies are used to understand and guide the vocational rehabilitation of the psychiatrically disabled. At that time it was also indicated that ideologies were frequently used to justify actions in the VR field. Since conflict provides the major context for the use of ideological justifications, observing the patterns of conflict in psychiatric rehabilitation furnishes an excellent opportunity to see how ideologies were used for justification purposes.

During conflicts, criticisms were often couched in ideological terms and at first blush it may have seemed that what was in dispute was how best to rehabilitate clients. More usually, however, ideology seems to have functioned as a weapon rather than as an object of dispute per se. It was used both for offense and defense, and while charges of moral turpitude might be exchanged, or claims of a special professional competence put forward, the underlying causes of the conflicts usually lay elsewhere. In most cases it was not ideology which was in dispute, but something of organizational or personal import. Ideology became the language of dispute, not its issue. It justified what individuals and organizations wanted to do rather than determining what they wanted to

do.

At the organizational level a need for institutional growth and security seemed to provide the energy for many disputes. As Dorothy Jones (1978) has indicated, in the social service field attempts to provide services according to rational formats are often subverted by hidden goals such as organizational survival. In the psychiatric VR field, agencies often fought over their relative power and their access to such necessary, but limited resources, as money and political support. Ideologies often assumed important roles in these disputes, not because the organizations were disputing how best to help clients, but because ideologies could be used to assert unique organizational roles. Ideologies were thus used to give a legitimacy to what each organization was doing, and hence to enhance the organization's status and power.

Individual professionals within the psychiatric rehabilitation system had many personal goals which were similar to those of the agencies for which they worked. They too had a need for status and power. For them, growth and security took the form of protecting their

careers and enhancing their self images. Counselor and therapist desires to help other people were often quite honest, and their recourse to ideological attacks or defenses often a necessary tactic. Nevertheless, at bottom, they were people with personal goals of their own which their ideological commitments helped them further. Being "moral" and/or a "proficient counselor", were often vital to their personal identity needs, and ideological justifications were often essential to their ability to defend the kind of work they were trying to do.

VR clients too became embroiled in the conflicts endemic in the VR field. They, however, were at the bottom of the hierarchy, and the ideological tools they used to defend themselves were of doubtful efficacy. Their idiosyncratic ideologies, or their assertions of normality, did little to influence their "superiors", and even less to increase the client's status or power. No doubt, their needs for self esteem were no less than those of doctors or counselors, but if conflicts arose, they were likely to lose (i.e., to be degraded). For clients, ideologies served more a defensive than an offensive role, but even in this they provided limited protection.

Ideological Specialization

Not all ideologies served equally well as justifications for all organizations or individuals. Consequently there was a kind of ideological specialization with some organizations and individuals favoring some ideological justifications over others. Psychiatric hospitals and community mental health centers, not surprisingly, tended to rely on medical ideologies, especially when engaged in disputes with non-medical organizations. They also, however, tended to use psycho-social justifications in their quest for security and power. When they were confronting an organization such as the state VR agency, they often presented themselves as the legitimate providers of "psychotherapy". These organizations felt secure in this sort of ideological assertion because they believed themselves to have a social and governmental mandate to provide therapy.

The state VR agency, in contrast, relied more on educational and placement ideologies to further its ends. It was not a medical organization, so it could not as comfortably fall back upon medical or psycho-social

ideologies. Since education, and specifically skill training, have historically been a rehabilitation function, VR agencies could with confidence appeal for justification to educational ideologies, even in the face of medical assaults. When disputes occurred between rehabilitation agencies, psycho-social justifications became more acceptable (see cases II and III later in this chapter for examples of how these ideologies were used).

When individual professionals found themselves in conflict with one another or with other organizations, in order to feel confident of the support of their own organizations they had to appeal for justification to the ideologies their organizations favored. This fact inclined hospital employees to use medical and psycho-social arguments even if they were little involved with medications or "therapy", and it induced state VR agency counselors to use educational ideologies in their defense even if they believed in medical or psycho-social ones. Thus, when I found myself in a dispute about counseling with state psychiatric hospital personnel, I encountered difficulty in appealing to counseling theory as a defense, and had to take recourse in my putative need to make skill diagnoses for educational purposes.

The use of moral ideologies for justification, however, was not so specialized. All participants in the rehabilitation field used these ideologies very vigorously. Everyone claimed that they or their agency was trying to do good. Indeed, counselors often invoked these as individuals, and asserted their own goodness without worrying about the support of their agencies. As has been seen, moral ideologies are very pervasive in the rehabilitation field, and indeed, as will be elaborated upon shortly, this is one of the primary reasons why conflicts in the field often become so intense. Contrary to what has been said about rehabilitation ideologies in general, moral ideologies were disputed for their own sake. They also acted as an intensifier of conflicts whose origin was basically elsewhere.

While the various ideologically based justifications were important in the VR field, it must not be supposed that they were the only tactics used during disputes. Non-ideological tactics were also used. Thus when agencies were in conflict, resort was often made to control over funding contingencies to make inter-organizational points. Similarly bureaucratic rules

might be invoked to win an argument. Thus, for instance, when state VR agency personnel were peeved at the Workshop agency they might threaten to reduce the latter's income by withholding referrals; and Workshop agency personnel, if rankled, might refuse to implement a recommended program on the grounds that it was against labor department regulations.

Psychiatric VR clients were the "odd men out" during disputes in the VR field. They found themselves ideologically isolated. None of the ideological positions they resorted to had much efficacy. If they appealed to their idiosyncratic ideologies, they were dismissed as "crazy". If they resorted to religion in the hopes of receiving institutional support, they found these ideologies being treated as irrelevant by VR professionals. If they attempted to use psycho-social, medical or educational ideologies, they found themselves regarded as pretending to an expertise they didn't have. Though from time to time clients attempted to invoke all of these ideologies, none did much to improve their positions. Within the psychiatric VR system, clients were simply primed to lose.

The Moral Ideologies and Conflict

The moral ideologies were the dominant ideologies in the psychiatric VR field. They were the most important of the ideologies used by VR counselors; among doctors, they were an unacknowledged but decisive element in their medical ideologies; in the form of public/political moralities, they had an enormous impact on the kind of work VR administrators did; and in the guise of the goals of normality and helping others, they determined much of the way clients behaved. (For further elaboration of this point, see chapters 9 and 10.) As was noted in chapter 4, the moral ideologies entail many "side effects". Of those which have been enumerated, conflict was considered a "master" side effect of the moral ideologies. It was described as both a cause and consequence of many of the other side effects, e. g., appeasement and avoidance. As per our promise in chapter 4, a more detailed discussion of conflict is now in order, and, in particular, the relationship between conflict and some of the other side effects merits a closer examination. This present section will attempt to delineate some of these connections, but first it must be asked why morality provides such a

fertile ground for conflict.

There seem to be three main reasons why moral ideologies foster conflict as a side effect. First, moral ideologies vary. People disagree about what is right and wrong; and the moral goals they attempt to achieve are not always consonant. For example, the work ethics which alternatively view work as a social duty or as a source of personal dignity often entail different rehabilitation prescriptions. Second, they are very pervasive. Because they are omnipresent, incompatible moral ideologies have a higher probability of confronting one another and hence leading to conflict. Third, both individuals and organizations seem to exhibit what may be called "moral sensitivity". Moral ideologies matter. People, and organizations tend to become very upset when their moral commitments are violated.

In the psychiatric VR field, this last factor was especially evident. There seemed to exist a kind of emotional investment by both individuals and organizations which exacerbated their moral sensitivities. Individuals who became VR counselors almost all seemed to want to be good and helpful people. For example, at a

university-sponsored in-service training session on counseling, when the group leader asked some of the counselors what they expected of themselves as counselors, the first answer he was given was: "to be a saint". The counselor who gave this answer went on to explain that she felt a strong need to do everything right; i.e., to do right for her clients, for the state VR agency, for society, and even for herself. But most of all, she stressed, that she wanted to do right by her clients. This she recognized was a heavy responsibility, and perhaps beyond her capacity to meet, but she felt a strong obligation to try anyway. She then apologized for wanting to do what might not be possible, but reiterated that that's how she really felt. "I can't help it", she concluded.

At the same in-service session, another counselor remarked that her clients often wanted her to solve all of their problems for them, and though she wanted to, often she did not know how. "They have such high expectations of me, -and I have high expectations of myself,- but I don't know everything." She then elaborated upon how vulnerable she felt, and how, in consequence, she felt a need to protect herself. She said that she wished that

other people understood that she had limitations too.

The strong desire that many counselors and therapists had for moral excellence seemed to make them especially vulnerable to demands for help. They were sensitive to both moral appeals and moral arguments, and so in situations where success was difficult such as in the rehabilitation counseling of psychiatric clients (see chapter 9), these appeals and arguments took on a threatening aura. Moral demands which they were unable to satisfy became painful reminders of their own perceived shortcomings, and of the limits of their own "goodness". This pain, or its prospect, induced many counselors to try to protect themselves from too many demands. The very strength of their moral needs provided the impetus for them to isolate themselves from the ideological demands made of them by their organizations and by other professionals; and in some cases to fight back with real vigor.

Organizations in the psychiatric VR arena were also quite sensitive regarding moral issues. They were subject to moral review from their governmental superiors and from political pressure groups. Thus the state VR agency had a

mandate to help virtually all "disabled" persons, whether or not it had the resources or skills to help them. If it failed in these tasks, it was judged by these superiors and pressure groups on moral grounds, and not technical ones. What is more, its perceived "goodness" really mattered, for this translated into political strength, which in turn affected the very survival of the agency. The organization was therefore quite sensitive to moral criticism, especially from politically active quarters, and so it did its best to protect itself from them. It resisted many of the demands of organizations such as the state psychiatric hospital out-patient unit (see case II); or it placated groups such as the "learning disability mothers (chapter 6); but either way it found itself in conflict, in part, because of its moral sensitivities.

Side Effects of Conflict

If the prevalence of often incompatible moral ideologies, coupled with moral sensitivities, either led to conflict, or exacerbated pre-existing areas of conflict, then the intensity of this morally colored conflict itself generated what I have called "side

effects". Because conflict often became passionate, attempts at intimidation or deception were fairly common. People and organizations felt a need to win, which was frequently related to their moral needs, and so threats and misstatements which furthered this end were used by many participants in the VR field. What was exceptionally striking, was that these tactics were decidedly at variance with some of the major ideals often professed by participants in the "helping professions", e.g., the importance of "direct communications" and the need for "supportive relationships". Indeed, this contradiction between ideals and tactics is a major reason for labeling intimidation and deception as side effects, i.e, as unintended consequences. At this point, I will not give examples of intimidation or deception, but instead will shortly be presenting three extended case studies of conflict in which I was a participant. By providing integrated cases rather than a series of isolated incidents, it will be possible to give a better account of the context in which these side effects occurred, as well as of how justification was used, and how conflict resolution was managed.

One of the other main side effects of intense morally

tinted conflicts was "excessive blame". This was very similar to the kind of excessive blame of clients which has been described in chapter 4. During disputes, however, large doses of blame were often directed at other professionals or their agencies, not just clients. As when directed at clients, this blame often spiraled out of control. Unlike with clients, however, it tended to be used more cautiously, that is, less openly. When I got into a dispute with the staff at a community mental health center (which will shortly be described in Case I), I was blamed for doing bad counseling, for doing counseling which it was believed I shouldn't be doing, and for the unauthorized dissemination of client diagnoses. Within the context of the CMHC, these were serious charges, and while they were gossiped about by staff members, initially none of these charges were made directly to me. I learned about them through rumor, and only at a later date and in a very sanitized form, from my superiors and from the director of the CMHC. Nevertheless, these charges were strong enough to help precipitate a transfer out of the CMHC. I was being blamed very harshly, and knew it, yet was given little opportunity to defend myself from attack.

Another major category of side effects were those

which have to do with avoidance. In this group of side effects I mean to include phenomena such as "rigidity" and "appeasement", as well as the more straightforward forms of avoidance such as literal isolation. Rather than fully explore these forms of avoidance as they occurred in response to intense conflict, I refer the reader back to chapter 4 for further explanations of how they operated. For the moment I will only note that there were some variations of "avoidance" techniques which occurred between VR professionals which did not occur between professionals and clients. One brief example of these is that professionals often restricted the face to face communications between themselves by mechanisms such as memo writing. Additional such mechanisms will be documented in the case studies which follow.

Avoidance techniques were an important way counselors and others protected themselves and their moral sensibilities. But for this they paid a price. Avoidance seems to be one of the main reasons why counselors, administrators, and doctors were not very conscious of their own use of moral ideologies. Indeed, the moral ideologies were relatively invisible to participants in the VR field. They were extensively used, but rarely

examined; and this, as will be elaborated upon in chapter 10, had consequences of its own.

Conflict Resolution

At one point during the conflict to be described in Case II, I was feeling frustrated about not being able to directly defend the kind of counseling I was doing. I complained to my immediate supervisor about what seemed to me to be an irrational ideological specialization fully expecting that he would support me. Instead he told me that he believed that there needed to be such specializations, because without them there would be a "duplication of services". He believed that a division of labor in the psychiatric VR field was a good idea because he thought it would reduce the chances of conflict. He explained that if the state hospital did psychotherapy and we did rehabilitation counseling, there might be fewer issues which could provoke dispute.

A division of labor seems to have been but one way the psychiatric VR field has attempted to cope with the conflicts endemic to it. Four others also seem to be of

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importance. These methods did not seem to me to have been consciously evolved for the purpose of containing disputes, but if questioned about them, many participants in the field might cite them as having been used for this purpose. The five mechanisms are: 1) a division of labor, 2) non-moral ideologies, 3) moral equality, 4) non-ideological, e.g., bureaucratic devices, and 5) ambiguity.

1) The division of labor. Despite my senior counselor's endorsement of a division of labor, this was at best an imperfect device. As has been remarked upon in chapter 4, in the psychiatric VR field it was very difficult to determine where psychiatric counseling left off and where vocational rehabilitation counseling began. Certainly in the case of L, her CMHC therapist felt therapeutically justified in encouraging L to work. In case II, to be discussed shortly, Robert's primary therapist felt that it was his job to help his client plan his college education. Similarly, I felt that in order to understand my clients' vocational aspirations and motivations I needed to understand the dynamics of their families of origin and their self images. In consequence, it might have been difficult for an objective observer to

tell when therapy was taking place and when vocational counseling was occurring. A division of labor which is based on a distinction which is not always discernable, is not the surest bulwark against conflict. In practice, the divisions of labor in the psychiatric VR field were as much a source of contention, as a mechanism for forestalling disputes. Counselors and therapists were exhorted to stay within their own specialties, but in private they often worked in similar ways. In fact, the extant division of labor seems to have evolved largely for historical reasons and to have been maintained in place largely for organizational ones. Attempts to enforce differences in counseling helped maintain organizational (and sometimes, individual) identities, but only marginally eliminated sources of contention.

2) Non-Moral Ideologies. By the non-moral ideologies are specifically meant the medical, the psycho-social and the educational ideologies. All of these may be thought of as technological responses to the moral ideologies. It will be recalled that Dr. Ausubel (1967) has argued that the disease model of the psychiatric disorders is one of the most significant advances made by mankind in dealing with insanity. His view seems to be that the

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medicalization of "mental illness" takes the religion, the mystification, and, most importantly, the moralism out of dealing with insanity. The view that the medical treatment of the psychiatric client should be technical and not moral, is a widespread one. Similarly, those in favor of psycho-social models often argue that counseling should be "non-judgmental" (Turner, 1978) and "value free". They too are attempting to replace the moral aspects of counseling with a technological device, only they recommend a different technology than is recommended by doctors. In both cases, and in the educational too, part of the hope seems to be that if rehabilitation and therapy decisions are made technical, and not moral, that treatment decisions can become objective rather than subjective. And if these decisions can be made objective, then they can be calculated, and the moral bases of treatment disputes eliminated, or, at least, reduced. The non-moral ideologies are thus often envisaged as ways of reducing conflict which has its origin in moral ideologies.

My impression is that this hope is largely unrealized. First, the non-moral ideologies don't work very well as technologies, at least, not in the

psychiatric VR field (see chapter 9). Second, moral ideologies remain operative even when other ideologies are being employed. Doctors' prescriptions, it will be recalled (chapter 5), are often quite moralistic despite their use of medical technologies. What is more, many of the goals in psychiatric vocational rehabilitation inherently have moral components. Thus, it is hard to imagine how work ethics can be eliminated and there still be "vocational" rehabilitation. Certainly in the area where I worked, the non-moral ideologies had not supplanted the moral ideologies, and, so far as I could see, had done little to reduce morally inspired conflicts. Moral sensibilities had not been defused, though to some extent the language of the non-moral ideologies had replaced moral language (e.g., one spoke of "illness" not "craziness", and "appropriate behavior" not "badness"). The language of the non-moral ideologies thus often became the language in which conflict was expressed. But this, it may be pointed out, may be considered but another form of "avoidance". That is, the non-moral language hid the moral nature of many disputes, and so may have inhibited a direct approach to moral problems.

3) Moral Equality. It has been stressed that VR

personnel felt a need to be "good" people, and that they were sensitive to moral criticism. It seemed to me that none of the counselors or therapists I worked with were willing to concede that others were morally superior to them. Indeed, new counselors seemed to have a special need to prove their moral "credentials". They seemed to go out of their way to assert the correctness of their judgments. It appeared to me that this assertion of moral dignity was not a mere affectation. It seemed to serve a very real function; specifically, it made the claim that the counselor and his judgments were as worthy as other counselors and their judgments and hence deserved to carry weight when joint decisions were in question. Counselors, both new and old, seemed intent on claiming "moral equality". With it, they entered moral conflicts on an equal footing. Without it, they might enter as an inferior, and hence have their moral sensibilities injured. Without moral equality, the reasons for moral conflict were enhanced. With it, they were reduced.

Counselors themselves seemed to realize this when they remarked, as many of them did, on the "territoriality" of the psychiatric VR field. On several occasions counselors told me how impressed they were with

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how often, and with what tenacity, counselors seemed to "defend their turf". At such times, it seemed to me that what was being described was counselors fighting for the worthiness of their judgments, and especially their right to make such judgments.

4) Non-Ideological Devices. This group of mechanisms for containing conflict were largely bureaucratic in nature. They seemed designed to make conflict resolution mechanical and impersonal. Devices such as inter-organizational agreements did in fact do much to reduce conflicts, as will be seen in case II which follows. Often they seemed to generate the time which allowed moral passions to cool, and hence permitted compromises to occur.

5) Ambiguity. In the chapter on administrators (6), the regional operations director used the vagaries of moral language to defuse the areas of conflict between the "learning disability" mothers and the VR counselors. Above, when I talked of "avoidance", it was suggested that indirectness and lack of clarity might help precipitate conflict. On the other hand, lack of clarity can also help avoid conflict. Ambiguities permit people to see

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what they want to see, and, if they so choose, to gracefully side-step conflict.

Next I turn to three case studies of conflict. Each consists of a description of a protracted conflict to which I was a party, and a discussion of a) how various ideologies were used by different organizations and individuals to justify what they were doing, b) how moral ideologies intensified conflicts and specifically how they led to side effects, and c) how conflict resolution occurred.

Case I: A Difficult Client

When I started my job as a state VR agency counselor, I was initially out-stationed at two places. One of these was a CMHC. I was introduced to it by the counselor whose caseload I was taking over. She showed me the office I would use; discussed with me some of the clients I would be seeing; informally introduced me to some of the clinic's staff; and set up some client appointments for me. One of the first clients I was asked to see was L. L

was described to me as a "difficult" client, one who might need to be pressured into taking a job. My predecessor also arranged for me to attend a case conference about L which was being held at her group home. The subject of this conference, I was told, was to be whether or not L was to change the apartment she was living in. (This conference has already been discussed in chapter 4.) As it turned out, the conference did not discuss whether L was to move. This, it seemed, had been determined beforehand. Instead, the conference addressed the question of what job L should seek and how. Considerable pressure was put on her to set definite vocational goals and to commit herself to a job search to attain them. I was delegated the role of enforcer in this process; L was instructed to come to see me each week with proof that she had visited at least ten potential employers.

These developments upset me greatly, for I did not envisage my job as that of an enforcer. When, however, I expressed reservations about the evolving vocational plan for L, the other professionals at the conference took offense, especially L's therapist. She then tried to prove to me that it was necessary to provide "structure" for L. This she did by eliciting L's psychiatric

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symptoms. I was apparently to understand that L's difficulties were of such a magnitude that close supervision was imperative. Instead, I became morally outraged by this form of persuasion, for I believed that L's human rights were being violated. L's therapist was similarly outraged by what she perceived as my obstructionism. She believed that I did not understand L's need to be pressed to work, and that I should hold my peace, especially since I was new to the case.

The next day L's therapist came to my office at the CMHC. She told me that she had worked with L for over two years, and she reiterated that since I was new I didn't understand what needed to be done. I defended myself by stating that I had read L's case record, and that in any event I believed in "working through" client's vocational problems, not in forcing them to go to work. I had expected that the therapist and I would then discuss the best ways of dealing with clients like L. Instead, she simply got up, said "well", and walked out of the room.

Two weeks later I heard gossip from a fellow VR counselor that some of the therapists at the CMHC were complaining about me. It was said that I had given a

diagnosis to a client and that I had done some other unspecified things wrong. What these were I did not know, for no one at the CMHC had made any complaints directly to me. The only clash I was aware of was the one over L, and I had not talked to L's therapist since she had walked out of my office. There was also a rumor that the director of the CMHC wanted to talk to me, but neither she, nor her secretary, had made any effort to contact me.

These events unnerved me. I had never before held a job in which I heard there were "accusations" about me being circulated behind my back. I, therefore, told my immediate supervisor about the situation, and that it seemed trouble was brewing. He advised me to wait and see what happened. Two weeks after this he came to me with the news that the director of the CMHC had contacted the director of the local state VR office and asked that I be transferred. He said there was some confusion about why she wanted me to go, but that our office director had agreed to the move, and that I was to work full time at the state psychiatric hospital. I then had a meeting with the local office director during which he asked me what had happened at the clinic. We also talked about arrangements for my transfer. In fact, most of our

meeting addressed the fears of the counselor who was to assume my responsibilities at the CMHC. She too was very upset by developments there, and feared that she might be the next target. The office director tried to reassure her that she was not at fault for the move, and that he would back her up if further trouble developed.

It was only after the date of my transfer had been set that the director of the CMHC called me in to talk to her. She was very sweet. She asked me about my purportedly having shared a diagnosis with a client, and then she asked me at much greater length about the conflict over L. She then apologized for having asked me to leave her clinic, but explained that she really did not want a VR counselor who was interested in doing counseling. All she wanted was someone to refer her patients to jobs and training. She then asked me what kind of services the state VR agency might best provide her people, and how VR counseling might better be coordinated with the work of her staff. I gave a brief presentation of my views on these matters, but though the director was smiling at me as I talked, I had the distinct impression that she was not listening to me. I had the feeling that she was trying to let me down easy.

A year after I left the CMHC, I had a discussion with the local VR office director about the incident. He confessed that there had been considerable friction between himself and the CMHC director for many years. He explained that he thought the real reason I had been asked to leave the clinic was not because of the dispute over L, but because he had assigned me to the clinic without having obtained its director's prior approval. He believed that this angered her because he was sure she wanted control over everyone in her office. It was for this reason, he asserted, that I had to go.

Discussion

Justification. If the local VR office director was correct, then the chief cause of the conflict I became embroiled in at the CMHC was an organizational power struggle. At issue was the question of who had the right and the power to appoint, approve and direct the VR counselor out-stationed at the CMHC. On the surface, however, the dispute was about the kind of counseling I was doing with clients. A specific incident, namely the conflict about L, apparently became its symbol. Since I

was unaware of the organizational rivalries involved, I took the counseling issue to be of central import. I had been prepared to justify the actions I took on psycho-social grounds, but this did not work. My attempts to talk to L's therapist about "working through" vocational problems had been ineffectual, and neither my office director, nor the CMHC director, cared to hear any of my arguments until after their decisions had already been made. Even then they listened without hearing.

Apparently one reason why my psycho-social position was so tenuous was because the CMHC and its personnel had appropriated to themselves the role of counseling arbiter. The director of the clinic made it clear that she intended to control "counseling". Only people who worked directly for her were to be sanctioned as counselors or therapists. From the state VR agency she only wanted a referral specialist.

The CMHC director also used medicine to help her define and defend her organization's power. The second item in the charges brought against me was that I had shared a medical diagnosis with a client. This she considered the wrong thing to do from a psychiatric

perspective; and medicine was so much considered the clinic's prerogative that I was never even offered an explanation of why it was thought to be wrong. Moreover, at no point did my superiors at the state VR agency challenge the CMHC's right to make the final decisions on counseling or medical matters. They simply deferred to the clinic director's authority in these areas. If I wished to challenge clinic personnel on psycho-social grounds, I was on my own.

Side Effects. Part of the conflict in which I found myself was, of course, moral in nature. Much of the conflict between L's primary therapist and myself was of this kind. She thought I was an obstructionist, and I thought her over-controlling and callous. Both of us blamed the other for being wrong. Similarly, the CMHC director and the VR office director judged each other in moral terms when each of them told me that they thought the other was not a "nice" person. Because of my newness on the job, I was especially sensitive to the moral censure I incurred, and was very prone to be morally critical of others. I was furious at L's therapist, and deeply hurt that anyone could suspect that I was not doing the right thing for a client of mine. I had always

thought of myself as a good person, and I expected everyone else to also.

The CMHC conflict was short and sharp. It was quite intense, and exhibited many of the side effects of intense moral conflict. First, there was much avoidance between the protagonists. Though charges were purportedly made against me, they were never directly communicated to me. I learned that I was under fire through gossip and innuendo. Save for L's therapist, no one else even attempted to talk to me, and she left my office after only a brief exchange. Nor did I seek out my alleged accusers. I was far too angry and hurt to want to speak to any of them.

Second, another mechanism used freely during the conflict was appeasement. Both the local VR office director and the CMHC director assured me that they had my interests at heart, and both went out of their way to listen to me, but only after their decisions had already been made. The clinic director especially smiled most benevolently while telling me that I must be transferred.

Third, there was also evidence of intimidation. L's

therapist, of course, tried to pressure L into doing what she "should", even going so far as to give L an ultimatum that she must follow instructions or no longer have access to the CMHC for therapy. More indirect attempts at intimidation were aimed at me through the manipulation of L and through the gossip I heard about a list of "charges" being drawn up against me.

Fourth, rigidity too was displayed by all parties. No one changed their ideas about anything, and no real negotiations about counseling or other matters ever occurred.

Conflict Resolution. The proximate conflict between the CMHC and myself was resolved only through the bureaucratic device of a transfer; and this may also be thought of as an ultimate form of avoidance.

Case II: A Hospital Unit Expands

After I had been a VR counselor for about a year, the state psychiatric hospital where I was out-stationed underwent a reorganization. "Deinstitutionalization" was

in vogue, and the hospital required a larger out-patient unit to provide more services to patients. The redesigned out-patient department had more therapists, new administrators, and greater control over other hospital units such as the day hospital division. It also began to assert the right to supervise the activities of some hospital units over which it had not been given formal control; in particular, it asserted an authority to monitor the activities of the hospital's rehabilitation unit and its staff. The hospital rehabilitation counselors were none too happy about this change in their circumstances. Many expressed real anger at being told what to do by out-patient therapists, but gradually they were forced to comply.

At this time, I was one of two state VR agency counselors out-stationed at the hospital. Since our offices were located in the rehabilitation building right down the hall from the hospital rehabilitation counselors, we were also perceived by the reorganized out-patient unit as a legitimate object of their authority. Because my co-counselor and I were often perceived simply as "vocational rehabilitation counselors", we were not always recognized as employees of a separate agency, and hence we

too began to receive instructions from the out-patient staff on how to work with clients.

Initially, however, neither I, nor my fellow state VR agency counselor, had any idea that the out-patient unit harbored any such aspirations. The first indicator we had that something was happening was a memo from the assistant out-patient administrator directing me to clarify the kind of counseling I was doing with one client. I drafted a provisional reply to this memo and showed it to my immediate supervisor who was located at the downtown state VR agency office. His reaction was that it was "too diagnostic" and "too psychological". He advised me to tell them less, because he feared that the information I proposed to give them might some day be used against me.

For the next several months, my overt relations with the out-patient unit remained cordial. There were occasional questions from therapists about what was happening with particular clients, but no interference with my activities. Then one day my co-counselor and I received an invitation to give a presentation to a full staff meeting of the out-patient unit. Our topic was to be the services provided by the state VR agency. The two

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of us decided to be candid in our presentation. We explained the various kinds of referrals and counseling we were inclined to do, and I made a pitch for cooperation. I thought I had learned from the CMHC incident, from some other unpleasant experiences, and from my supervisor that not all professionals would welcome my being involved in counseling activities. My strategy was to face this problem head on. I therefore told the out-patient people that I liked to do counseling, that I probably got more deeply involved in it than most VR counselors, and that they should take my interests and strengths into account when deciding to make a referral to me. I said I knew there might be some overlap in what we did, but that I was willing to work as closely with them as necessary in order to assure that we would not be working at cross purposes. I further told them that I believed that the quality of the relationship one developed with a client was of paramount importance, and that wherever good relationships were achieved they ought to be exploited. Some of the in-patient units, I noted, had utilized the counseling rapport I often developed with clients and in some instances had even assigned me as a client's official "primary therapist".

The reaction I got to these remarks was guarded. There was reluctant agreement that good working relationships between counselors and with patients were of primary importance, but there was some confusion about what kind of vocational counseling this implied. Finally, one of the administrators present turned to the doctor in charge and asked him what he thought. The doctor agreed that relationships were of primary import, and that perhaps I could be assigned primary responsibility for some clients with whom I had developed positive counseling relations. I was asked to talk to one of the out-patient administrators after the meeting to see how we could coordinate our services.

Shortly before the presentation ended, however, there were some rumblings which indicated that all was not well. I was discussing the kinds of psychological testing services the state VR agency could provide when one of the psychiatrists wondered out loud if I could legitimately use some of the tests the way I said I could. He expressed a fear that I might "unfairly pigeon-hole people", and he was not satisfied until one of the out-patient unit's own psychologists assured him that these tests could be used fairly.

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After the meeting, as had been arranged, my co-counselor and I got together with the out-patient unit's assistant administrator to talk about coordinating our services. He then informed us that since we were going to be working with some of his organization's patients, he would like us to write some notes in their records so that they might have some idea of what we were doing. When we agreed that we would be willing to do this from time to time, he proudly showed us the record forms his unit had designed and explained how we were to use them. He also requested that in those cases where the VR agency was providing intensive counseling for clients, that we take part in the writing of the client's treatment plans. This we also agreed to do.

One month later, I received a letter from one of the psychiatrists attached to the out-patient unit. It requested my presence to "clarify the policies discussed previously". He expressed a concern about "duplication in performing insight-oriented psychotherapy on some of our mutual patients/clients." Copies of this letter were sent to my immediate supervisor and to various hospital administrators including its deputy director.

When I arrived at the meeting, which was held in the out-patient unit's conference room, I had the distinct impression that I was walking into a courtroom. Four therapists sat lined up behind a table; the psychiatrist sat opposite them behind another table, rather like a judge I thought; and I was relegated to a side table between them. It soon developed that the principal accusation I faced (and it was put very much in the form of an accusation) was that I had interfered with the therapy being provided by one of the therapists present. As it happened, I had had some friction with this therapist six months earlier when he had been a psychologist on an in-patient ward. At the time, I had sent a mutual client to a private psychologist outside of the hospital for a standard battery of psychological/vocational tests. The hospital had not sent me any psychological testing on the client and I wanted additional information regarding the client's vocational limitations. When the results came back, I noted that the private psychologist had come to the conclusion that the client was a "sociopath". Since the hospital referral I had indicated that the client was suffering from schizophrenia, I felt obligated to pass on this new

information to the in-patient staff. This I did by calling the ward nurse in charge. A week later I learned that the ward psychologist was furious with me. It seemed that, unknown to me, he too had done some psychological testing on the client, and he had concluded that schizophrenia was the proper diagnosis. He was incensed that I had duplicated his work and contradicted his findings.

Now that the former ward psychologist was an out-patient therapist, he was angry that I had contradicted some advice he had given to a current patient of his. He felt that I was digging too deeply into the patient's private affairs; affairs he believed to be properly in the domain of "psychotherapy", not vocational counseling.

It turned out that the client in question was one I had been working with for over a year, that is, for half a year longer than the therapist himself had been involved with the client. This client, whom I'll call Robert, was of foreign origin. He had obtained a degree in engineering in his native country, but in the United States he had found himself unsuccessful in a graduate

program and unable to hold a job in engineering firms. In school his grades were abysmally low, and on jobs he acted in ways others described as "manic". Psychological testing indicated that he was functioning at a very low intellectual level, and my talks with him about his history and feelings indicated that he had never really been interested in engineering; that he had gone into this field primarily to please his father, a man he described as highly autocratic. Robert told me that he felt he had to succeed in engineering school, but I advised him that this would probably not work, and that for the time being he should try to concentrate on supporting himself, and on trying to understand what he really wanted to do.

When the out-patient therapist began working with Robert, he was impressed with his academic background and urged him to return to school. This Robert did. Shortly thereafter he began having the same academic and emotional difficulties he had had previously. Robert then told the therapist that he thought perhaps I had been right and that he wanted to follow my suggestions. This upset the therapist who apparently felt that if he were sufficiently supportive Robert would be able to handle school work. When Robert continued to disagree, friction developed

between them, especially over my role in working with Robert. The therapist then gave Robert an ultimatum. He told him that he must either work with him or me; not both. Much to the therapist's chagrin, Robert elected to work with me. It was this occurrence, it seems, which triggered the out-patient meeting.

The psychiatrist chairing the meeting went to considerable pains to elicit the details of the case. He was not concerned, however, about what was the best course of action for Robert, but with who should have jurisdiction in this instance. He appealed to me in the name of harmony to relinquish my authority this one time, i.e., to tell Robert that I could not continue working with him, and that he would have to return to his out-patient therapist. Despite considerable misgivings which I openly expressed, I reluctantly agreed to the psychiatrist's proposal, especially since he stated that this was not to set a precedent. I still had hopes of establishing a good working relationship with the out-patient unit. With this agreement reached, the meeting ended.

Some weeks later, the out-patient unit's assistant

administrator called me to talk about record keeping. I had been going over to the unit's offices on a monthly basis to make notes in their charts. Now the administrator told me that this would not be enough. It would be necessary, he informed me, that I make chart notes every time I saw one of our mutual clients. Since I was already keeping records of this sort for the state VR agency, I balked. I felt that this would require more time and energy than I had available, and was unnecessary in any event. But the out-patient administrator was adamant. He insisted that for the good of our patient/clients, the out-patient unit needed a record of every meeting I had with them. What's more, he informed me, the law required this. I, nevertheless, refused to go along. It seemed to me that this was more than had previously been agreed upon.

The result of my refusal was that the administrator sent a letter to my supervisor (again with c.c.'s to his superiors) stating that I was providing "insufficient documentation". He continued, that since I was doing "insight-oriented psychotherapy.... It is, therefore, necessary that you document each and every clinical visit.... As I am sure you are aware, the provision of

clinical services to patient/clients is a very serious matter, and carries with it a definite ethical, moral and legal responsibility that it be done within a responsible professional context."

By this time I was furious (a condition to which by now it should be apparent I have a proclivity). I started asking other counselors and administrators how I could counteract the pressures being brought to bear on me. During the course of these explorations, I was informed by someone in the hospital's record department that, in fact, my making entries into the hospital's records was against state regulations, and certainly not required by law. Armed with this information, I informed the out-patient administrator that I would no longer be writing any notes in their charts. At the same time, I kept my supervisor apprised of what was happening. I spoke at length to him about the kind of counseling I was doing, and though we agreed that it was "intensive counseling", we also agreed that it need not be described as "therapy". Thus, one case we thrashed out involved my doing a kind of client-centered counseling with a client who was having difficulties dealing with authorities. The rationale I offered for this work was that in order for him to hold a

job he would need to be able to get along with a boss, and that, in effect, I was teaching him how he might do this by helping him to learn how to relate to me. In any event, my supervisor and I agreed that the borderline between vocational counseling and "psychotherapy" was a nebulous one, and that the out-patient staff ought to know this.

After a delay of about a month, my supervisor replied to the out-patient administrator's letter. In his letter he first asserted the state VR agency's right to supervise me. The out-patient unit, he wrote, "doesn't have the privilege of imposing reporting schedules on Mr. Fein. Only (the state VR agency) can do that." Next he argued that the out-patient department's records should not indicate that I was designated to provide "insight-oriented therapy". He noted that the state VR agency "does not perceive itself as an agency which delivers psychotherapy and counselors are not encouraged to take on the role of therapist." The out-patient administrator seized upon this latter point and in a return letter suggested a resolution to the conflict. He agreed that "as long as clinical services are not being provided, a much more liberal and less comprehensive

approach to medical record keeping is, of course, indicated."

-Despite the civilized character of the letters exchanged by the hospital and the VR agency, gossip transmitted to me by the hospital staff indicated that the out-patient administrators were very unhappy. They reportedly felt that they had lost a battle, and they did not like it. One counselor went so far as to take me aside and whisper, "Watch out. Be careful, because they're out to get you."

The next incident which occurred in this conflict, for it had by no means run its course, centered around L. I had started seeing L on a regular basis after her therapist at the CMHC had refused to see her any longer. In part, I felt responsible for what had happened to her, and believed that I had an obligation to offer her what support I could. Indeed, when at one point L re-entered the state psychiatric hospital, I was officially delegated the role of her primary therapist by an in-patient psychiatrist. I continued to work with her on vocational issues and with time was learning about the depth and tenacity of her emotional limitations. In the meantime, L

was developing a "transference" towards me. She began telling everyone that she was in love with me, and others, such as E (see chapter 4), became alarmed.

As was the hospital's wont, in time L was transferred to a therapist on the out-patient staff. This new therapist quickly became aware of L's feelings toward me, and she too became concerned. As often happened with hospital personnel, she did not bring these concerns to my attention, but brought them to her supervisor. One morning, two minutes after I arrived at my office, both she and her supervisor appeared at my door. The supervisor asked if they could speak to me, and after they sat down, he told me that I was to stop seeing L. I asked him why, but he replied that I was not to worry why; that I was just to stop seeing her. When I said that that was not enough of a reason, he responded that if I were to continue to see her, he would make a "cause celebre" out of her case, and that the first thing he would do would be to talk to my supervisor. Again I asked what his complaint was, and this time he answered that he could not tell me because the case material was "confidential". With this, he warned me one more time to take his "advice" and stop seeing L; and then he, and the therapist, who had

said nothing, left my office never to return. It was not until three weeks later that this out-patient administrator accidentally met my supervisor in a hospital hallway and then he casually "mentioned" to him that perhaps I was getting too involved with L.

At this time, my immediate supervisor was preparing to leave the state VR agency. He consequently arranged for a meeting between himself, my new supervisor, the local VR office director, and myself. At this meeting he filled in the other administrators on the state of relations between our agency and the psychiatric hospital's various units. He warned them that with the out-patient unit it was unwise to attempt compromise. His firmly stated opinion was that the administrators of that unit regarded compromise as a sign of weakness and that they would take advantage of it.

A month after this supervisor left, the assistant administrator of the out-patient unit wrote a letter to my new supervisor again complaining about my counseling. He said that I had "blatantly disregarded" the agreement that had been made between his unit and the state VR agency, and specifically that I was still seeing L frequently and

having discussions with her about her "anger, hostility and depression". He reported that, "Mr. Fein still continues to provide psychotherapy and has been totally remiss in giving feedback to primary therapists regarding his clients." He then requested a quick resolution of this problem.

When I received a copy of this letter, I requested a meeting with my new supervisor and with the local VR office director. At this meeting I briefly reviewed the history of the conflict which had been going on with the out-patient unit, and asked them to "back me up" as they had previously promised they would. I asked that they at least send the out-patient unit a letter stating that while the type of counseling I was doing might be intensive, that its purview was vocational and that it was well within the agency's mandate. This they declined to do. Instead, I was advised to do less intensive counseling and that in the meantime they would attempt to establish a working agreement with the out-patient unit. This was to be based on a proposal that I send copies of the vocational plans I did for the VR agency to the out-patient department. The purpose of this would be to keep them informed of my activities with clients and to

demonstrate to them that the work I was doing did have a vocational orientation.

There then followed a series of meetings between my new supervisor, the local VR office director, and the chief administrators of the out-patient unit. These resulted in a series of drafts and counter-drafts for a proposed "local agreement". The first of these drafts was prepared by the out-patient unit's assistant administrator. It was a four page, single spaced document which suggested that the hospital and its staff have control over "clinical" issues, and that the state VR agency agree to various reporting procedures in order to keep the hospital therapists current with what VR counselors were doing with mutual clients. It included the following clauses:

- 1) The state VR agency does not perceive itself as an agency which delivers psychotherapy, and counselors are not permitted to engage in psychotherapy as a purpose of their contact with patients.

- 2) Whenever significant clinical issues are raised by the patient when receiving treatment by VR (counseling), this occurrence will immediately be reported back to the (out-patient) primary therapist.

- 3) The primary therapist, in consultation with the consulting (out-patient) psychiatrist

will make a decision as to whether the VR counselor can resolve the issue on a short term basis or whether a referral back to the primary therapist for further clinical intervention is necessary.

I was shown a copy of the first draft of the agreement and asked to prepare a memo on my reactions to it. This I did, detailing my objections to what I read. A major point I made was that if the hospital out-patient unit were allowed to define "clinical" services, then this could be used to control any and all VR services. I argued that if the state VR agency agreed to this, "it would mean giving up any semblance of independent authority and competence." These organizationally oriented objections apparently carried considerable weight, because the final draft of the "local agreement" made no mention of out-patient unit rights to define or supervise "clinical" services provided by VR personnel. Nor did it include a provision for VR reports to out-patient personnel beyond sending them copies of VR plans as had originally been proposed by our office.

Meanwhile the out-patient unit's assistant administrator sent the local VR office director another letter of complaint about me. I was again accused of

providing "clinical psychotherapy", specifically for L. He asserted that I was still discussing with L her "anger, dreams, feelings, and memories of growing up with her family.... Moreover the patient openly admits to being "in love" with Mr. Fein." This letter also alleged that I had urged another patient (M) not to take her medications, and that I had advised her that living with her mother might cause her emotional upset. The letter noted pointedly that I had "admitted" to doing "therapy". It concluded with a request that these matters be "investigated".

The local VR office director's reaction to this was to initiate such an investigation. He requested my supervisor to look into the kind of counseling I was doing and to conduct a close examination of my records. This he did, and he subsequently submitted a memo to the office director detailing his findings. Among the points he made in this summary were: 1) that I felt I was trying to change unproductive vocational patterns which were, in part, a result of my client's "considerable pain and distress", 2) that I denied the interventions I was said to have made with M, 3) that he found no evidence that I had "reciprocated" L's feelings in any way, 4) that he

thought there was a "grey area" between counseling and therapy, but that at times I did come "damn close to therapy", and 5) that he recommended that I see L for counseling less often.

I too submitted a memo in reaction to the out-patient administrator's letter. I wrote that "the kind of counseling I have been doing with Miss L cannot be called psychotherapy, but it is intensive counseling. It has been designed to help Miss L overcome the resistance to employment which she has consistently demonstrated in the past, and which indeed, now seems to be abating." I then pointed out that L was now relating better to people, i.e., she was less paranoid, and that she was starting to take part in training programs. I next turned to the case of M and explained that in this instance the out-patient unit had simply got the facts wrong, e.g., that I had not made the alleged recommendations regarding M's medications. Finally, I asserted that the out-patient administrator "seems to confuse any kind of counseling in which genuine feelings or significant information are revealed with therapy. Were this true, vocational counseling would be a trivial endeavor. If I have good or intensive relationships with my clients, this does not,

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perforce, make it therapy. Rather, it makes it vocational counseling in which the focus is upon the genuine needs of the client. With psychiatric patients, vocational needs are inevitably entwined with their psychiatric difficulties. There is and can be no sharp distinction between the various kinds of assistance provided by different professionals." In addition to this memo, I argued as strongly as I could to my supervisor that in order to make sensible and relevant referrals for my clients I needed to develop some depth insights. I asserted that diagnosis was a proper, indeed, mandatory function of vocational counseling with the psychiatrically disabled.

Shortly after this, a full six months after I had requested that he back me up, the local VR office director sent a letter in my defense to the out-patient unit. He wrote:

We find Mr. Fein's actions to be entirely professional and essentially congruent with the VR policies of providing the services which may help achieve a vocational outcome.

We recognize that Mr. Fein's counseling was intensive and have advised him to confine this, as much as possible, to vocational matters.

Two months subsequent to this, the "local agreement" between the out-patient unit and the state VR agency was completed and signed. In its final form it promised only that the state VR agency would send the out-patient unit copies of VR plans for all of our mutual clients and that periodically our lists of active clients would be exchanged so that we could keep track of which of our clients were mutual. All references to out-patient unit authority over counseling had been eliminated, and no forms of direct reporting by VR counselors to the out-patient unit had been agreed upon.

With the conclusion of the local agreement, communication between the out-patient unit and the state VR agency slackened appreciably. There were no more meetings between VR administrators and out-patient administrators; nor did I have any conversations with out-patient staff, this though out-patient counselors had moved into offices on both sides of mine. We simply ignored each other when we passed in the halls. For six months virtually the only communication between us consisted of the copies of the VR plans which were sent to the out-patient unit and the client referral forms they sent to me.

Not until the next summer was communication resumed. It began as the whole VR/out-patient conflict had begun, namely with a request from the out-patient unit that VR staff come to explain the state VR agency's programs at an out-patient staff meeting. My immediate supervisor, the local VR office director, and I were asked to attend this meeting. None of us knew what to expect, but we all feared renewed friction. We, therefore, held a strategy session before our presentation, and we decided that we would avoid all mention of VR counseling and talk solely about the kinds of referrals possible through the state VR agency. I was delegated to perform this task.

At the meeting, after I had completed my planned presentation, the assistant out-patient administrator specifically asked if there was anything we wanted to say about the nature of vocational rehabilitation counseling or about its relation to therapy with the psychiatrically disabled. When we demurred, he indicated that there were a few remarks he felt it necessary to make. Much to the surprise of my supervisors and myself, he then explained that it was his belief that in order for a VR counselor to make sensible referrals that he needed to have "insight"

into the psychiatric problems of his clients, and that he also needed to have "good relationships" with his clients. If VR counselors did not have the expertise to do this, he reasoned, they would be little better than state employment agency counselors. He continued that it was his hope his staff would understand this, and that any frictions which might develop between VR counselors and therapists might be worked out. Finally, he asserted, that because I had such a large caseload I could not reasonably be expected to report to therapists all that was happening with our mutual clients. They were then instructed to call me if they had any questions, and I gladly agreed to provide them with the information they needed. On that note, the meeting ended.

The next week I received a letter of thanks from the out-patient administrator. He wrote, "I have received excellent comments from the staff who attended the session.... It was apparent that your knowledge and commitment to your organization made a very positive impression...." I was also stopped in the halls by several out-patient staffers who complimented me on the quality of my presentation. Within weeks I began to receive invitations to attend out-patient unit case

reviews. I also began to receive more referrals and out-patient therapists started to commend me for quality of my work with their patients. At case conferences my opinions and "insights" were both solicited and listened to, and two of the unit psychiatrists went out of their way to tell me that my vocational plans were excellent. I even began receiving compliments on the quality of the letters I was sending out on clients' behalf. There was still wariness between the out-patient staff and myself, but our overt conflict was over.

Discussion

Justification. Ideology per se, it should be plain, was not the prime cause of the conflict between the out-patient unit and myself. Our dispute was not over fundamental questions of how clients should be worked with; though it was often couched in these terms. The conflict between us did not arise until after the out-patient unit was given increased responsibility within the psychiatric hospital. It then began asserting its authority where and when it could. It was very effective in this endeavor and eventually the staffs of many units, including that of the rehabilitation unit, came to defer

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to the out-patient staff. When the out-patient unit turned its attention to me and my co-counselor, it treated us as if we were also hospital staff and demanded that we report to it on a regular basis. Control over our activities seems to have been the aim, and to achieve this goal both ideological and non-ideological means were used.

The out-patient unit and its staff employed a potpourri of ideologies in asserting and justifying their primacy. Medical, psycho-social and moral ideologies were all used. But of greatest importance was the attempt made to establish the out-patient unit and its therapists as the authorities on "psychotherapy". As early as the first presentation we made to the out-patient staff, a psychiatrist asserted his right to judge the use to which VR counselors were putting psychological tests. He suggested that this was a professional responsibility, but also made his claim in moral terms when he wondered aloud if these tests were being used "fairly", i.e., if VR counselors were "pigeon holing" clients.

The first major attempt by the out-patient unit to assert authority came when I was summoned to attend the meeting regarding "duplication of services". This meeting

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was set up in such a way that I was required to justify the kind of counseling I was doing, while interested members of the out-patient staff functioned as accusers and judges. The main accusation made was that I was illegitimately getting involved in "therapy". One of the therapists apparently felt that I was usurping his prerogatives by doing psychological testing and by exercising "undue" influence over the programs his clients were in. His needs to crystalize his new identity as a "therapist" were then exploited by the unit to assert its rights regarding "therapy". The fact that the conflict over Robert was largely over vocational issues, namely whether he should be in school or not, was treated almost as if it were irrelevant. Instead, the issue became the way I did counseling. It was asserted that my methods were too personal and too "therapeutic". It was considered inappropriate for a VR counselor to talk to Robert about his relationship with his father, even if this did impact upon Robert's vocational goals.

The fact that I was allegedly doing "insight oriented psychotherapy" became the major theme of my running dispute with the out-patient unit. It was said that I talked to my clients about their feelings and dreams and

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family histories, all of which were assumed to be under the purview of "therapy". Since vocational counselors presumably did only "vocational" counseling, this must mean that I was trespassing on their area of responsibility, and hence was an argument for why I should defer to them. In short, "therapy" was used to justify the out-patient unit's attempt to exercise its claimed authority.

A more strictly medical ideology was also used as a tool to claim authority when it was later asserted that I was counseling some clients not to take their medications. The state VR agency, in its turn, did not challenge the medical or even psycho-social aspirations of the out-patient unit. It eventually defended the kind of work I was doing by describing it as "intensive counseling" and by emphasizing that its goal was vocational. This distinction between "vocational counseling" and "therapy" became the crux of the dispute.

It should be noted that the etymology of the crucial concept "therapy" is clearly medical. The dictionary defines the word as meaning "to cure or nurse". Though many psycho-social ideologies have adopted the word, in

doing so they have made themselves vulnerable to medical appropriation. The core meaning of the concept of "rehabilitation", on the other hand, is "to restore to good order and suitability". (Webster, 1970) Its origins are more clearly moral, and hence more difficult to identify with a single institution. Because the state VR agency had some pretensions to doing psycho-social counseling, but had no proprietary concept with which to justify this counseling, it was at a disadvantage. "Therapy" was a concept the out-patient unit could revel in, while the state VR agency felt a need to dissociate itself from it. Still, it did not have a unique alternative to which it could repair.

I found out very early that attempts to defend what I was doing in terms of "therapy" would not work. The state VR agency and its administrators would not back them up. Nor could I expect support from other VR counselors. Many of them felt that "therapy" was somehow too deep and too emotionally demanding for them to handle. Some who did do a lot of counseling had also found the word "therapy" used against them, and so were loathe to identify themselves with it. One secretary told me that she admired the close way the counselor she was assigned to worked with her

clients, but that this counselor was constantly being told to stop doing "therapy". The secretary said that she didn't know how the counselor managed to stand up to the pressure.

Another counselor, who was at pains to tell me that she did not feel emotionally tough enough to handle real therapy, related that she too had been under attack for being too "therapeutic". "People tell me that I get too involved", she said, "But I can't help it. That's the way I am." She then explained that she did do a lot of counseling; that she had to for her own sense of satisfaction. She was, however, careful not to tell anyone what she was doing. Her hope was that no one would find out, and then feel compelled to stop her. By protecting her privacy, she sought to forestall conflict. Secrecy, i.e., a form of avoidance, was thus used to prevent conflicts over counseling from being worse than they already were.

Medical use of the concept of "therapy" to guard what are perceived of as medical prerogatives, in fact, seems to be very common. Rushing (1964) describes how psychiatrists at a teaching hospital regularly discouraged

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social workers from doing "psychotherapy". When the latter attempted to work closely with patients, they were accused by the doctors of trying to be "junior psychiatrists". They thus attempted to define "therapy" as a "medical" specialty.

Because the state VR agency and its staff deferred to medical authority regarding "therapy", I found it expedient to vaguely define what I was doing as "intensive counseling". This, at least, could be accepted, because the VR agency was supposed to do "counseling". And so it was that VR agency memos, even those from the local office director, began referring to my "intensive counseling".

Still more successful, however, were defenses which relied on educational and/or placement perspectives. When I described what I was doing as a diagnostic process necessary for the effective referral of clients to training programs and/or competitive employment, I could count on receiving the whole-hearted support of the VR agency; both from its counselors and administrators. This clearly was "vocational" counseling. There was no confusing it with "therapy". Nor could the out-patient unit refute such arguments. Indeed, in the end the

assistant out-patient administrator who had been most vigorous in trying to assert out-patient unit authority over me came to my defense by using this very argument. Similarly successful was the rationale that I was teaching clients job and/or program survival skills. By pointing to the fact that L was learning how to take part in a training program, I successfully asserted that I was doing my job.

Ultimately, it must be observed, non-ideological ploys were probably the most effective instruments in the protracted struggle between the VR agency and the out-patient unit. The out-patient unit, for example, quite unnerved me when they told me that the "law" required me to write notes in their charts. It was implied that legal sanctions could be used to force me to do what they demanded, and this was quite unsettling. Similarly, my best defense against this ploy turned out to be the invocation of state regulations which enjoined me from writing anything in their records. Bureaucratic rules ultimately carried more weight than ideological arguments.

Side Effects. Moral issues cropped up repeatedly

during the VR agency/out-patient unit conflict. On several occasions the assistant out-patient unit administrator explicitly questioned my "ethics". Others implied that I was involved in some sexual misconduct. I in turn defended myself by arguing that the out-patient unit was not properly concerned with client "needs". My defense of the kind of counseling I was doing had become a very personal affair and depended largely on my own moral commitments to psycho-social counseling. I argued very strongly for what I perceived to be my client's needs and rights, and for what I thought of as "positive" relationships. In a real way, the persistence and energy with which I defended my turf was contingent upon the intensity of my moral views.

The moral character of the disputes seems to have contributed to the intensity of the contest and to have led to some "side effects". There was, for instance, much intimidation. This feature was introduced with the trial-like character of the meeting regarding the duplication of services. It continued with assertions that I must report to the out-patient unit because that was "the law". It escalated with letters to my supervisors which were c.c.'d to the highest echelons of

the hospital administration. It reached a crescendo with the threat to create a "cause celebre" over L. And it culminated in demands that my counseling be investigated.

Also present was dissimulation. This occurred when I was summoned to meetings without their true purposes being revealed, or when the "law" was invoked as a sanction, when, in fact, state regulations required the opposite of what was being demanded, or when confidentiality was cited as a reason for not telling me why I was supposed to stop working with L. Appeasement too occurred as a by-product of our conflicts, for when I was initially asked to write in the out-patient charts, this was done with a great show of "niceness", and when the psychiatrist had finished arranging our compromise regarding Robert, he concluded by explicitly telling me what "nice" people the out-patient staffers were, and that he was sure we would be able to get along just fine. Rigidity too was embodied on all sides, for throughout the whole conflict there was little giving of ground by anyone.

When at last an impasse was reached; when it became clear that neither I nor the state VR agency was going to submit to out-patient unit authority and that I was going

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distance, and allowed all concerned to avoid feeling that they had sustained an unacceptable loss. The anger which was experienced by the participants could thus subside and its disruptive effects reduced.

The final resolution of the conflict appeared with what seemed dazzling suddenness. In retrospect, even now I am not fully certain how it occurred. Many factors suggest themselves. Surely the reduction of passions over time must be considered one element. It made mutual adjustments possible. Also involved were organizational changes. Deinstitutionalization had become less important, and the out-patient unit had in any event consolidated its position within the hospital. After two years on the job the out-patient therapists had become more secure in their roles and hence had less need to justify themselves. It also seems likely that the tenacity with which both parties to the conflict upheld their positions induced a kind of grudging respect. Each side had to accept the other as a fact not subject to immediate or substantial change. What seems to have emerged is a state of "moral equality"; that is, a state in which both sides stopped asserting their moral superiority and accepted the moral parity of the other.

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It should also be observed that the conflict's resolution did not grow out of a clarified division of labor. Neither the kind of counseling I did, nor the kind of therapy done by the out-patient unit, changed much. We did tacitly agree to call my work "counseling" and theirs "therapy", but the accommodations finally achieved had more to do with a growth of tolerance than with an agreement not to duplicate services. In part we seem simply to have agreed to respect the ambiguities inherent in the concepts of "rehabilitation", "therapy", and "counseling".

At this point, it should perhaps be added that clients had virtually no role in settling the issues in dispute. Their wishes were almost never considered, and their views rarely solicited. Thus in the case of Robert though he made an explicit decision about whom he wanted to work with, in the end this decision was not respected. By the same token, neither L nor M was consulted about whom she wanted to work with, or how. When staff conflicts developed regarding "treatment" issues, clients were largely helpless. Whatever ideologies they may have held were irrelevant to what transpired. And though they usually knew when they were the subject of a dispute, and

often expressed guilt about having caused so much trouble, there was little they could do to resolve the differences.

Case III: Moral Equality

Conflicts between state VR agency personnel and Workshop agency personnel occurred during the whole period of my employment as a VR counselor, and according to other counselors had been a fact of inter-agency relations for as long as anyone could remember. I was especially unhappy with the way the Workshop agency was treating my psychiatric clients. It seemed to me that they were too often put under unnecessary emotional pressures, and then when they predictably reacted with an intensification of the psychiatric symptoms, this was used as a reason for terminating them from the program. I simmered about this state of affairs for a long time, but was reluctant to confront anyone at the Workshop agency with my feelings. It seemed to me that there was enough friction in my relations with other professionals without my needing to provoke new conflicts.

Nevertheless, when I went to one conference at the

Workshop agency a conflict did erupt. I was unprepared to be told that the client under discussion was going to be asked to leave the program. It was only a week earlier that she had been invited to return to the Workshop by its staff after she had been in an interruption status, and it did not occur to me that she might be asked to leave so soon. When this request was made, the Workshop counselor justified his decision by telling me that the client's program attendance was poor, and what was worse, she was reacting badly to requests that she improve her performance. According to the counselor, he had told her that she would have to comply with agency standards and he had asked her to acknowledge verbally that she would try to do this. Since the client was very non-verbal (she had been catatonic), and rarely responded verbally to demands made of her, this was not something she could easily do. Her lack of response, however, deeply upset the counselor, and he was further upset when after a confrontation she would return to her work station and simply stare at the ceiling for a while. So far as he was concerned, she was "day-dreaming", and this was unacceptable behavior, too. During our meeting, he insisted that clients must meet standards, and since she didn't, she must leave.

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I tried to explain to the counselor that I thought this was the wrong approach to take with psychiatric clients. He replied by insisting that "standards must be met". I responded by trying to persuade him that while the techniques he was advocating might be appropriate for the physically disabled, they were not suitable for the psychiatrically disabled. In consequence, I suggested it might be appropriate for the Workshop agency to overhaul some of its standards. He still insisted, however, that "there must be standards". I then told him rather firmly that I thought he was being foolish.

After the meeting had concluded, I felt that it had been an unpleasant and unproductive experience, but that nothing remarkable had transpired. It was, therefore, with great surprise that I learned that I was requested to report to the downtown VR office to discuss the Workshop agency incident with the local VR office director. When I met with him, he told me that the program director of the Workshop agency had protested my behavior. He purportedly complained that I had been badgering some of his staff. The local VR office director told me that he knew how difficult the Workshop agency and its program director could be, but would I please try to be more diplomatic. I

agreed that perhaps I had come on stronger than I should have, and that I would try to discipline myself a bit better.

Some weeks later, I had occasion to attend another client conference at the Workshop agency. This meeting was presided over by the program director, and he indicated that he wished to talk to me privately about what had happened at the previous conference. When the two of us later sat down to talk, he began by telling me that he thought I had been "unprofessional" in what I had said to his workshop counselor. He pointed out that this counselor was relatively new on the job, and that he had "good intentions". The program director heatedly asserted that it wasn't right for me to have "put him down" the way I did. In response, I told him I was very annoyed that the counselor had complained to him about me, and that he in turn had complained to my agency director without his first having registered his feelings with me. I said that I did not think that was very professional. He replied that his counselor did not complain to him about this incident. Rather, he had personally observed the incident through a see-through mirror. I then told him that I thought unannounced observations were more unethical than

anything I had done.

Up to this point, the program director had been very forceful in pointing out my errors; now he became rather subdued, and confessed that he felt guilty about what he had done. He then explained the circumstances of his having been in the observation room and hoped that I would not hold it against him. I said I would not, and that I hoped he would not hold my exasperation with his counselor against me. He agreed that this was fair, and after this we started talking without recriminations about how my psychiatric clients might best be handled by his agency. By the time we had concluded, we agreed that my clients would get special attention and that their psychiatric conditions would be taken into account in their programs. He said that he would personally ask his staff to "flag" my clients; and in this he kept his word. Thereafter, I was given much better notice of the difficulties my clients got into, and several of the workshop counselors (including the one with whom I had my encounter) and I held productive consultations on how we might work with our mutual clients.

Discussion

Justification and Conflict Resolution. In clashes between the state VR agency and the Workshop agency, there was not a conflict between different ideologies. Both organizations were on equal ground when they invoked educational or psycho-social ideologies, and neither was comfortable with medical ideologies. When I criticized the workshop counselor for his counseling, it was essentially on psycho-social grounds. His response was in terms of non-ideological organizational "standards", and in moral terms. He was upset that my client was not following either workshop or moral rules. Neither of us, however, accused the other of poaching on the other's territory. Rather, we were speaking the same ideological and non-ideological language and trying to make our points within a common, albeit vague, framework.

What often happened was that issues devolved onto a purely moral plane. This became most clear during my confrontation with the program director. Both of us accused the other of being "unprofessional". This meant not that our respective counseling or training techniques were wrong, but that how we had conducted ourselves was "unethical". Both of us attempted to gain moral leverage

as a pre-condition for discussing other issues. When, however, we confronted each other very directly and very sharply and neither of us fled the field, there followed a mutual decision to temper our dispute. It was as if we had arrived at an agreement to desist from trying to achieve moral advantage and to henceforth treat each other as "moral equals". Having reached such an agreement, we could then go on to negotiate a settlement of our other differences. Without the achievement of moral parity, there seems to exist the potential for interminable conflict, with one or both protagonists trying to take advantage of their perceived moral superiority and the other trying to resist being victimized because of their perceived moral inferiority.

One of the reasons the workshop counselor was apparently so upset by my client's "misbehavior", and by my criticisms of his behavior, was that he was new on the job (see chapter 9, re: counselor socialization). Apparently his rigid invocation of "standards" was, in part, due to feelings of moral insecurity. He was not sure where he stood relative to others, and so he felt a need to assert his own moral credentials as vigorously as he could. Indeed, when I had begun my tenure as a VR

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counselor, I too was especially sensitive to potential moral lapses. Thus it was that I was so terribly upset by the way L's therapist treated her, and why I felt so absolutely impelled to make a moral stand. It was as if I too needed to establish my moral credentials. These credentials, it seems, are vital to establishing moral status, and hence to the achievement of the moral equality so often required for the successful negotiation of other issues.

Chapter IX

COUNSELOR SOCIALIZATION and the ECLIPSE of IDEOLOGY

Learning the Counselor Role

Counselor socialization is a process which may be expected to have an ideological component. Because ideologies presumably provide an understanding of what rehabilitation is and also encourage the use of preferred rehabilitation solutions, ideologies may be expected to help counselors learn a) to understand what it is they are supposed to do qua counselors and b) learn how they may successfully perform their assigned tasks. In fact, though ideology is abundantly present in the psychiatric VR field, it functions very poorly in guiding participants as they try to discover what their job is. It functions

even less well in leading them to a "successful" performance of their job roles. Psycho-social, educational, medical and religious ideologies, in particular, turn out to be largely irrelevant to the establishment or the performance of the job counselors learn to do directly with their clients. Of the ideologies we have examined, only the moral ones play a really influential part in determining what VR counselors actually do with clients.

The central fact of psychiatric VR counselor socialization is that it is an adaptation to failure. However rehabilitation is defined, i.e., by whatever ideology, failure is the norm when VR counselors are working with psychiatrically disabled clients. For the most part, neither psycho-social, educational, medical, religious nor moral goals are attained for the vast majority of these clients. This is a fact most VR counselors do not anticipate when they initially come to their jobs. Both their schooling and their personal commitments have led them to believe that if they use the correct techniques, e.g. client centered counseling, and have the right motives, i.e., really want to help, that they will be able to aid the disabled, including the

psychiatrically disabled, to make successful vocational adjustments. Only with the passage of time and a great deal of unsuccessful effort do they learn the full extent of limitations they confront.

There seems to be a general socialization pattern (albeit with variations) which most counselors experience. When they are first hired by a state VR agency, they bring with them an initial idealism. They are eager to work with clients because they expect that the goals of rehabilitation are achievable, e.g., that they can personally help train clients for jobs; that these clients will then be able to hold jobs; and that everyone, counselor, client and society, will benefit as a result. After a fairly short period of time difficulties are encountered. The ideals they brought with them do not seem to be working, and the job they thought they would be doing fails to materialize. Most counselors then seem to resort to problem solving behavior. They look for solutions to the problems which confront them. Why don't most clients seem to be job motivated? Why can't most of them seem to hold jobs? Why are they so demanding? In varying ways, and with different degrees of effort they look for other ways to do what they conceive of as

"rehabilitation". Most of these attempts, however, wind up achieving results far short of those intended. Failure becomes more and more apparent, and in the end must be accepted as such. This then leads to some form of inner resignation and/or to exiting the field.

During this process of adjustment to failure, the psychiatric VR counselors are very much on their own. The state VR agency, the psychiatric hospital, and their various ancillary educational institutions each offer little which helps the counselor cope successfully with the problems he daily encounters on the job. Nor do viable ideological solutions emerge from the counselor's own efforts to understand or solve the dilemmas with which he must live. Psycho-social, educational, medical and religious ideologies tend to become progressively less functional and to slide from day to day awareness. The moral ideologies, both the political and personal ones, though they remain in force, tend mostly to reinforce the counselors' sense of failure and so may not be welcome as conscious tools of the counselor trade. In short, the psychiatric VR counselors who have been on the job for a while, the kind of counselors euphemistically called "experienced", are very likely to be unhappy with what

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they are doing, or as they are likely to perceive it, as "not" doing.

Initial Idealism

One of the things which struck me most when I began working for the state VR agency was how rarely counselors alluded to what they had learned in school during the process of doing their jobs. When asked about their schooling in rehabilitation most described the experience as "absolutely irrelevant" to their work. This was often said with some bitterness. During one in-service session, a counselor emphasized that she learned "right away" that what she had been taught wasn't going to do her much good. She had received a Master's degree in rehabilitation counseling from a program which emphasized client centered counseling, but, she reported, that once she started working with clients, she discovered "reflecting" was not enough and that her clients "wanted information" which she felt unequipped to provide. She made it plain that she was very disappointed that the psycho-social ideology she had learned did not provide her with the job guidance she had innocently hoped it would.

Whether because of ideologies they learned during a period of training, or because of ideologies, especially moral ones, which they brought with them from their private lives, most counselors started their job with large measure of idealism. As one counselor told me, she only became a counselor because she felt "a need to do good". Indeed, she emphasized, she couldn't have remained in the field if that need had not stayed with her.

Perhaps the most striking example of idealism I encountered was displayed by a rehabilitation counseling intern whom I was assigned to supervise one summer. She had just completed the first year of her graduate program and my job was to help her acquire some practical experience. When she was introduced to me, the first thing I noticed was an almost breathless desire to "help" clients. Time and again she told me how important it was to her that she do things right. And when I cautioned her that she might not be able to do as much as she hoped, her most typical response was to purse her lips in an effort to hold back her enthusiasm, something she only imperfectly accomplished. Not only was her moral idealism very strong, but so were her psycho-social and educational aspirations. Most often what she wanted of me was help in

putting her classroom lessons into action. Thus after interviewing clients she would write up very lengthy accounts of what had transpired and then show them to me for approval. We would then discuss what had occurred and invariably this included a discussion of why the session had not gone as she had anticipated it would. Why, she wondered, had clients not "opened up" to her as she had seen them do with me? Was she doing something wrong? Was there something wrong with her? Certainly she was trying to listen to clients as she had been taught to do, but they were not responding as they were supposed to. Many of them were just sitting there "just being polite". I then tried to tell her methods of getting things started with psychiatric clients; methods which her client centered-training had not covered. It was terribly important to this intern that she be able to make her counselor training work, and so she applied herself to the task with unremitting industry. After a while, in a private conversation, I asked her why she worked so hard, and she haltingly related the story of her relationship with her parents. She explained that they were close to divorce and blamed this largely on her father's long term alcoholism. Her job, she said, had always been to help her parents cope with their problems, but now she was

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feeling at wits end. She did not know if her father could survive without her mother and she did not know any way to keep them together. Part of her need to make the VR counseling work (i.e., her idealism), she believed, was a need to find a successful form of intervention she could apply with her parents. In fact, the intensity of her need was very realistic, for toward the end of her internship her father wrote her a letter threatening suicide, and some weeks later he made good on this threat.

The personal need of this intern to make counseling work was not, however, unique. A VR counselor who worked with me for several months at the state psychiatric hospital, confided that she had become a counselor in reaction to her mother's having been a social worker. This counselor perceived her mother as being inept at her job, and yet as giving more energy to it than to her own children. She told me that she had intentionally sought out a job counseling psychiatric clients so that she could learn to avoid her mother's mistakes. She stressed that she wanted to learn the right way of caring for people; a way which would not require her sacrificing herself or anyone else in the process. She confessed that though she intensely wanted to succeed she felt that she had not and

that there were times she wondered if she would be able to continue meeting the strain of not being able to achieve these goals.

Another counselor, one who was severely disabled physically, told me how much he enjoyed giving things to clients. He said that it made him feel good providing things for people which he had once longed for himself. Nevertheless he related that the idealism he had had in his earlier years had not been fulfilled. When he had first left school he had taken a job with the state employment service, but transferred to the state VR agency as soon as he could. He anticipated that he would be able to do much more for the disabled in the capacity of VR counselor than as an employment interviewer. "I was told it was going to be difficult", he said, "but I didn't believe it." After a pause he added, "I've since learned better." He then told me, "When I came to the agency I thought I knew the job. I had been a good student. -But I was wrong. I didn't know the job."

I too, it must be noted, was swept up in idealism when I began working as a VR counselor. Though I was a graduate student in sociology and had no intention of

making VR counseling a career, I did have very definite ideas about how counseling should be done and was quite convinced that I could make them work. I had very strong sympathies with psychoanalytic and cultural formulations of client problems and was determined to help clients reformulate their vocational relationships. Perhaps even more importantly, I too had intense moral convictions, and indeed believed that I would be morally culpable if I could not, or did not, convert my sociological and psychological insights into effective change processes. Furthermore, I held a layman's notion of "rehabilitation" and believed that rehabilitation meant reintegrating clients into the vocational world by helping them to acquire the skills they would need in order to function as independent, self supporting human beings.

Another counselor who was ostensibly quite cynical about the possibility of doing significant work at the state VR agency also began his tenure with some measure of idealism. This counselor, who was hired the same time I was, told me during one of our orientation sessions that he knew the state VR agency was a governmental organization and that hence he could not expect much more from it than he had obtained at the state employment

service which he was leaving. Nevertheless, he explained that he was changing jobs because the employment service had become "too restrictive" and that he was sure the VR agency would be an improvement. He said that he thought he would be able to do more counseling and less "computer stuff".

Along with the idealism counselors brought to their position went, almost as a corollary, a very high initial estimate of their abilities to induce change in their clients, and this probably helped support their idealism. Certainly, this was true of me. From the beginning, I was anxious to work with schizophrenic clients, for I knew of their reputation for being difficult to change and I wanted to prove that if anyone could make a difference, I could. It was partly for this reason that I was anxious to work with L despite her therapist's warnings that she was a difficult client. After having read L's case record, I thought I knew how to help her "work through" her vocational problems. Indeed, I felt so sure that I knew what I was doing, and so sure I could succeed, that it would be immoral if I didn't try.

This high initial estimate of their ability to change

things was often fostered in counselors by the reactions of their clients. Often, especially in the beginning, clients told counselors what a good job they were doing. Thus from my second session with L she was already telling me how much I was helping her and how I was able to understand her where others had failed to do so. During informal talks and at in-service training sessions other counselors reported having had similar experiences with their clients. They also reported that this positive feedback made them feel good and "important". Equally flattering, especially to new counselors, was the tendency of clients to share "confidences" with counselors. A supervisor of mine told me that in his experience this was a very common phenomenon. He explained that he thought these confidences made counselors feel trustworthy and hence special. Certainly this was the effect L's early confidences had on me. When she told me that she was having friction with people because she was a "leader", I was inclined to agree. I thought that it was her attempts to be assertive which were alienating people. It was only after I had been working as a VR counselor for some time that I learned that L's descriptions of what had transpired in a given situation might not accord with my description of the same situation. With time, I also

acquired some knowledge of the cycles clients went through, and was not so impressed by what first seemed to me to be significant successes. I learned that clients who entered programs did not necessarily complete them, and that those who acquired jobs might also lose them. It became apparent that problems which I thought were solved might crop up again almost in their original form. Thus L was rehospitalized several times for similar problems, e.g., when relationships she was in fell apart, and another client, who first seemed to me to have learned that she could not do housekeeping jobs came back on an annual basis to ask for housekeeping jobs. It began to seem to me that when I began the job I had what amounted to a need to misread the extent of my successes. It was as if I needed to prove to myself that my idealism was justified.

Nevertheless, at the same time I had my doubts about my abilities and projections. I knew that I had yet to prove that the kind of counseling I believed in could really be done, or that I was as good a person as I felt a need to be. One way this anxiety manifested itself was in "showing off". During my first year whenever I thought that something needed to be said I got up at in-service

training sessions and said it. There was a part of me which felt impelled to instruct others on the proper ways to do counseling, and, in the process, to acquire public confirmation that I did have the expertise I claimed. One of the more blatant forms of showing off in which I engaged was "sharing" psychodynamic interpretations with social workers who had no way of putting these putative insights into practice. In one case I gave an "anal" interpretation to a client's behavior on the basis of a drawing she made for me which included a detailed representation of her own alimentary tract right down to the feces being excreted. I simply had to let others know how clever I could be.

This sort of showing off was a widespread phenomenon among new counselors. Perhaps half the new counselors I observed engaged in it at some point. One VR counselor, for example, during her first six months at the agency regularly got up at in-service sessions to tell the assembled counselors how things were done at her previous agency. At the Workshop agency this showing off by new counselors often took the form of their writing excessively detailed recommendations regarding client programs. One of my co-counselors said that he thought

this kind of behavior was a matter of "establishing one's turf", i.e., of letting others know that one should be reckoned with; a process I have in chapter 8 called the establishment of "moral equality". It seemed that in order to demonstrate one's moral worth, and hence one's right to be taken seriously, one had to show that one was at least as capable of doing good as the next fellow.

On the other hand, some new counselors' doubts were overtly manifested. Some displayed extreme, one might almost say, ostentatious, diffidence. These counselors tended to say little at meetings, and some, like one young hospital counselor, openly declared their ignorance. She was given to telling others that she was new, and when she felt threatened often asked people what she should do. "You've got to tell me what to do", she would say, "I'm new." Similarly, many new counselors looked to authorities to help define the situations they encountered. This was particularly true in the psychiatric area where many, including myself, hoped that doctors might have answers to questions about how clients might really be changed.

Encountering Difficulties

While counselors typically began their job in an idealistic frame of mind, the job itself usually taught them in very short order that their ideals would not be met. Firstly, though counselors felt that they had a lot to give, and indeed that they "should" give a lot, the clients that they were asked to work with usually demanded more. It quickly became apparent that these client expectations would be difficult to fulfill. Most psychiatric VR clients were in terrible pain. They were usually frightened and/or angry and/or confused. They wanted better from life, and often insisted upon it. Among the demands that were commonly made were for "a job, NOW" or a training program that will "pay me money". Many clients asked for help in obtaining jobs at which they had failed several times in the past. Some just wanted to be told what to do. They had no idea of what kind of work they wanted or where, but expected that the counselor as an expert ought to know precisely what would suit them and precisely where they should go to get such a job. This kind of job selection, it should be added, was frequently expected to occur "at first sight" ,i.e., the counselor should be able to tell what was appropriate just by looking at the client.

Some clients, to be sure, wanted their vocational and personal lives straightened out, but only on their own terms. Very widely desired was a sense of security and hope. Some clients would literally say "tell me what my problem is", while others would cling and complain all the while expecting some miraculous counseling intervention. For the most part client demands were very straight-forward and in a sense "standard". Thus some clients who were having family problems asked me to talk to their husbands, while others wanted advice on raising their children. Some made more idiosyncratic requests like a client who asked me to sell one of her gold chains so that she could get some money. More frequently, however, requests were made for forms of assistance which clients knew VR counselors were equipped to provide, e.g., bus passes to facilitate job hunting endeavors. Many times the goals clients sought to achieve were different from those envisaged by their counselors, and some clients were quite frankly anti-counseling.

In general though, clients wanted "success". They at least wanted to avoid failure, though with their actions they frequently embraced it. These demands for success

and for "help" almost always carried moral overtones, and were quite often blatantly moralistic. It was not uncommon for a client to conclude a request with a plea such as, "I deserve it. After all I'm a person too", or "Aren't you going to help me? I'm being good. I'm trying." Phrases such as "I have a right..." or "give me a chance" were especially common, and several times a week I could count on some clients to knock on my door to ask for special consideration in light of their straitened circumstances.

The very large number of clients involved (I had a caseload which averaged 140) served to magnify the demanding character of client requests and also added to their moral weight. The limited amount of time, money and program slots available, not to mention counselor energies, virtually insured that client's demands would be greater than any given counselor could satisfy. In my case, for instance, though I initially tried to see clients on a weekly basis, I quickly had to change this to a bi-weekly, tri-weekly and even a monthly basis, despite a drumbeat of client requests for quicker action or for more attention.

Because clients almost invariably got less from VR counselors than they demanded, there was an undercurrent of frustration and unhappiness in the relations between psychiatric clients and their counselors. This client unhappiness usually frustrated the counselor as well. After all, the counselors started as idealists and for them client unhappiness betokened failure. By whatever ideological criteria, the goals counselors set for themselves, or had set for them, remained largely unattained because of the flood of client demands. Counselors found themselves being a) not as good as they had hoped, b) not providing the effective training modalities they thought they would, c) not engaged in productive client-centered counseling and d) not facilitating medical cures.

Beginning counselors (as well as their clients) had usually accepted the political and ideological promises they had been taught in school or had absorbed from their personal social backgrounds, but when on the job, they soon found that they could not seem to keep these promises. At the very least they found that they were not able to get large numbers of psychiatric clients real jobs that they would in fact be able to hold for a while.

Counselors quickly learned that failure was the norm. They found, as I did, that six or seven "real" rehabilitations a year was a lot. Counselors found that the ways psychiatric clients could fail were legion and that failure was on-going and endemic. They also found that it was hard to eradicate. Perhaps this is best illustrated through the medium of examples and to this end I offer brief synopses of three of my cases.

Client A: A, a man in his thirties, had held only a few jobs in his life. The last was at a college bookstore as a general helper. It had been obtained through the auspices of a volunteer work program. After two years, however, he lost this job and had difficulty obtaining another. At this point he was referred to the state VR agency for assistance. His first VR counselor sponsored him in some courses in electronics at an adult education center, but for unspecified reasons these did not lead to a job. A's next VR counselor talked to him at some length about what he should do and the two decided that perhaps he should try to become a locksmith.

At this point A was transferred to me and when I asked him why he wanted to become a locksmith his only

reply was "I don't know. It seemed like a good idea at the time." He then asked to be re-referred to an electronics course because, though he was clumsy with his hands, he liked electronics and it at least gave him something to do. After completing a second course in this field, he did not come to see me for awhile, but when he did said that he now knew that he could never really hold a job in electronics; that he would never really have sufficient skills to do so. Previous psychological testing had shown that his greatest skills were in the verbal area, but it also showed that his greatest fears were of interactions with people. We concluded that this ruled out jobs in sales which he had been contemplating. Since he insisted that he now wanted to work, we decided that a referral to a program which evaluated vocational skills and then attempted work placement was in order. Such a referral was made and A did very well in the evaluation portion of the program. Surprisingly, he showed work aptitudes in many areas and his work motivation was described as good. During a placement conference, however, A declined to be referred to any kind of work except night watchman work. He explained that he had previously had some success in this sort of work and that furthermore, he didn't think he could get up early

enough for a regular job.

A then did obtain a job as a night watchman, but after three months he quit it blaming his leaving on transportation problems. He had not, however, consulted his employer or the job program to seek some relief from these problems. When he returned to see me he declined to be referred to any other job or program. He said that he did not feel able to handle a job and confided that he felt like "a little boy". "I don't know what it is," he said, "I just seem to panic." After this he stopped coming to see me for vocational help, though he did occasionally phone to say hello. At no point during the next two years did he resume looking for employment. Instead, as was typical of many clients he was supported by a form of public assistance, in his case SSI (Supplemental Security Income), and, as he later told me, he spent most of his time at a neighborhood community center doing arts and crafts.

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Client B: B had worked for the post office for about ten years, but ten years before working with me had quit and then simply stayed home with his mother. When she died he rapidly consumed the inheritance she left in an

orgy of alcohol and women. He then attempted suicide which in turn led to his hospitalization. Once in the hospital he found ways to avoid release. When he was referred to me he had been an in-patient for over a year. Initially he came to me mostly to talk. He shared his ideas about religion, about people, and about himself. Eventually he felt able to talk about vocational plans and we decided that something simple like maintenance work might be within his emotional competence. In any event, we decided that an evaluation at the Workshop Agency in their maintenance program would be worth a try. At the Workshop Agency he did well; indeed he did so well that his supervisor, a man who had some contacts in industry, offered to help him get a competitive job. At this B promptly left the program saying that he didn't think it was helping him. He then left the hospital. Later he explained that he had decided to try to succeed on his own. After about two weeks on his own, B was found wandering the streets of Northern City in a daze. The police then returned him to the state psychiatric hospital where he lapsed into a catatonic condition. When he recovered from this he claimed that he could not remember much of what had happened. He then came to see me several times and insisted that he was feeling better.

Nevertheless, he declined any vocational help from me. One day he stopped by to tell me that he would shortly be leaving the hospital and that he thought everything would be okay. Several months later B's naked body was found washed up on a beach, an apparent suicide.

Client L: L has already been discussed in several other contexts, but it is important to observe that in the more than four years that I worked with her she was never able to obtain a job. Indeed, she had never held a job for more than a few weeks. Her longest work involvement had been as a volunteer laboratory assistant, but the place where she worked refused to hire her for their regular staff. L had also failed to maintain herself in long term therapeutic relationships, she had been asked to leave several group homes, and her relationships with men uniformly seemed to end in disaster. When I referred her to a placement agency she left it after two days. She was more successful in maintaining herself in art courses, but though she insisted she was "basically an artist", this was not a field in which she could earn a living. L also had a difficult time keeping herself out of the hospital. Occasionally she even wound up in jail.

The ways psychiatric VR clients found to fail were very numerous. They might fail to return for VR appointments, or they might not go to an agreed upon program. If they did go to programs they might leave even if they were doing well. Some stayed in program, but failed to achieve a job as a result. Some got jobs, but were soon fired. Some were hired, but then left on their own. For others the question of a job or a program never came up for they made it plain that they wanted neither. Many elected simply to stay on social security. If they came to see a VR counselor, it was because in order to leave the hospital they were required by law to have several hours of programing, or because they wanted to keep their hospital therapist happy. Finally some clients came for VR counseling because they wanted someone to talk with, not because they wanted a job. Given this potential range for failure, it is not surprising that "genuine" rehabilitation was so rare.

(To judge from official state VR agency statistics, failure to rehabilitate psychiatric clients was no more likely to occur than failure with other sorts of agency clients. Thus according to the agency management information report for 1981, psychiatric clients accounted

for 22.7 per cent of active cases, while these same clients yielded 22.4 per cent of all rehabilitations. Nevertheless, the way "rehab" were measured (see chapter 6), there is reason to believe that these figures may not represent real success.)

When counselors first encountered massive client demands and pervasive client failure, they also found that the ideologies of which they were cognizant did not seem to address the problems they now had to solve. None of the major ideologies we have discussed, not the educational, not the psycho-social, not the medical and not the moral ideologies seemed to provide the beginning counselors with strategies for coping with the difficulties they confronted. The educational ideologies told counselors that a lack of client skills was the root of client vocational difficulties and they indicated that training was the preferred solution. Unfortunately, the training available to psychiatric VR clients did not seem to address the problems which made it difficult for clients to get or hold jobs. With client A, for example, electronics training was beside the point. Vocational testing showed that he did have work skills, but he could not hold a job because, as he said, "I panic". Training

and conventional skill development programs seemed not to affect this panic at all. Thus the Workshop Agency's personal adjustment training programs provided lessons in job discipline, but seemed to ignore the problems which made it difficult for most psychiatric clients to accept any such discipline. The upshot of this was that perhaps 80% of the psychiatric clients referred to the agency were ejected from it because they resisted its demands for discipline. In my own caseload, only two of the almost clients I referred to the Workshop Agency became sheltered workers, and only one attained competitive employment. In almost all of the other cases, my clients were asked to leave the Workshop because they were not following its "rules", e.g. about attendance.

Psycho-social ideologies fared no better than the educational as guides to successful action. Firstly, most clients did not come seeking "role change". Much more frequently they just wanted a job or simply to feel better. Secondly, the psycho-social techniques with which most counselors were familiar, specifically client centered counseling, did not have the advertised effects with psychiatric clients. As has already been mentioned at several points, these clients seemed much more to

demand an active counselor intervention. Unfortunately beginning counselors did not seem to have psycho-social techniques which allowed them to do this successfully.

Similarly, medical ideologies were of little help in the counselors' daily rounds. Counselors were not doctors and so were largely discouraged from engaging in medical techniques. Nor could they depend upon the psychiatric establishment to send them "cured" clients. A counselor might ask doctors and social workers to send him only clients who were "job ready", but, in fact, such clients seemed rare. Doctors, etc, might then be asked to change client medications or to provide "therapy", but again, this seemed to do little good. Client problems remained, and many of them appeared to counselors to be more "human" problems than "medical" ones.

Finally, the moral ideologies seemed to arouse more problems than they dispelled. They contributed ever more demands from ever more sources, and if the counselor felt that his ideals were failing him, turning to morality for answers often only increased his sense of guilt and failure. More always seemed to be asked of him than could be accomplished; and specific morality techniques, such as

the use of blame, seemed more to exacerbate conflicts than to eliminate failure.

Thus, by and large, the counseling methods and the ways of understanding problems which counselors brought with them to their work were ineffectual and apparently irrelevant. As a counselor mentioned in chapter 4 observed, VR counseling was not anything like what she had been taught at school. Clients did not come and cooperatively ventilate their problems, nor did they meekly accede to counselor judgements or desires. Above all, they did not readily change and become "rehabilitated", and this confronted counselors with the fact that they did not have the answers." The ideological solutions upon which they may have wanted to depend were not reliable sources of inspiration.

Nor could counselors turn to the state VR agency for much guidance in coping with demands made of them. The agency was largely indifferent to the tasks of counselors qua counselors. At an in-service training session held for "experienced counselors" a group of counselors was assigned the task of enumerating what the agency really wanted from counselors. It took these counselors less

than two minutes to come to a unanimous consensus. They did this with considerable mirth, for they were all surprised to discover how sure they were about the agency's real priorities. The first thing they agreed was that counseling was definitely not one of these. All the agency really wanted, they decided, was 1) lots of "rehabs" , 2) done quickly, and 3) cheaply, with 4) the required documentation, 5) more or less following agency procedures and 6) done without embarrassment to the agency. Given the accuracy of these priorities, the agency could not be expected to be of much help to counselors as their ideals painfully clashed with job realities. Indeed I have perused three years of memorandums and directives sent to counselors and not one makes a single suggestion designed to help counselors do counseling.

Nor could counselors turn to their immediate environment for support. From others with whom they had regular contact they could usually expect more demands. Thus from client therapists they were more likely to get a request to place some client than aid in coping with a particular rehabilitation problem. Another example of how the demands made of counselors tended to multiply,

especially the moral ones, is provided by the establishment of a "client assistance program".

Counselors were introduced to this new program during an in-service at which they were told that this state funded program would help counselors by keeping clients better informed of their "rights". They learned from counselors at another city, however, that when such a program was instituted in their area it quickly became but one of many "advocacy" agencies with which counselors had to contend. New counselors early on discovered advocacy agencies to be a fact of their work environment. They could count on getting calls from social workers and other "interested parties" asking why something had been done or not done for a particular client. Rather than experiencing these programs as sources of support, for counselors they became but another source of demands.

Even the news media could be experienced as a source of potential demands, and in Northern City ,at least, this potential occasionally became reality. While I was a VR counselor both newspapers and television stations accused local psychiatric hospitals of engaging in "patient abuse" and whether they were involved in anything approaching abuse or not counselors working with psychiatric clients

felt that they too were threatened by such accusations. Thus, for counselors, their work world was much more often an arena of threats rather than of support.

Looking for Solutions

One of the first things counselors did in an attempt to improve their situation was to seek support, especially emotional support. At an in-service training session a counselor broached this subject with some delicacy. She hesitantly noted that her supervisor was present in the room, and expressed a desire not to embarrass him, but declared that there was something she felt impelled to say. She described herself as frequently uncertain about how to work with clients and said that at such times she felt a need for "support". She then apologized for putting her supervisor on the spot, but went on to say that what she really needed from supervision was not advice, but "someone to tell me that everything will be okay."

Counselors also sought support from one another. Confronted with so much failure and so many demands, they felt a need for hope. To judge from the amount of

complaining they did when they got together, counselors did not get much of this. The complaining was probably, in part, an attempt by counselors to solicit support from one another, but it was so pervasive and so pessimistic that counselors often groused about the complaining itself. "Why can't you people look at the good side" was a comment I heard many times toward the end of complaint sessions.

Looking for support was but one of the ways counselors attempted to solve the problems that their job thrust upon them. They also looked for 1) experts on rehabilitation and psychiatric disabilities, 2) programs which accomplished results, 3) money to finance client plans and 4) improved counseling techniques. When counselors looked for experts on vocational rehabilitation per se, they met with rapid disappointment. Certainly no one I met in Northern City or in the state VR agency claimed to have such expertise as it applied to psychiatric clients. Psychiatrists did claim to have some authority in a related area. They often asserted an expertise on psychiatric conditions and by implication on psychiatric disabilities. When VR counselors looked to them for answers, the counselors were implicitly

expressing a hope of finding solutions in medical ideology.

Counselors generally met psychiatrists either in the process of having a client referred to them by a doctor or when they referred clients to doctors for therapeutic treatment. On such occasions they might ask psychiatrists why things were going wrong with a particular client and what sort of techniques were indicated to improve the situation. Usually these requests resulted in disappointment, for the answers given usually did not result in the achievement of successful rehabilitations. Thus counselors remained frustrated. On many occasions I was present while groups of counselors discussed which psychiatrists were "good", i.e., which ones gave good advice and/or good therapy. Sometimes I would hear a counselor say "well, I've been using so and so", but never did I hear a psychiatrist given a ringing endorsement. Rather the tone of these discussions always indicated a search which had yet to be completed. Similarly counselors compared notes on which psychologists they were using for testing, but here too the typical judgment was that they wished that the sort of expertise demonstrated was more relevant to rehabilitation needs.

Just as counselors searched for experts, so they searched for effective programs. As with psychiatrists, most of their searching was done during the course of their referral activities. Since most of the programs counselors dealt with were based upon educational ideologies, searching for answers in this area placed an emphasis on educational ideologies. Counselors regularly tried to find new programs, and having found them sought ways to make them more effective with psychiatric clients. The usual method for doing this was to try get a program to use training techniques which worked with psychiatric clients. And this usually came down to pleading with programs to be more responsive or humane. Counselors did not usually suggest specific technical improvements. The idea seemed to be that the programs should know how to conduct their business. Ultimately the result was typically clashes of the sort already described as occurring between VR counselors and the Workshop Agency. In effect the counselors' search for better programs simply became a demand that programs do better.

As they did with psychiatrists, counselors compared notes about specific programs. With these, the emphasis

of their consultations was on how to get the programs to perform better, and on which programs were to be preferred to others in specific circumstances. On a few occasions attempts to make more efficient use of programs were formalized as when one of my supervisors held regular meetings with his counselors so that they could try to develop a better understanding of the various agencies with which they dealt, and ultimately to work with them more productively. As has been noted, however, this particular attempt was disbanded when the supervisor concluded that there were no ways that counselors could substantively influence programs to perform better, and that no new programs on the horizon were likely to compensate for the defects of those already in existence.

For a while, counselors placed most of their hopes on finding more case service monies. When the state VR agency was expanding, it seemed reasonable to many that more funds for more programs would reduce the level of client failure. Increased funding would also enable counselors to meet more client demands whether or not doing so would lead to more rehabilitations. With more money there would be less need to say no to clients, and so at least there would be less initial counselor

discomfort. When agency funds started to dry up, however, counselors simply stopped looking in this direction for hope.

Many counselors at some point decided that better counseling techniques were their best hope for reducing failure and for coping with client demands. In the chapter on counselor ideologies, counselor efforts to use various psycho-social ideologies, for example, rational-emotive therapy, transactional analysis and stress therapy, have already been discussed. None of these efforts succeeded, however, and so they tended to be discarded. Counselors were handicapped in their endeavors to improve their counseling by what many described as their own fear of "depth" counseling. Most psychiatric clients lived in emotionally overwrought worlds and most psychiatric VR counselors felt uncomfortable dealing with so much feeling and pain. More than one counselor told me that dealing with such things was just "too tough".

Nevertheless, most counselors liked counseling and wanted to do it better. At the special university sponsored in-service for experienced counselors, most of the counselors firmly asserted that successful counseling

was very important for their own professional satisfaction. If this were true, one might expect counselors to try to do something about it, and ,in fact, there is reason to believe that many did. It seems that many VR counselors had a "guilty secret", i.e., many engaged in clandestine attempts at intensive counseling. One of my initial responses to the resistance I met when working with clients like L was to see them on a regular basis but not to advertise this to anyone. For a while, I thought I was unique in this, but when I confided what I was doing to one of my colleagues, she told me she was doing the same with one of her clients. Not long after this, the counselor who was out-stationed at the teaching hospital told me that during his first years on the job he had had some special clients whom he saw regularly for a long period of time. Even when I went to a training session in another city, a psychiatric VR counselor responded to my descriptions of my attempts at depth counseling with stories of his own attempts. Since none of these counseling endeavors had official sanction, none were spontaneously shared. All were in response to my disclosures, and I would not have known of them otherwise. For this reason, it is very difficult for me to estimate the extent to which counselors try to hone their

counseling skills by private attempts to do intensive counseling. That this practice may be fairly wide spread is indicated by the fact that even the Northern City VR office manager engaged in it when he was a counselor. Since he had discouraged me from doing intensive counseling, I would not have imagined him to have engaged in it himself until one of my supervisors told me that for years the manager had special clients whom he saw regularly; indeed clients he continued to see even after he had attained a supervisory capacity.

It would be nice to say that these private counseling enterprises ended with successful rehabilitations and satisfied counselors, but what meager evidence I have points against this. Thus the counselor at the teaching hospital told me that after a few years he gave up his attempts at intensive counseling. He said that he simply got too much flack for too little gain, and he expected that I would have the same experience.

Adjusting to Failure

At the in-service training session for experienced counselors, when the discussion turned to methods of

dealing with psychiatric clients one of the senior counselors present asked if he could say something. After being given the floor he began with considerable emotion to tell the assembled counselors that he believed that there was a definite limit to the amount of time any counselor could spend working with a psychiatric VR caseload. He said that the limit was about four years and that he had learned this from bitter personal experience. He told how he had had a psychiatric caseload at Northern City's teaching hospital and that he had tried to hold on to it for as long as he could because of the perks involved. The job allowed him an office of his own and considerable autonomy, both of which he enjoyed. Nevertheless, he said, he had found that psychiatric caseloads inevitably wear you down and that counselors need to change. In his own case, he said that the strain involved had led him to drink and he urged that no one else allow themselves to fall as low. He then gave an example of another counselor who had only with great difficulty been persuaded to give up her caseload at a community mental health center. In his view, the job had been driving her crazy and he declared that she had gotten out just in time.

Certainly VR counselors seemed to have considerable difficulty in dealing with psychiatric caseloads. Almost all of the psychiatric VR counselors in Northern City had some degree of difficulty adjusting to their work, and indeed in the long run most failed to make a livable adjustment. Besides the senior counselor who spoke at the in-service and the counselor he mentioned, what follows is an enumeration of all sixteen Northern City VR counselors who had primarily psychiatric caseloads during my four years with the state VR agency. For each a brief description of their adjustment to their caseload is given.

Counselor 1: My immediate predecessor at the state psychiatric hospital was there for about two years. She openly expressed a distaste for working with mental disabilities and as soon as an opening for a "floating" counselor occurred she took it.

Counselor 2: She too was at the state psychiatric hospital which she described as a mad house. She too requested a transfer and after a year she was given a general caseload. Later she decided to take a partial caseload at a community mental health center.

Counselor 3: He served as a replacement at the state psychiatric hospital. Most of his years at the state VR agency had been spent with general caseloads. He agreed to transfer to the state hospital because his wife worked there. Within a year he had to quit his job because of a severe physical disability.

Counselor 4: He had worked as a state VR counselor out-stationed at the state hospital several years before I arrived. After four years in this capacity he quit, loudly complaining of the paper work. He then took a job working directly for the hospital as a vocational counselor. In this capacity he talked often of quitting just as soon as he was eligible for a pension.

Counselor 5: He too had put in four years as a state VR counselor out-stationed at the state hospital. When he quit he was determined to find a more effective way to do VR counseling and he went on to obtain a Ph.D. in vocational counseling. He then accepted a job working for a local health agency.

Counselor 6: She was another counselor who had put in

a few years at the state psychiatric hospital. A colleague of hers quoted her as saying that she was "not a therapist" and hence would only refer clients to programs. He continued that "people thought she was cold and uncaring with clients, but maybe that's the way you have to be with psychiatric patients." After a while, she volunteered to learn sign language and was transferred to a caseload working with the deaf.

Counselor 7: She was attached to a partial hospitalization program at a city hospital. When another counselor left his job there and she was asked to assume it, she refused. She then requested that she be removed entirely from working with psychiatric clients. She claimed that she was just tired of the "revolving door" which went with working with psychiatric clients.

Counselor 8: She worked for several years attached to the psychiatric unit of a city hospital. She quit the state VR agency saying that if she was going to work with psychiatric clients she would rather do it as a therapist who had scope for action rather than a VR counselor who didn't. She then went to work for the state psychiatric hospital as a primary therapist. A year later she had

herself transferred to work in a partial hospitalization program.

Counselor 9: He worked attached to the psychiatric unit of a city hospital and after six or seven years showed no signs of leaving or of complaining. Clients, however, told me that he spent little time on the job and that he often missed appointments. My own observations indicated that he was much more interested in working with some race horses he owned than with psychiatric VR clients.

Counselor 10: This counselor had spent many years at the local teaching hospital. He described himself as getting along the best he could. At one point he quit his VR job to go to work for a local company. When this did not work out he returned to his state VR job, but he was still considering other options.

Counselor 11: The local VR office manager had once been out-stationed at the state hospital as a VR counselor, but moved up and out as fast as he could.

Counselor 12: He had worked many years out-stationed

at a rural psychiatric hospital, but quit to take a job working directly for this hospital as a vocational counselor. He felt that this would allow him more responsibility, but quit shortly thereafter because he felt it gave him less.

Counselor 13: He was out-stationed at a rural psychiatric hospital, but after three years started finding the frustrations of his job unbearable. In conjunction with his supervisor it was decided to give him half of a general caseload so that he could experience some feelings of successful rehabilitation.

Counselor 14: He too was at a rural psychiatric hospital and he too was given half a general caseload in order to have some feelings of accomplishment. Much of his energies, however, were devoted to establishing a private recording company.

Counselor 15: She was persuaded to accept a psychiatric VR caseload at a city hospital which was expanding its psychiatric facilities. Though she had considerable praise for the job this hospital was doing, within half a year she was lobbying for a change of

caseload.

Counselor 16: She was a relatively new counselor who was assigned to replace a counselor who had been transferred out of a city hospital's psychiatric clinic. As of my last contact with her, she seemed to be getting on well.

The above list does not present a history of very successful adjustment to the rigors of psychiatric VR counseling. It seems that over time the counselors' unhappiness with their jobs deepens. The frustrations they encounter seem to have a cumulative effect, and as can be seen, most opt to do a different kind of work. But before they do this, they do other things. First of all, they complain. They do so much of this that counselors complain of counselor complaints and eventually they talk little to one another about on-the-job stresses. This then results in a form of professional isolation in which each counselor must cope with the pains of failure on his own. When I mentioned my own sense of isolation to other counselors, they uniformly agreed that they too were isolated, but this shared sense of frustration did not in any way seem to lead to shared attempts at overcoming the

burden of failure. Counselors simply did not know how to do this. Rather a kind of cynicism seemed to develop, which served to cover over the tenderness of their thwarted idealism. A co-counselor of mine, whose idealism I know to have remained intact, became verbally very pessimistic about the chances of improving rehabilitation practices. Rather, he would caution me, "don't let the bastards grind you down". This was the best that he thought could be done. Another counselor who I talked to was so upset by the "bad week" that she had had that she cried. She told me about a client program that went wrong and then said, "all I get a chance to do is pick up the pieces when things go wrong."

Counselors try in various ways to adjust to the demands and failures inherent in psychiatric VR counseling. Among the methods used are the following:

- 1) The Reduction and Mechanization of Rehabilitation Services. With time, counselors do less and less face to face counseling and more paperwork. My predecessor on the caseload I worked with told me that she tried to "size up" clients as quickly as she could and then refer them to program. In so doing, she reduced the contact she had

with clients. Initially this method of working appalled me, but eventually I found that I too began making quicker judgments about clients and quicker referrals. This was especially true about clients whom I judged to have little chance of success. I found that with these clients I also made fewer appointments and at longer intervals.

Along with a reduction in direct client contact went an increase in paperwork. This record keeping, however, tended to become more defensive with time. Early on, one of my co-counselors at the psychiatric hospital showed me a file of memos she was keeping on her contacts with other professionals. "C.Y.A.", she said, and when I asked what she meant, she replied, "cover your ass." This practice, I was to learn, also covered the ordinary forms used in the course of rehabilitation counseling. The idea was to not commit to paper anything which might subsequently prove embarrassing. So, for instance, counselors were charged with keeping a running account of their contacts with clients. As counselors gained experience, however, these accounts became less and less revealing. What was written became a matter of formula, i.e., of mechanization. By giving the state VR agency only what it officially wanted, counselors sought to protect themselves

from further demands and further instances of failure. Counselors wanted to be "covered".

2) The Development of Emotional Toughness. The emotions presented by psychiatric clients were often quite intense, and to cope with these counselors required some toughness. They had to find ways of dealing with clients' anger, or fear, or sadness. Often this was accomplished by counselors becoming less open to caring. Clients were treated more impersonally, and what empathy a counselor would ordinarily show to a human being in pain was choked off, or at least strongly constricted. To judge from my experience, to feel deeply for all or even most clients was an emotional impossibility. Too many psychiatric clients were in too much pain for that to happen. To feel for all would have meant unbearable pain for the counselors, and much to the chagrin of many counselors this meant feeling less.

Emotional toughness also required a reduced vulnerability to failure, and for many counselors this was accomplished by lowering their goals. They became less idealistic. They built up expectations of failure, so when these occurred there was less surprise or pain.

While few counselors told me that this is what happened to them, I was acutely aware of these processes occurring in me and when I shared my feelings with others was usually greeted with knowing looks.

3) Changing Caseloads. A major form of counselor adjustment to the difficulties they encountered was changing caseloads. Almost all of the psychiatric VR counselors who I met in Northern City eventually ceased having psychiatric caseloads. These transfers (or changes in occupation) were in every instance accomplished at the request of the counselor himself. People reported that they could no longer "take it" working with psychiatric clients and that they had to "get out"... Before I had been at the state psychiatric hospital for a year both of the VR counselors with whom I was out-stationed had transferred out. One was so glad to go that she told me that I had no idea how important it was to her that she leave.

4) Accepting Personal Limits. Counselors may in response to the dilemmas they face come to believe that they are less able to accomplish what they once thought they could. This is not merely a matter of toughness or

of reduced services, but of accepting the fact that the demands made of counselors, including injunctions to avoid failure, are more than can reasonably be expected of them as finite human beings. Such an attitude entails an acceptance of failure as unavoidable and not blameworthy. My observations, however, indicate that counselors are only able to achieve this sort of adjustment to a limited extent. Most do not feel comfortable enough with their human limitations in order to avoid a sense of guilt. There is a knowledge that what is asked of them may not be possible, but a simultaneous feeling of aspirations unfulfilled, i.e., of ideals held in abeyance, not renounced. This lack of ability to achieve an easy acceptance of personal limits seems to be one of the reasons so many counselors ultimately feel compelled to change caseloads. Counselors seem to require more of an opportunity to fulfill their inner goals.

5) Accepting the Limits of the VR System.

Counselors have an easier time adjusting to the demands made of them by the state VR agency, the psychiatric hospitals, and other agencies they deal with. They do not like these demands and consider many of them unreasonable. Indeed counselors fight back against the limitations

imposed upon them from without. At in-services, for instance, counselors were rarely shy about telling their supervisors what they disliked about the latest agency regulations. But when these regulations stood, as usually they did, counselors accepted them with a weary resignation. The ultimate attitude, one which was in fact overtly expressed, was that one must give the system what it wants and try to get one's personal satisfactions on the side as best one can. Counseling was one of the things deemed necessary to do on the side and privately.

6) Obtaining Personal Satisfactions. Counselors did want a sense of personal accomplishment, and in order to achieve it budgeted their work time to do more of the kind of work they enjoyed doing. For some this meant counseling, for others more record keeping, for still others placement activities. Most, however, agreed that the state VR agency allowed them the autonomy to make these decisions. This autonomy itself was an important source of counselor satisfaction and enabled many counselors to keep going despite their other frustrations. At the in service for experienced counselors, autonomy was cited as one of the counselors most important perquisites. As one counselor put it, "At least they (the agency) don't

bother us, and if we want to, we can do counseling in our own way."

Given the difficulty VR counselors experienced in working with psychiatric clients one might have expected the state VR agency to take some interest in facilitating a viable work adjustment for these counselors. Either work conditions or ideology or some other factor might be manipulated to make counselors more comfortable with their job, and hence perhaps better able to perform their tasks, or at least better able to survive in their positions. The agency, however, did very little directly to support its psychiatric counselors in their assignments. It seemed to me as a counselor that the only direct response the agency made to help me tolerate the failure I daily confronted were occasional in-service sessions on "burn out".

These sessions were provided both by the Northern City VR office and by a university sponsored in-service training program. In both cases, two main sorts of solutions for their difficulties were offered to counselors. One answer given was that counselors should look more to non-work situations as a source of personal

satisfactions. Usually a whole array of potential satisfactions was provided. And at the top of the list there always seemed to be the option of jogging. Movies were presented which extolled the virtues of exercise and/or bio-feedback machines and/or transcendental meditation. In one way or another counselors were told that they ought to relax and not let their job bother them so much.

The other major answer offered was that counselors should stop and re-evaluate their own work goals. They were asked to look deep within their own personalities to find the source of their current dissatisfactions. Sometimes exercises and games were provided in order to further this introspection, yet somehow real introspection hardly ever seemed to emerge from these sessions. Counselors knew that if they decided that their VR agency jobs could not provide them with the satisfactions they wanted that they might have to consider some other form of work and for most this sort of realization made for too much insecurity. Thus I can remember no "burn-out" session at which a counselor openly explored the option of searching for another job. Most counselors had too many family responsibilities to casually entertain ideas of job

hopping.

Then too counselors knew that the major purpose of "burn-out" sessions was not to solve their problems, but to divert their anger and frustration from the VR agency itself. They invariably began these sessions by complaining about the "inane" policies of the state VR agency and just as invariably they were told by the session leader that there was no point in considering what could not be altered. It was then that they were usually urged to look inward to find personal deficiencies which they could control. Though this might have been good advice, it also carried with it the message that the system was not to be challenged, and having closed off this possible avenue to solutions, counselor frustrations were further exacerbated and their incentive to find personal solutions correspondingly reduced.

On one occasion a "burn-out" session concluded with a hand holding exercise. Counselors were asked to stand in a circle, hold hands and vocally affirm that they were all good people. While some counselors said that they enjoyed this exercise, I could discern no lasting effects which flowed from it. Certainly counselor isolation remained as

great after as before.

The Eclipse of Ideology

Despite the initial idealism of counselors and their predisposition to accept ideological definitions and solutions, after some years on the job ideology played a progressively smaller role in the day to day work of psychiatric VR counselors. Neither medical, nor educational, nor psycho-social ideologies provided counselors with workable understandings of rehabilitation or with viable counseling techniques. Ideological solutions have not been enumerated as among counselor adjustments to work demands and failures, because they were not, in fact, a major part of these adjustments. These ideologies did survive and were fairly ubiquitous, but were mere shadows of what they had been for beginning counselors. Their main function became that of justification for work practices when justification was demanded by outside sources as it often was during inter-agency conflicts. Even someone as ideologically sophisticated as the former state VR counselor who had obtained his Ph.D. in rehabilitation counseling claimed that he picked and chose among ideologies as circumstances

demanded. In doing this he said that he felt like a "connoisseur" of rehabilitation models, and that perhaps this was his real expertise as a VR counselor.

Of the various ideologies, only the moral ones survived with substantial vigor. Counselor idealism, though circumscribed, retained a real influence on how counselors understood their jobs and how they judged their success. The lingering failure that counselors experienced itself took on a moral aspect, and their inability to achieve "genuine" rehabilitation success became an ever present specter of reproach. Even the failure to achieve other than moral goals, i.e., medical, educational or psycho-social ones, became for counselors a moral failure. I can think of no counselor I met who did not after however many years still want to be a "good" person. The fact that so many counselors left the psychiatric VR counseling field I think speaks most eloquently of the pain they felt regarding their "moral" failure. It seems to me that the chief reason for their endemic job dissatisfaction was that perpetual rehabilitation failure made for a perpetual lack of confirmation of counselor "goodness". Their only option then became to "tune out" or "drop out". The pain of

moral failure was just too severe.

The situation counselors found themselves in has been well described by Michael Lipsky (1980) in his book "Street-Level Bureaucracy. He has observed that governmental social service workers are asked to provide what are essentially "moral goods", while the demand for such goods is infinitely expandable. The more that is provided, the more clients seem to want. In such a situation, failure is an inevitable consequence. Often, as Lipsky observes in the case of teachers and policemen, workers are forced to protect themselves through various forms of "withdrawal". This seems to be what happened to psychiatric VR counselors.

VR counselors have earlier been described as free lance ideologists and free lance moralists, and this seems to be a reflection of their ideological isolation. While morality remained very salient for them, they were on their own in applying it. No other ideologies provided a dependable source of guidance and/or support for counselors; nor did the state VR agency or the psychiatric hospitals provide a moral perspective which commanded counselor respect. External, especially non-moral

ideologies, fell into eclipse for experienced counselors because they were impotent in addressing counseling problems. Moralities, however, retained their saliency, not despite, but in some measure, because of the failure of other ideologies.

Chapter X

CONCLUSION:

THE DOMINANCE OF MORALITY

Summing Up

When we began this inquiry into the ideologies functioning in the field of vocational rehabilitation for the psychiatrically disabled, a major objective was to discover how ideologies helped to define the field. Psychiatric rehabilitation is a very recent invention. Its rise in the United States coincided with the growth of psychiatry following World War II, and it has only reached its current extent in the wake of federal social legislation in the 1960's and 1970's. This study, by exploring the ideologies current in the field, sought to discover 1) how rehabilitation problems were being understood, and 2) what sorts of rehabilitation solutions

were being favored in an attempt to solve these problems. Ideologies were considered a potential source of direction which might be helping to determine the nature of the new field. The a priori guidance of rehabilitation decisions and actions was emphasized, although the a posteriori justification of actions was also examined.

Five different kinds of ideologies were identified as especially significant in the field. These were moral ideologies, medical ideologies, psycho-social ideologies, educational ideologies and religious ideologies. We have tried to determine the extent to which each influences the activities of psychiatric vocational rehabilitation. Of these, it is clear that morality is by far the most dominant ideology. It will be recalled that in chapter 1 moral ideologies were defined in an operational manner. They were described as understanding the problems with which they deal as matters of "good" and "bad", and "right" and "wrong" (Theodorson and Theodorson, 1969). Typically they try to solve problems by employing "praise" and "blame", and "punishment" and "reward". By these criteria, moral ideologies are very pervasive in the psychiatric VR field.

Counselors, the pivotal actors in the psychiatric rehabilitation field (e.g., the coordinators of client programs), operate, as we have seen, as "free lance moralists". Their job gives them the opportunity to choose which ideologies will influence the way they perform their tasks and though they explore the use of many ideologies, e.g., the psycho-social, in the end it is personal moral ideologies which affect their work the most. Psychiatric VR counselors become disillusioned after years of unremitting demands which result only in failure, but they do not give up the self-imposed demand that it is their job to "do good". They may become cynical, but they continue to feel a sense of failure and guilt. Indeed their moral commitments are a major reason for their disillusionment, and their frustrations a major indicator of their continued moral involvement.

VR administrators, though primarily non-ideological in their aspirations, also retain strong moral commitments. In their case, however, the commitments are to public/political moralities rather than to private/personal ones. They strongly wish to avoid scandals and to present a public appearance of doing good. They are more concerned with matters which reflect upon

their organization's public reputation, such as the appearance of sexual and financial propriety, than they are with questions about the dignity of individual clients. Other more technical ideologies, though used by them to justify actions and policies, are not nearly so salient in determining their ideas about what psychiatric vocational rehabilitation is.

Doctors, on the other hand, ostensibly have their greatest commitment to medical models, yet in some ways this is very misleading. "Medicine", as practiced with psychiatric patients, is a very moralistic endeavor. Many of the "prescriptions" given psychiatric patients are more moral than medical. In fact, the evidence suggests that medicine is being used to try to make "objective" the moral decisions which in practice are decisive. Physiological explanations often are actually being used to give added moral weight to basically moral stances.

With psychiatric VR clients themselves, moral ideologies are likewise of paramount import. Though clients rely heavily upon idiosyncratic and religious ideologies, "normality", a moral concept, is their most pressing objective. They want to be normal and they want

to do good. In this they are very candid and very deeply and personally immersed.

The organizations in which psychiatric vocational rehabilitation occurs have largely been built around educational, medical and moral paradigms. Vocational rehabilitation was born of moralistic "humanitarian" legislation and initially it was expected that it would attain its end of returning the disabled to the dignity of competitive employment through the use of vocational training and/or medical stabilization. Organizations such as the state VR agency emphasized the training mechanism, while those such as the state psychiatric hospital concentrated on the medical. Inasmuch as the major organizations in the field are government entities (or, in some cases, remained dependent upon government funds for their continued existence), they are very vulnerable to political processes, and hence to public/political moralities. Ideologies such as the educational and the medical became very important as mechanisms of self-justification and self-protection. Nevertheless the necessity of a public appearance of doing good made morality the dominant organizational ideology. Without first having a structure which gave the public appearance

of being designed to help the psychiatrically disabled, it is unlikely that the VR organizations could have survived. A public perception of helping the disabled translated into political support, and political support was necessary in order to maintain governmental funding.

On all sides, therefore, morality emerges as the dominant ideology. It is the only one which really does help define psychiatric rehabilitation services and their preferred solutions. Psycho-social, medical and educational ideologies represent themselves as performing this service, but (especially for counselors) they fail in this endeavor. Psycho-social methods rarely bring about the changes they promise and certainly not within the time spans allotted by the psychiatric rehabilitation system. Neither do the medical or educational ideologies. The change technologies they offer, e.g., chemotherapy and training in work discipline, while used in the field, have nowhere near the hoped for effects. In consequence, moralism emerges with enhanced influence.

On all sides participants in the field want to do good. On all sides they invoke praise and blame and find themselves susceptible to guilt and shame. Moral

ideologies do not seem to be as easily undermined by failure as other ideologies are. If anything, failure seems to strengthen them. Idealism is the very stuff out of which morality is made, and so failure to reach ideals may only intensify the drive to attain them. There seems to be an absolute, an imperative, quality about morality which, for example, induces counselors to pursue it despite their failures (see the following sections on "moral blindness"). In the logic of moral standards, failure is a sign of not being good enough, and hence a reason for trying harder. To be sure, many participants in the psychiatric field "burn out", but this seems evidence of the fact that they feel so strong a need to attain moral ends that they become psychologically and physically exhausted in the attempt to reach them. This pervasive moral intensity is one of the reasons why conflicts in the field can become so bitter and protracted.

That moral ideologies should be dominant in the psychiatric VR field is not surprising given the fact that psychiatric problems themselves may be essentially moral in nature. Certainly they have been identified as such by many who have studied them. Probably the leading advocate

of this viewpoint has been Thomas Szasz (1961,1970,1977). He has called "mental illness" a "myth", and has described the problems which psychiatrists address as "problems in living". It is Szasz's firm contention that the violation of social rules, and not physiological deficits, lies behind our notions of mental illness, and he advocates that psychiatrists should openly acknowledge their moral biases. More recently, Sarbin and Mancuso (1980) have examined the research evidence which has been offered to support the thesis that schizophrenia is a medical condition and have concluded that despite its bulk it is not persuasive. They assert that the label "schizophrenia" operates more as a "moral verdict" than as a medical diagnosis. They conclude that the "pejorative" label "schizophrenia" is used "to designate a degraded social identity" and to delegate its victims to a "non-person status". This they argue is a moral enterprise.

Whether or not Szasz or Sarbin and Mancuso are correct in their analyses, and whether or not there are physiological determinants of psychiatric conditions, the evidence that moral judgments play a leading role in the way that psychiatric patients are treated is quite strong.

Labeling theorists such as Thomas Scheff (1966,1981) and social observers such as Erving Goffman (1961,1963) have eloquently portrayed the stigmatizing effects of psychiatric diagnoses and the degrading effects of psychiatric institutions. Doctors and others may have wished to limit the influence of morality within the psychiatric arena (Ausubel,1967), but in this they have not succeeded. If, then, morality is so ubiquitous within the field of psychiatry, it ought not be unexpected that it is dominant in the psychiatric VR field as well. Likewise it also seems true that the evidence of the dominance of moral ideologies within the psychiatric VR field supports the contention of those who argue that morality is dominant within the realm of "mental illness".

A hierarchy of ideologies seems to be operative, with moral ideologies functioning as the "baseline" ideologies. Moral goals seem to set minimum standards which other ideologies then attempt to improve upon either by being more "objective", or more technically proficient. When these other ideologies, such as the medical or the psycho-social, fail to achieve their goals, moral ideologies then seem to act as "default" ideologies. Their direct influence on what is done and how it is done

becomes more salient. But if moral ideologies themselves fail, if, for example, moral demands are too insistent to be fulfilled, then "burn-out" and "withdrawal" from the field seem to result.

Not only is morality dominant within psychiatric VR, but it has important, and not readily evident, consequences for how rehabilitation is conducted. Despite its ideological ascendancy, it is almost invisible to participants in the field. Counselors, doctors, administrators and clients all underestimate the effect it has on their understandings and their actions. They simply do not think of themselves as moralists, and they are often not consciously aware that their moral commitments often impel them to try to achieve goals which may not be attainable. This blindness to moral ideals and to their frequent unattainability seems related to an inherent limitlessness in the human demand for moral goods. People always seem to want things to be better than they are, hence moral achievements seem always to lead to a hunger for more moral achievement; and few people seem to be aware that this is an endless cycle. Certainly few people in the psychiatric rehabilitation field seem aware of this dilemma.

Furthermore, moral ideologies are inherently ambiguous. What is "good" may in theory seem very clear, but in practice it is usually vague. People are rarely certain in a given situation what is best, and frequently they disagree. Moral language seems to cover this fact and hence induces people with very different goals to work in conjunction with one another. Nevertheless their underlying differences often lead to conflicts which they don't understand because of their assumption of shared moral aims. Conflicts of just this sort emerge between counselors and administrators at the state VR agency. Because counselors lean toward personal moralities and administrators toward public ones there are often disputes between counselors and administrators about what the agency really ought to be doing, e.g., whether or not it should be counseling clients, or whether "rehab" are really important. Typically these conflicts are blamed on the "bureaucratic numbers game" or on "procedures", when real moral differences are at their root.

Morality as an Ideological Baseline

Sociology since its inception has been concerned with understanding the moral order which exists in society. Durkheim, in his works on religion, on the division of labor in society and on moral education (1915, 1933, 1961), was concerned with this question. So was Sumner (1960) when he studied social mores and their impact on social welfare. And so was Weber (Gerth and Mills, 1946) in his famous work on the Protestant Ethic. This sociological tradition has continued into the present day with numerous current studies on the socialization of moral values (Clausen, 1968, Kohn, 1969), on the use of morality to achieve organizational compliance (Etzioni, 1961), and on its role in defining deviance (Becker, 1964). This present study on the ideologies used in the psychiatric VR field may be viewed as being part of this tradition. Though it was not originally intended to be so, its central concern has become how moral ideologies operate in a particular sort of social service organization, namely agencies charged with rehabilitating the psychiatrically disabled.

The question at hand has become, How are ideologies, and in particular, moral ideologies, organized within the psychiatric VR field? Part of the answer seems to be that

they are organized hierarchically. Schmitt (1964) has suggested that when people have the power to achieve compliance with their desires that they tend to use this power in a direct fashion. If this fails, however, there is then a tendency to try to use moral persuasion to achieve the same ends. This suggests that morality can operate as a kind of fallback position; one might also say, as a "default" position. If other methods of achieving one's aims fail, then one takes recourse to moral arguments. This would especially seem to be an attractive strategy where moral ideologies provide the basic means of understanding and guiding an activity, as is the case in psychiatric VR.

In psychiatric VR, moral ideologies form a kind of "baseline" ideology. As we have seen (in chapter 3), the historical roots of the field lie in a moralistic, "humanitarian" social movement. Morality is even built into its definition, i.e., the dictionary (Webster's, 1970) defines it as "to restore to suitability", that is, to restore a moral standard. And some authors in the field (Parker and Hansen, 1981) have described it as being fundamentally a "philosophy" based upon propositions such as "All individuals possess human dignity and worth

regardless of their disabilities or limitations". -But most important, morality is clearly the dominant ideology in the field. Even when other ideologies are being used, it seems to be in the background furnishing the fundamental goals being sought.

In some ways, the other ideologies in the psychiatric VR field seem to be attempts to clarify, systematize and/or objectify moral goals and methods. Often their aim seems to be to make the implementation of moral goals more certain, and to avoid the ambiguity, the diversity and the subjectivity which seem to be part and parcel of moral ideologies. When the social reformers of the nineteenth century sought to put the care of the insane into the hands of medical doctors, much of their motivation came from a desire to put the insane into better moral circumstances (Ausubel, 1967; Alexander and Selsnick, 1966; Wilson, 1975). They aimed to stop the punishment and neglect of the insane by taking them out of prisons and almshouses and putting them in hospitals which would use the most modern forms of "treatment" to "cure" them. They hoped that by rationalizing the treatment of the deranged that their moral condition would simultaneously be improved. This motivation also extends into the

psychiatric hospitals of the present. The medical personnel of today hope that by using scientifically tested medications and procedures that their patients can be treated fairly and effectively; that is, that moral aims can most consistently be achieved by utilizing rational medical means.

Similarly those who invoke psycho-social and educational ideologies believe that in doing so they can improve upon the use of unvarnished moral ideologies. Those who would employ psycho-social ideologies believe that modern psychological and sociological knowledge can be used to accomplish more expeditious vocational change than morality alone can. Investigators such as Carkhuff (1969) have had precisely this hope when they have done research on how to make counseling more effective. -And while education possesses an ancient and well tested technology, rehabilitation theorists such as Anthony (1980) have worked to improve its efficacy by developing techniques of skill diagnosis and specific skill training. It would, for instance, be their aim to improve a client's moral condition by teaching him communication skills, e.g., they would hope that better communications would reduce client violence by allowing client's to formulate

more coherent demands with a better probability of success, and hence less likelihood of untoward conflict.

Nevertheless, these non-moral ideologies have usually failed when applied to the vocational rehabilitation of the psychiatrically disabled. As we have seen, they have certainly failed to supplant the moral ideologies. Medical personnel, for example, regularly incorporate moral prescriptions into their ostensibly medical prescriptions. And though psycho-socially oriented personnel may have dearly wanted client-centered counseling techniques to work with their psychiatric clients, they were frustrated in this hope. Nor did educationally oriented personnel fare any better. They often found that psychiatric clients did not seem to learn the skills they were being taught, or having learned them nevertheless had difficulty in maintaining competitive employment.

When these other ideologies, which are in effect refinements of moral ideologies, fail, morality still remains salient. Within psychiatric VR, it is a fallback position. Despite failure, VR counselors remain morally sensitive people, as their reactions to conflict

situations indicate. They also retain a good deal of the moral idealism which brought many of them into the field in the first place. Counselors become "free-lance" moralists and make individual, often morally based decisions on how to work with their clients. As has been observed earlier, they regularly invoke dignity issues, and treatment rights issues, and conventional social values. Nevertheless, it is not as if these moral interventions are pre-planned, but rather, because other ideologies do not provide adequate understandings or guidance, moral ideologies are employed by default.

This ideological hierarchy also seems to work in reverse. While the failure of the non-moral ideologies to provide workable understandings or effective rehabilitation strategies results in a default downward to the more basic moral ideologies, when engaged in inter- or intra-organizational conflict there is a tendency to appeal ideologically upward for justification. Thus when I was in conflict with the hospital out-patient unit I may have felt that my position was morally sound, and may have wanted to justify myself in moral terms, but I found that it was far more effective to appeal to educational ideologies. Similarly, when hospital personnel confronted

me, they found it was much better tactics to defend themselves using medical or psycho-social ideologies. These were ostensibly more objective and rational. By claiming proprietary rights over "psychotherapy" they found themselves in a stronger position than if they had claimed that their decisions or judgment were morally superior. It seems that when particular ideologies are associated with institutions or organizations, that for justification purposes these ideologies come to share the strength of their organizational associations. Given the strength of medical institutions within current American society, it was wise of hospital personnel to use medical justifications.

There also seems to exist a hierarchy among moral ideologies. Within the psychiatric VR field, the public/political moralities of the administrators seem to rank above the personal/private moralities of the counselors, and the latter seem to rank above the idiosyncratic moralities of the clients. As with the relationship between the moral and non-moral ideologies, there seems to be a default downward regarding the operation of these ideologies, and an appeal upward regarding justification. For example, when VR counselors

attempt to apply some of the public/political moralities to work with their clients, they find them inappropriate. Perhaps the best example of this is the politically potent value of "equity". Public agencies, including the state VR agency, are supposed to help all of their potential clients, and to help all equally. The counselors who are charged with providing these services, however, find it impossible to help all, or to help all equally. Nevertheless they must make choices about who they will work with and how. Despite the moral luster of the concept of equity, it is not a sufficient guide to counselor decisions. In consequence, counselors must resort to their personal moral commitments when working with clients. Some, as has been seen, have commitments to mentally retarded clients, some to the learning disabled, and it is these personal commitments which become salient to counselors.

VR clients find themselves in similar position. Often they confront counselors who tell them what is right or wrong. But frequently, for reasons they themselves don't understand, they find themselves incapable of following this advice. In consequence, they fall back upon their own idiosyncratic moral ideologies, and behave

in ways others find unfathomable.

In general, the public/political moralities are the least effective guides to action because they are the most vague and ambiguous. For this very reason, and also because of their institutional supports, they make an excellent court of appeal for justification purposes. Their very vagueness disguises differences in moral opinion and makes them seem universal in their application. Besides having the weight of the government and of society behind them, they seem unexceptionably true, and hence, during arguments, incontrovertible. Client moralities, in contrast, make the least effective source of justification because they are the least universal and the most private in their application.

The Invisibility of Moral Ideologies

While counselors and other psychiatric VR personnel are very aware of the limited success they achieve with psychiatric clients, they seem very unaware that this may be related to the sort of moral goals they are aiming at. Indeed there is little conscious awareness of the dominant

ideological stamp of morality within the field. During an in-service training course for experienced counselors which I attended, the instructor asked for aid in compiling a list of "models" which govern the rehabilitation field. The final list which he compiled included Personnel, Medical, Educational, Psychological, Social Work, Welfare, Business, and Social Control models. It did not include Moral models. When counselors or administrators discussed the work they were doing, they did not talk about its moral aspects per se. VR personnel made moral judgments all the time, but they did not talk about the moral nature of these judgments. There seemed almost a willful, albeit unconscious, obliviousness to the moral aspects of what they were doing, as if by acknowledging the moral aspects of judgments they would automatically become illegitimate. Judgments which were officially medical or psycho-social acquired an aura of objectivity, but judgments identified as moral seemed subjective, personal and arbitrary, and hence vulnerable to contradiction.

It is not that VR counselors did not know that demands were being made of them by clients, administrators and social workers, or that they were entirely ignorant of

their own ideals. On the level of action these were too ubiquitous in the psychiatric rehabilitation field to be avoided. Nor were they unaware of their failures, or their guilt, or the impossibility of some of the goals being sought. As will be recalled, counselors were all too aware of the absurdity of some of the demands made of them to work with the learning disabled. And they saw very clearly that attempts were being made to manipulate their guilt feelings when LD mothers told horror stories about the rehabilitation of their children and then pleaded with counselors to "care". Nevertheless, few counselors explicitly recognized that they were part of a predominantly moral enterprise. There was a lack of consciousness that their own ideals were ideals and that the demands made of them were "moral".

Because of this lack of conscious awareness of the morality entailed in their daily work, counselors (administrators, and others in the field) were not aware of the effects of moral ideologies on their job performances. Many did not realize that they routinely made moral judgments (e.g., regarding what client "should" do), and that these judgments might be subject to opposing moral views. For example, many counselors did not

consider the possibility that competitive employment might not be a categorical imperative. Nor were all counselors cognizant of their own "idealism", that is, of the fact that some of the goals they were striving for (e.g., "rehabilitating" certain clients) might be virtually impossible.

Sometimes counselor goals were difficult to achieve because a kind of perfectionism was being sought, and sometimes because the human, organizational or technological resources necessary to attain these goals were not available. In either event, lack of awareness of the moralism involved made it difficult to appreciate where limits existed. There was therefore a tendency to persist in trying to attain impossible goals. This lack of consciousness of moral models also contributed to "burnout" phenomena. Because they did not see the limits of what they were trying to achieve, even though they regularly banged up against them, many counselors continued trying to actualize their goals until they were past the point of personal exhaustion.

The need many counselors had to be "good" seems to have impelled them not to look at things they already

knew. Apparently this was because acknowledging limitations would be tantamount to admitting that "the good" could not be achieved, and this was not an admission one could make and still "be" good. For many, morality seems to demand that if something is good, it must be actualized, without consideration of whether or not it is possible. There is an absolute quality to morality; witness Plato's (1941) world of unchanging moral "ideas", or Kant's (1949) "categorical imperative", or G.E. Moore's (1929) "quality" of goodness, all of which indicate that value is inherent and hence beyond examination or contradiction. An ineluctable need to be good also seems to be part of the explanation of why counselors and doctors were sometimes blind to some of their failures, e.g., to the failure of medications to make many clients ready for employment. (The lack of client job readiness was very apparent, but a faith in medications persisted nevertheless.)

Any kind of failure is difficult to accept, if it implies a moral failure as well. An impartial observer might not have blamed counselors for their failure to achieve many rehabilitations with psychiatric clients, for given the tools with which they had to work it is doubtful

that many rehabilitations were possible. Nevertheless, counselors do feel a kind of guilt. As was observed in chapter 9, some wanted to be "saints", and others felt discomfort at not being able to help clients even though they knew they did not know how. Because psychiatric VR is basically a moral enterprise, failure to rehabilitate is experienced as a moral failure, even though this might not appear to make sense. As Morris Rosenberg (1979) has observed, "In most respects human beings appear scarcely capable of seeing something without at once passing judgment (on it)", and this seems to include themselves, especially when they are engaged in a moral endeavor. One of the reasons the apparent "objectivity" of medical models has been embraced in the psychiatric field is that it seems to allow for a kind of moral neutrality, and hence permits an apparent reduction in personal moral responsibility.

It is very difficult to escape the reflexive kind of blindness which intense moral commitment brings to moral ideologies and their effects. Certainly during my tenure as a psychiatric VR counselor, I was not immune to this sort of blindness. My moral judgments and their consequences were often quite invisible to me. One of the

reasons I worked so intensely with L was because I felt an obligation to succeed in "rehabilitating" her. This obligation seemed to me to be a job requirement; not a moral commitment. Failure meant incompetence. Because of this feeling, it was difficult for me to accept that L might never be able to attain employment. (And for the four years I worked with her, she never did.) My sense of obligation also motivated me to keep searching for ways to make psychiatric vocational rehabilitation work despite constant frustrations and failures. I did not see this need as something generated from within me, but as an objective necessity. Indeed, it was only my concomitant research on the ideologies operative in the rehabilitation field, and the frustrations I felt when engaged in seemingly interminable moral conflicts, which eventually induced me to perceive the personal nature of my own moral commitments.

Another example of this kind of blindness is provided by Michael Lipsky. In his book "Street Level Bureaucracy: Dilemmas of the Individual in Public Services" (1980), he makes some very astute observations about the moral constraints on public service organizations and their participants, yet in the end he succumbs to the very moral

imperatives he warns of in the first part of his work. Central to Lipsky's thesis is the idea that when clients make demands of human service agencies, "the goods demanded are moral and hence infinitely expandable" (p.35). An analogy he uses is to the Long Island Expressway in New York. This superhighway was in such demand when it was first built that it was usually jammed with traffic. In order to reduce congestion, the capacity of the roadway was virtually doubled, but this only succeeded in increasing the number of drivers who wanted to use it, so that in the end the level of congestion remained unchanged. Lipsky observes that the same sort of thing happens in human service agencies. The more moral goods they provide, the more people want, and so there is never enough to go around. In consequence people are perpetually dissatisfied with the level of services they receive, and they express this dissatisfaction in their subsequent demands. Because the resources available to meet these demands are always finite, the government workers responsible for distributing them are forced to rely on various rationing strategies. Often it is they who must decide who is to get what.

Yet government workers are not morally neutral. If

they must make rationing decisions, they must inevitably fall back on their own value judgments. Lipsky questions the "legitimacy" of their doing so, for they were never "elected" to make such decisions. Government service workers themselves seem frustrated by having to impose limitations, especially since they, too, recognize that they have no explicit mandate for doing so. But this is only one of the frustrations they experience, for rationing (or alternatives such as providing "quantity" versus "quality" services) will be perceived by them as personal failure. They know they will not be meeting the moral demands made of them. In consequence, Lipsky describes them as "retaining a frustrated idealism".

Among the ways they attempt to handle this frustration is by emotional withdrawal from their work, e.g., by becoming uninvolved "functionaries", or in other words what we typically think of as "bureaucrats". Another way of handling this frustration, one also mentioned by Lipsky, is by selecting a small number of clients to receive special attention. This, it will be recalled, was one of the things VR counselors did when they elected to do intense counseling with only a few clients.

Though Lipsky does not discuss the reflexive invisibility of moral demands, he admirably describes this phenomenon in action. The government workers he discusses are caught in a moral whirlwind trying to meet demands beyond anyone's capacity to meet. Nevertheless, they subscribe to the legitimacy of these demands, and hence in their idealism become frustrated and withdrawn. They apparently do not consciously appreciate that the demand for moral goods is infinite, though they are all too well aware that the specific demands made of them cannot be met with the resources available to them.

Paradoxically, though Lipsky has clearly adumbrated the moral dilemmas facing government human service workers, including those confronting psychiatric VR counselors, he also retains a moral idealism of his own which demands that there be solutions to their predicament. Because of this need of his, in his final chapter he, too, is blind to the limits of possible solutions. Lipsky favors equity and legitimacy. These are strongly held values of his. Throughout his book he cites them as valid goals. He also wants government bureaucracies to provide "quality" services to their

clients; for example, to accord citizens due "respect". Despite the fact that he understands that these are moral goods, and hence should also understand that the demand for them will be unlimited, he would like to see these moral objectives more fully achieved. While earlier in his work he repeatedly recognizes that such goals can never be completely met, in the end he seems to believe that they can be. Within the body of his work he recognizes a need for rationing, but in his conclusion he argues for reforms which he hopes will obviate this need. Similarly, while in his earlier chapters he is sensitive to the frustrations human service workers experience when trying to improve things, in his conclusion he advocates that they become more active proponents of change, almost oblivious to the fact he has himself several times alluded to, namely that their likely failure in this might further exacerbate their frustrations.

Among the reforms Lipsky advocates are greater client autonomy and policy influence; increased financial support for human services; rewards given to workers for quality performance; professional peer review and support; and organizational decentralization. All of these strike me as admirable aims, but one wonders if they address the

underlying limitations encountered in government human service agencies. For instance, Lipsky says that "ways must be discovered" to make clients a reference group for workers. But if the resources available to meet client demands are always destined to be inadequate, then won't workers always feel a sense of failure from which they will have to protect themselves? Lipsky has shown that withdrawal is one such protective mechanism; that is that workers specifically avoid using clients as a reference group in order to reduce the frustrations they feel. If this need workers have for self-protection persists, (and what reason is there for thinking it will not?), then it is not enough merely to say that "ways must be discovered" to overcome the defensive maneuvers workers use. These ways must be specified and there must be reason to believe that they will help workers to handle their frustrations. Otherwise all one has is morality legislating its own success.

Lipsky's main concluding thesis seems to be that workers who control their work and who regard clients as "people" will enjoy their work and will perform it better. But in putting forth this thesis he seems to disregard workers' needs to defend themselves against over-work and

an inherent lack of requisite resources. Lipsky very admirably wants movement toward more social and economic justice. But this is a moral position, and in its reflexive blindness it seems to induce him to overlook the structural frustrations built into human service workers' jobs. One wonders why Lipsky did not instead call for a recognition of the limits of the services these workers can provide. One wonders why he did not recommend an explicit rationing of services, rather than such utopian measures as college training which is designed to encourage "idealistic leaders". Though Lipsky explicitly points out that in the past such training has foundered on the realities of job frustration, because of his own moral commitments finally he cannot help but recommend it again. He too retains a frustrated idealism.

Psychiatric vocational rehabilitation counseling is an inherently moral business. Its goal is to make people "suitable" for normal living; to restore them to a "living" condition. The resources available for doing this, however, are always limited. There are only so many counselors, and so much expertise, and so much money, and so much time. Invariably not all clients are going to achieve the ends sought. (In fact few now do.) There

will, therefore, always be conflicts and frustrations and pain. Because human services, and in particular, psychiatric VR counseling, seems to attract workers with strong moral needs (e.g., people who are morally sensitive --though not necessarily more moral-- and fairly idealistic)(see chapter 9), it is likely that they will be especially pained by the inevitable failures. Thus it may be that the reflexive moral blindness they experience acts as an anesthetic which permits them to retain their ideals; ideals which on a personal level may be very important to their psychological stability and to their sense of personal identity, and to their ability to keep working in the field as long as they do.

On the other hand, one may speculate that greater candor about the moral ideologies which operate in the psychiatric VR field might lead to more realistic goals for clients and counselors, and hence to less frustration and pain for all. Explicit rationing of services might make for less over-promising and so for less disappointment and frustration in the face of failure. With less false hope, there might be less recourse to devices such as appeasement, and less inter-personal and inter-organizational conflict. A clear eyed view of the

limits of psychiatric VR might restrain idealism and hence soften the sense of personal and organizational failure.

Still, if the operation of moral models were more visible, there might be other losses worth contemplating. Perhaps counselors and clients would be less frustrated, but society might be more so. Perhaps it is the function of governments to use agencies such as the state VR agency to build social hopes. The existence of socially designated specialists in idealism may provide a social release and a kind of social glue. Certainly there seems to be a demand for the hope that these agencies and their personnel provide. People do want to be told and to believe that the disabled can be helped. This good may be provided in part at the expense of counselor and client frustrations, but there seems to be no a priori reason for thinking that this isn't worth it; or that some people shouldn't want to provide it despite the personal cost.

It may even be that the reflexive invisibility of morality is an unavoidable consequence of the nature of morality. One of the "side effects" of moral ideologies which has already been discussed (chapter 4) is counselor rigidity. It has been suggested that this rigidity may be

the result of the emotionalism, and in particular of the anger, which seems to be part of the mechanism by which morality works. Strong emotion, especially anger, makes it hard to think (Sullivan, 1953), and this difficulty in thinking may be the origin of moral "blindness". The anger apparently inherent in taking and holding a moral position may make it difficult to entertain or even conceive of positions other than the ones to which we are already committed.

Moral Ideology and Bureaucratic Conflict

It has been alleged that one of the difficulties in state VR agencies is the conflict between professional and bureaucratic values (Emener, 1978). In response it has been recommended that a dialogue be initiated in order to try to reconcile these differences. This seems to be based upon the assumption that a better understanding of organizational goals by counselors and of counseling aims by administrators might lead to a common set of values. Such common goals might then reduce the conflicts which abound in the VR field, and in the process reduce the negative side effects of these conflicts. The present

study provides reason to doubt such an outcome.

If one examines the value conflicts which occur in the state VR agency, many of them seem to be between personal/private and public/political moralities. The personal/private moralities tend to emphasize personal worth, normality, autonomy and individual growth, while public/political moralities tend to stress equity, universality, and the social utilitarian benefits of activities such as psychiatric vocational rehabilitation. The goals of bureaucratic organizations tend toward the ideal of impersonality (Gerth and Mills, 1946), while VR counselors are charged with providing services to clients on a face to face, personal basis. Within the psychiatric VR field both sets of goals are usually very idealized. Also, as Lipsky (1980) notes, "In the ideology of the Welfare state, humanitarian impulses (are supposed to be) coincident with the requirements of system maintenance." In fact, public and personal values are often not at all coincident; nor are they necessarily coincident with goals of organizational survival and growth. For instance, the attempt to help a single individual to overcome his demons and to make a contented, long-term adjustment to gainful employment may be at odds with attempts to increase the

appearance of helping people by maximizing the number of "rehab" produced by the state VR agency; nor is there any guarantee that maximizing "rehab" will continue to redound to the agency's organizational health into the indefinite future.

The disparity between public/political and personal/private moral systems is often a very real one, though it is frequently obscured by the ambiguity of moral language. Terms such as "equity" and "dignity" are used in both personal and public moralities, but often with a very different import. The word "rehabilitation" is itself a prime example of the ambiguity inherent in moral language. For state VR administrators, "rehabilitation" is virtually synonymous with "rehab"; while for counselors, and even more so for clients, the meaning of "rehabilitation" varies enormously with the needs of the individual being rehabilitated. The field of vocational rehabilitation probably exists because of the ability of the word "rehabilitation" to mean different things to different people at different times. Its imprecision and elasticity have allowed it to represent many different ends and still to enlist people with different aspirations in what has seemed to them a common social cause.

On the other hand, alliances facilitated by verbal ambiguity are simultaneously vulnerable to nagging and seemingly irreconcilable conflicts. Before entering the state VR agency, prospective counselors might assume that they and the agency had the same goals; namely vocational rehabilitation. After functioning as a psychiatric VR counselor for a while, however, they were likely to feel betrayed by the agency. They surely found that they were not being supported in the kind of rehabilitation counseling that they thought they would be doing. But because what they were doing was still called rehabilitation, it was difficult to see that there was a difference between the personal and public moralities which both made demands of them. If anything, the conflict between these demands was increased by the fact of their differences being obscured. These conflicts caused a strain between participants in the psychiatric VR field, and fostered the feeling that one's colleagues were willfully violating moral imperatives.

At this juncture it would be nice to say that clarifying the differences between public and personal moralities might reduce the potential for conflict, and

that this in turn would reduce the strains in the psychiatric VR field, and hence improve services. Unfortunately, as has already been stated, the differences between these moral systems are more substantial. Clarifying them might only result in making their conflict more intractable. By retaining their ambiguity people are at least allowed the option of pretending that they are striving for the same goals, and this permits them to avoid overt disputes if they so choose. Morality, as practiced in our mass industrial society, contains a "fudge factor" which enables competing interests to exist side by side in relative security, and sometimes even to collaborate toward mutual aims. After all, in the state VR agency, counselors do help administrators achieve "rehab" goals, and administrators do look the other way and allow counselors to do some personal counseling.

Moral language may be understood as a species of human camouflage. It permits deceptions and cover-ups, yet it allows people to persuade others to do things which they might not otherwise do, and which may be to their mutual benefit. To be sure, it also provides a forum for much rancorous conflict, but then perhaps it may only be through such conflict that workable social action programs

can evolve. While moral ambiguities may exacerbate some interpersonal conflicts, they may also serve to temper others.

Very closely related to the ambiguity of moral ideologies is their tendency to "over-promise". Public moralities promise to turn the disabled into productive taxpaying citizens. They promise equity and dignity, and to answer virtually all public problems. For example, they promise to help the learning disabled and the psychiatrically disabled even though the technologies for helping either of these groups are primitive at best. To these ends, modern governments often legislate success, that is, they specify that certain target populations will be rehabilitated and brought up to predetermined levels, and not merely that particular services will be made available to them.

Personal moralities are not much better, for they promise people that they can grow and develop, and that they will be treated with dignity and sensitivity, while the limits of moral resources dictate that most people who seek these goods will fail to receive them, and what is more, that they will be treated impersonally and indeed

sometimes callously. Government in the United States has come to closely approximate a secular church, and no more than other churches has it been able to eradicate sin or to insure the saintliness of its minions. Nevertheless, the over-promising and ambiguities of rehabilitation moralities, by obscuring the limits of rehabilitation, reinforce moral blindness and contribute to personal and social hope in the face of lingering failures and irreconcilable conflicts.

Conflicts which are alleged to exist between professionalism and bureaucracy within psychiatric vocational rehabilitation (Emener, 1978) seem as much a function of the nature of moral ideologies they represent (i.e., the personal and the public moralities) as of structural differences between professionalism and bureaucracy. Professionals in the vocational rehabilitation field tend to act as a repository of personal moralities, and the bureaucratic organizations for which they work as a repository of public values. They thus embody the conflict between public and personal moralities. Nevertheless, this moral conflict seems no more intense than the conflicts between and within other moralities. For instance, there exist different and

competing interests within public moralities, and within personal moralities. In the public/political domain learning disability advocates, whether they realize it or not, are in a competition for scarce resources with advocates for helping the psychiatrically disabled. And similarly within the domain of personal moralities there exist clashes between counselors who have different moral allegiances and different aspirations for their clients, though sometimes these clashes are obscured because counselors usually work independently of one another. The value differences between professionals and bureaucracies reflect genuinely different value interests, and not merely differences between organizational and moral interests, and hence are not something which might be removed by the expediency of reorganizing bureaucracies along professional lines, or even by dissolving bureaucracies in favor of independent client-professional relationships. Public/political values as embodied in governmental bureaucracies reflect real moral demands, as real as those of personal/private values. They will not go away by dismantling either professional organizations or government agencies; nor will well meaning attempts to merge public and personal moralities into a harmonious whole eliminate underlying differences. The conflicts

which occur in government social service agencies may not always be structural ones between professionalism and bureaucracy per se, i.e., between the non-ideological demands of organizational maintenance and growth and the moral ones of client rehabilitation, etc., but between real differences in public and personal moralities. And until the millenium arrives, these seem destined to be with us for awhile.

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