Contact email: sylviapackra@gmail.com

New Zealand counsellors talk about ritual abuse:

A discourse analysis

A thesis presented in partial fulfilment of the requirements for the degree

of

Master of Arts

in

Psychology

at

Massey University, Palmerston North, New Zealand

Sylvia Jean Pack

2009

Abstract

Research indicates that in the last five decades, claims of Satanic ritual abuse (RA), and the numbers of clients receiving counselling for RA, have increased in all Western countries. This has resulted in an increased corpus of related literature overseas, which includes studies in which facticity as well as aetiology, symptomology and treatment are debated. This present study focuses on a New Zealand context, and examines the talk of New Zealand counsellors in relation to their views regarding RA and the counselling of RA clients.

Social constructionist and positivist epistemologies were evaluated in terms of their suitability for this research, and the discourse analytic method developed by Potter and Wetherell (1987) chosen as the means by which participants' talk might be analysed in such a way as to allow the inclusion of multiple constructions and the emergence of the many discourses and conflicting ideas which occur in overseas literature. A broad selection of the literature was first critically analysed to give an understanding of the topic.

Nine counsellors gave interviews, eight women and one man, all Pakeha, six of whom were ACC-registered (Accident Compensation Commission, 2009). The participants constructed RA as a physical reality, which was justified by the use of the *credible client* discourse. A traditional linguistic repertoire furnished a discourse of *government backing*, which was employed to warrant voice. A moral stake in counselling, named *concern for the client*, was shown to be present in all arguments. The participants constructed three truths relative to context: a *legal truth*, the *counsellor's truth*, and the *client's truth*. Recovered memories were given a dual construction which legitimised correct and incorrect recall. DSM-IV (American Psychiatric Association, 2000) *labelling* was debated in a discourse of *ambivalence*. Finally in a discourse of *preparedness*, the participants constructed the therapeutic skills needed to treat RA clients. The thesis concludes by highlighting the participants' comments regarding the need for openness and awareness, and specialised literature and training for counsellors treating RA clients.

Acknowledgements

I wish to acknowledge and thank the nine professional counsellors who volunteered their time and expertise to give a fresh New Zealand insight into a topic which is often ignored. It was an honour to study their informative, thoughtful and intelligent contributions, born out of their lived experiences as counsellors and therapists. Without them, this study could not have taken place.

My thanks to my supervisor Dr Keith Tuffin, who cheerfully answered all my questions, gave constructive feedback and criticism, and challenged and encouraged me to enlarge my knowledge of discourse analysis.

My thanks to Massey for the scholarship which has helped me achieve this goal, to the library for the helpful communication and inexhaustible flow of articles and books, to the library Endnote advisers, and the staff at the Wellington School of Psychology for their efforts in providing post-grad students with information and fellowship.

I would like to acknowledge and thank my wonderful husband and our three equally wonderful adult children, who have been unfailingly supportive and vocal regarding their belief in my ability to write this. I also wish to thank the many friends who continually expressed curiosity, encouragement and affirmation.

Table of Contents

Chapter One

Introduction

Ritual abuse (RA) is a controversial topic, and a prolific source of internet sites, books and articles, both overseas and in a much lesser way, in New Zealand. Allegations of RA have been made by children and adults, and explained away as the result of suggestibility, media presentations, rumour and iatrogenesis; but such allegations have also been at least partially believed, by therapists and counsellors who treat RA clients. This introduces a variety of questions, all worthy of study. Is there physical proof of such activities? Is there consensus among professionals regarding either the imaginatory status of the "condition", or the facticity of the phenomena? By professionals, I refer to psychologists, therapists and counsellors who may work with RA clients. Given that discourse analysis focuses on language, and that the action orientation of language resonates with therapy, I decided to make the focus of my research the spoken response of such professionals to the subject of RA and RA clients.

When I began reading for this study, I had no idea that I would end up knowing far more about RA than I had ever wanted to know, or that it would cover a very wide spectrum of related traumatic experience. I did not anticipate having to briefly investigate the history of Satanism, which is not included in this study. Perhaps most surprising to me, being used to orderly textbooks and accounts, was the lack of resolution and specificity that would erupt each time I opened the pages on this topic. Scientific "proof" in the form of conclusive experiments with proven hypotheses, quantitative surveys and measured symptomatic responses, complete with new actuarial instruments to supplement existing psychometrics, would abound on both sides of the debate, with each claiming to disprove the other's argument. Both sides also cited consensus and corroboration, first person accounts as witnesses, and creditable category entitlement. This however is grist to the mill for the discourse analyst, who may embrace confusion, diversity, contradiction and paradox.

New Zealand yielded a much more orderly response; the only New Zealand writings on the subject seemed to be from two openly sceptical writers. However when I looked online, I found that there had been allegations of RA made in this country also. The debate appeared to be extant in New Zealand, but on a much smaller scale. I began to see an even more focused possibility for

study. I asked among counselling friends, and some contacts started to emerge, people who might be willing to participate in such research. As the time grew nearer for the interviews, I mentally reassembled some of the concepts I had read about, in all their fire, seriousness, mockery, and challenge. I formulated questions, and began to look forward to interviewing New Zealand counsellors; what would *their* accounts discuss, what discourses would be revealed? How would they justify their accounts, in a war zone where nothing was proven or satisfactorily agreed on? How would they make sense of the situation?

Although the project's title was *New Zealand counsellors talk about ritual abuse, a discourse analysis,* it soon became apparent in the interviews that their constructions around RA would not be limited or decontextualised. Arguments led off into broader issues which impinged on and affected the treatment of RA clients. What was truth? Could it be decided scientifically, or was it relative to context? Far from being a disconnected philosophical digression, this was shown to relate clearly to the larger topic at hand. The recovered memory debate, so often raised in RA literature, was also well known to the participants, who had worked with the phenomena with sexual abuse (SA) clients aswell as RA clients, and it therefore provoked strong discussion. The importance (or not) of using the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR* (American Psychiatric Association, 2000) (DSM-IV) was also strongly argued.

The interesting and challenging findings are contained in the eight chapters of this study, the first of which (Chapter One) aims to introduce the topic to the reader, and includes a brief look at definitions of RA in the overseas literature. Chapter Two provides a critical review of New Zealand and overseas literature, and examines a wide range of views, from the openly sceptical to the committed apologist. At the end of the review, the reader has been familiarised with the RA debate, but the question remains, why this study, and why in New Zealand? The rationale and aims of the study are then set forth. Chapter Three talks about the epistemology which informs the study, with particular attention to the extent of findings made possible by positivist and empirical epistemologies. Discourse analysis is chosen as the most suitable method, and a brief look at some of the principles of Potter and Wetherell, is presented. Reflexivity is explored, along with epistemological uncertainties. Chapter Four, Methodology, outlines the sequential study procedures, from inception through transcription and coding, to analysis. It pays particular attention to ethical issues involving confidentiality, and the representation of talk.

The following five chapters contain the results of the discourse analysis, which is organised into three broad areas. Chapter Five presents features which will recur throughout the analysis, and has two sections. In the first, the participants lay down a foundation for further discussion by constructing RA. An ongoing moral stake in counselling is encountered and examined, and a discourse is named which participants will repeatedly employ to warrant voice. Chapters Six, Seven and Eight, explore three notions frequently debated and subject to continued intersubjective reconstruction: truth, recovered memories, and labelling, the counsellors' term for the practice of diagnostic procedures. Chapter Nine moves to practical considerations, as participants share their beliefs, knowledge and experience to construct some notions towards a "how to" for counselling RA clients.

Chapter Ten provides a summary of the results of the analyses, and suggests how these might lead to further developments. A reflexive critical perspective is taken regarding the study itself, in order to validate as well as to provide a critique regarding what might have been done differently or could be improved on. The consequences of the epistemology with which the study is informed, and discourse analysis itself, are also scrutinised with a view to justification and limitations.

In order to orient the reader to what is for most an unfamiliar topic, there follows a short section which provides some clarification regarding RA, according to definitions in the literature.

There is as yet no single clear definition of the term, ritual abuse. Ritual abuse is a generic term used to indicate severe repetitive traumatisation of many kinds, one of which is Satanic ritual abuse (Sakheim & Devine, 1992). Satanic ritual abuse is that most often referred to in the debate around "ritual abuse" which resounds in the literature; little disagreement is generated regarding other forms of repetitive ritual abuse. Because there is no standardised acronym for the phenomena of Satanic ritual abuse, researchers use varying acronyms, most commonly RA, but also SRA, and SCS (Satanic cult survivors). Throughout this study, RA is the acronym used to represent Satanic ritual abuse.

It can be seen immediately on consulting the literature, that RA is defined as a criminal activity. It is alleged to include sadistic abuse (Faller, 1990; Sinason, 1994), multiple sexual abuse acts, child abuse and child pornography (Schmuttermaier & Veno, 1999), animal mutilation

(Schumacher & Carlson, 1999) sacrifice (Fraser, 1990) ceremonial cannibalism (Young, 1992) torture and mind control (Rockwell, 1994; Noblitt, 1995). A religious component which is not in itself illegal, differentiates Satanic ritual abuse from other forms of group abuse; RA is described as a planned part of Satanic worship for the purpose of indoctrination into Satanic beliefs and practices. Mind control techniques, and mind altering drugs, are alleged to be used to establish control, and instill in victims an overruling terror of the cult and evil forces believed to be commanded by the cult (Los Angeles County Commission for Women, 1989).

It is important to remember that members of any religious group may commit crimes including that of child abuse, and the practice of Satanism as a religion may or may not necessarily include illegal acts. Some have suggested that two branches of Satanism exist; establishment (respectable) and underground (involving extensive illegal activities) (Taub & Nelson, 1993).

Whether or not RA is a reality, is hotly debated in the literature and by participants. However, given that reality as a notion is also debated in discourse analysis, it was difficult at times to convey in this study, the reactions of counsellors without debating the nature reality itself. Although it is touched on in Chapter Six, the scope of such a topic is beyond the bounds of this study, and therefore the word "reality" is sometimes used in its most common form, to reflect a belief in a physical event. In Chapter Five, the counsellors discuss grounds for believing RA takes place in New Zealand, and in so doing construct *a New Zealand reality.*

It should also be noted that the literature on ritual abuse referred to in this study, with the exception of two writers, originated overseas, in Northern America, England, Europe, and Australia. The focus in this study is on New Zealand counsellors' talk around RA similar to that defined in the overseas literature. This literature is further explored in the next chapter, the literature review.

Chapter Two

Literature Review

The body of literature that addresses ritual abuse is prolific and recent, most of it spanning less than four decades to the present day. In excess of six million internet documents (Briggs & O'Neill, 2006) are in existence, and many thousands of journal articles, newspaper and magazine articles and books. The literature is varied, vigorous and colourful, and to the discourse analyst, redolent with the fumes of acrimonious debate. Ambiguity, contradiction, argument and lack of conclusive scientific evidence abound in a burgeoning text corpus. Basic demographic and ethnological data is inconclusive and subject to disagreement, and complicated by the knowledge that many groups who have adopted the name "Satanic" hold many different beliefs and practices (Katchen & Sakheim, 1992). The lack of quantifiable data pertaining to universal truth is anathema to those prescribing to the disciplinary matrix of the positivist, but provides a rich in depth tapestry for the social constructionist. Few topics in the world of psychology have allowed the great exogenic-endonymic debate to flower with such forcefulness. Are RA clients essentially mentally disordered, with RA an external symptom of an interior condition, or is RA an existing external physical truth, or (confusingly) either a physical reality created externally by words, or a phantasmagorical fiction veritably or intentionally constructed?

The first writers in the short history of these texts might well have been the autobiographers, who believed their accounts to be factual. These were authors who described RA personally endured, who began publishing in the early 1970s, and were joined by others in the years that followed (Adams, 2003; Buchanan, 1994; Daymore, 2001; Lorena & Levy, 1998; Moore, 2005; Richardson, 1997). Two noteworthy members in this group produced best selling books early in the explosion of related writings. An American, Mike Warnke, wrote his memoirs, in which he told the story of himself as an ex-Satanic high priest who converted to Christianity, and thence become a well known minister and public speaker (Warnke, 1972). In *Michelle Remembers* (Smith & Pazder, 1980) a Canadian woman gave shocking descriptions of suffering RA throughout her childhood, memories which included bizarre accounts of sexual abuse and infant sacrifice. The memories were first related to her psychiatrist, who co-authored the book. These two books were widely read and influential, but to argue that they alone produced the reaction which followed, with vast number of articles and books being published by the four groups

mentioned in the following years, would be to erroneously adopt the *post hoc, propter hoc* fallacy, by assuming these books' timely occurrence before the landslide of academic research meant that they were the cause of it (Greaves, 1992). Sceptics of RA have nonetheless attempted to discredit these two books, believing that the arguments which followed were at least in part the result of their success.

Much of the academic literature that followed, concerned itself with argument regarding the validity or lack of validity, of the accounts of RA clients. With little exception, researchers aligned themselves with a traditional epistemology in order to warrant voice, when defending, discrediting, or clinically analysing the accounts of RA clients. Many therapists sidestepped the need to prove RA's reality, by supporting a client's truth. Greaves (1992) divides non-autobiographical RA writers into four groups: nihilists, or sceptics, who argue that claims of having survived RA cannot be true; apologists, who argue (with varying degrees of conviction) that the accounts are probably, or definitely true; heuristics, who are uncommitted but find that treating the client's truth as real has positive results; and methodologists, a group who work with RA reports and case studies as clinical data.

The sceptics

Greaves (1992) argues that sceptics are nihilists, because they describe theories rather than the results of phenomenological experiments with RA clients, and that in making assumptions about the reports of RA clients, they are creating hypotheses which are *a priori* in nature; they presume their version to be true independent of the subject matter. Because sceptics hypothesise using a scientific or visual, phenomenological ontology, in which finite truths exist, these must be discovered by the use of the scientific method, reason and logic. They therefore attempt to claim evidence for the non-existence of RA, by utilising logic, or the *lack of* physical findings. Greaves (1992) goes so far as to describe the sceptics as Nihilists, thus positioning them as researchers embracing the freedom of no moral code. He suggests that they pose in the guise of scientific researchers, but because they cannot conclusively prove their hypotheses scientifically, they instead challenge the apologists to scientifically disprove their hypothesis of scepticism. Until this happens, the lack of physical evidence, and logic, are regarded by the Nihilists as evidence which disprove the existence of RA.

The hypotheses of the sceptics create an interesting smorgasbord, prepared in an apparently traditional manner by chefs attempting to warrant voice in the Western world mainly by using the discourses and linguistic resources of a scientific epistemology. The Foucauldian rightness of a traditional medical model, referred to within an apparently scientific ontology, is implicitly present to underscore the apparent logical moral correctness of suggestions made.

Denial of the unseen is the initial reaction of sceptics, who claim to be epistemologically informed by the scientific method in which only the observable and measurable may assume facticity. The RA account is constructed as a yet another witch-hunt for something which does not exist (Lotto, 1994; Nathan & Snedeker, 1995) or reassuringly and paternalistically constructed as unfounded fears (Bottoms & Davis, 1997; Frankfurter, 2006) or as private fantasies (Lotto, 1994). They reason empirically with de-contextualised data, arguing that there is no sensible reason for the RA crimes to suddenly increase numerically in the 1970s and 80s (Aldridge, 1995; Goldstein, 1997). The 1970s context in which this is embedded, which Social Constructionists might explore, a climate in which previously hidden sexual abuse (SA) began to be increasingly disclosed, is regarded as irrelevant.

Sceptics hypothesised that if RA existed it would be impossible to hide (Lanning, 1992) that no physical evidence of RA existed (Frankfurter, 2006) and that this was why there were no convictions of those accused (Lanning, 1985). A moral discourse is employed; it is a waste of public money to investigate legal claims of RA (Carlson, 1989). In line with a scientific epistemology, the continuing emphasis on the lack of scientific evidence for RA (Putnam, 1991; Showalter, 1998) and these texts are interspersed with calls for conclusive scientific research, which alone will establish the truth which they attest cannot be established by subjective accounts (Bottoms & Davis, 1997).

The freedom of the Social Constructionist to embrace subjectivity and multiple interleaved truths is thus invalidated as an epistemological standpoint from which it can be reasoned that RA may exist. The sceptics go further, erroneously explaining that because RA is a social construction, there is nothing physical or phenomenological involved in RA; it is merely words. This misuse of the term ignores the concept that all physical entities are constructed in words. De Young (1994) exemplifies this form of misunderstanding by describing RA as *a social construction* which *grows* in three stages; firstly false claims of RA, secondly public fear which is subsequently

given legitimisation by therapists, police, and Christians, and thirdly, an acknowledgement of RA as reality. De Young implies that social constructionism allows words the power to construct something which does not exist. Self help books are blamed for constructing RA as a reality (Freyd & Goldstein, 1998). RA is also declared a social construction of sexual abuse (La Fontaine, 1994). Mayer (1991) defines accounts of RA as constructs containing a mixture of partial reality, fantasy, and phantasmic versions of reality. Although these imagined versions of reality can be verbalised, they are not a physical reality. RA is *no more than* a social construction, a reflection of our culture rather than any actual danger. Social constructionism is therefore itself erroneously constructed as being unworthy of credence to those informed by science and positivism.

The mainstream scientific discourse is associated with biopower, and often unquestioned; Foucauldian discourse analysts tell us that the supposedly scientific observer is able to warrant voice even if the resulting assumption differs from lived experience (Gergen, 1998). Sceptics epistemologically informed by scientific positivism are credited with being the *knowers*, and therefore have a resultant duty to explain why claims of nonexistent RA should have occurred at all. To do this, a *sociological* discourse is employed, in which it is found that panics about Satanic cults, or *Satanic panics* (Victor, 1993) have taken place regularly throughout history, imagined myths which come about as the result of social and psychological patterns (De Young, 1994; Prendergast, 1995), myths which are in each historical period, believed and mistakenly encouraged by doctors, media (Showalter, 1998), and Christians (La Fontaine, 1994). RA is therefore constructed as a non-physical event, a recurring myth continuing today in urban legend, but with a cultural and sociological aetiology (Prendergast, 1995).

A *medical* discourse is employed, to construct RA as a symptom of mental disorder, using the authoritative and rich nomenclature of DSM-IV and its categories. Decontextualised neurophysical evidence and empirical findings are also employed. Temporal lobe disorder is suggested as a neurophysical cause for subjectively real fantasies in RA clients, and Bipolar I Disorder the cause of RA accounts (Yeager & Lewis, 1997). RA accounts are said to be imagined to support the client's narcissistic balance (Mayer, 1991). or to be symptoms of Factitious Disorder of the Munchausen type (Coons & Grier, 1990). Others decided RA memories were screen memories manufactured from exogenous sources as a defence mechanism then adopted as real (Gannaway, 1989). Multiple Personality Disorder (MPD) (Lotto, 1994) and Dissociative

Identity Disorder (DID) or Dissociative Disorder Not Otherwise Specified (DDNOS) (Coons, 1994) were said to be cause of RA "memories". RA clients had self victimisation syndrome (Schnabel, 1994) The DSM-IV diagnoses allow the clients' accounts of RA to be constructed as symptoms, or imagined fears, the product of a disturbed mind. RA, it was hypothesised, was an invention stemming from illness (Victor, 1993).

The RA accounts of people who showed no signs of DSM-IV conditions, or those who healed from them after therapy for RA, were explained by discrediting therapists, in a discourse of *correction*. Teaching and correction of mental health professionals (MHP) in the field of psychology remain the deontic right of those professing to adhere to mainstream traditional methods. RA therapists must be corrected, because they have been unwittingly damaging, misled, and have induced false memories in clients by using poor protocol, highly suggestive interview techniques, irresponsible and questionable regression therapies resulting in iatrogenic influences, bringing about RA "memories" and the inadvertent creation of full blown imitations of genuine psychological conditions (Chu, 2002; Mayr, 2005). Sceptics also charged RA therapists with diagnosing MPD and DID where there was none, and claimed that empirical reports showed a too sudden rise in the condition (Aldridge, 1995; Gelb, 1993).

The moral discourse also facilitated an attack on paid employment for RA therapists, which was constructed as an unnecessary money making industry (Goldstein, 1997). Sceptics purported that RA therapists had used their influence to cause an updated version of MPD, which was DID, to appear in the Diagnostic and Statistical Manual, fourth edition (DSM-IV) (American Psychiatric Association, 2000) (Loftus & Ketcham, 1994) and persuaded their RA clients that they were DID (Ofshe & Watters, 1994) so that insurance companies would pay for their treatment (Loftus & Ketcham, 1994). Sceptic moralists also deplored what they term bad publicity caused by RA therapists, who have spawned a backlash undermining the credibility of *genuine* victims of sexual abuse (Bottoms & Davis, 1997). The moral discourse is also employed against Feminists, who are advised to deflect their attention from RA clients to genuine SA victims who are suffering because of the diversion of attention (Freyd & Goldstein, 1998; Nathan & Snedeker, 1995).

Many prolific sceptics such as Jeffrey S. Victor, Richard Ofshe and Elizabeth Loftus were also members of The False Memory Syndrome Foundation (FMSF), which was founded in 1992. At its establishment, the Foundation coined the term "False Memory Syndrome". This term was a

reconstruction of the term “recovered memories”, a new linguistic device which discredited abuse memories, including those of RA clients. It aided in the construction of recovered memories as distorted and destructive confabulations which grew independently, resistant to correction and threatening families (False Memory Syndrome Foundation, 2008). The so-called repressed memory, usually a memory of sexual abuse or RA, was denounced as a fraud (Loftus & Ketcham, 1994). The professed aims of the Foundation were to study the reasons for the increase in what they had termed False Memory Syndrome, to try to prevent this increase, and to aid those accused by relatives, of sexual abuse. It aligned itself linguistically with mainstream epistemic authority by the naming of its “Scientific and Professional Advisory Board” (FMSF, 2008).

A number of research articles were published, probably the most famous being the “Lost in the Mall” experiments by Foundation member Loftus and co-researchers. In these studies, the process of combining actual memories with false content and producing false memories, is described. The participant was given an account of childhood events by a trusted older relative, which included a false event of being “lost in the mall” and later returned unharmed to the family. The participant, in what FMS proponents term a classic example of source confusion, dissociated content and source, taking the memory as his own and believing it to have happened. The conclusion was that false memories, such as those of RA clients, were no more than iatrogenesis, implanted, installed by trusted therapists (Loftus & Ketcham, 1994).

To sum up, the sceptics first denied RA because it was unseen, but unable to prove their hypothesis of scepticism, instead challenged apologists to scientifically disprove the theory. Accounts of RA were constructed as *only* a social construction. By positioning themselves in a Foucauldian medical discourse, scientific assumption was privileged over accounts of lived experience; RA accounts were constructed as the result of a mental disorder, or the result of the unscrupulous implanting of false RA memories in order to generate clientele. The strong public reaction of researchers, therapists and counsellors faced with such accusations, a group termed the apologists, is looked at in the next section.

The apologists

Apologists reacted to such claims firstly by vigorously refuting the supposed scientific neutrality of FMSF researchers. Deploying the discourses of traditional psychology, and invoking the tenets

of the scientific method, they attested that far from being scientifically detached and uninterested in the results, researchers funded by the FMSF were involved and invested, in both a moral and a financial stake, which relied on discrediting the claims of RA clients. The False Memory Syndrome Foundation, RA supporters alleged, was founded by Dr Pamela Freyd, who had no clinical training, and whose daughter had accused her father of molesting her as a child (Bloom, 1994). In inflammatory style reminiscent of the sceptics' attacks on the integrity of RA therapists, apologists attested that Freyd had been joined by abusers and paedophiles, whose aim was to fund the legal costs of their court cases, and promote studies which would give themselves academic credence and credibility with the media (Rockwell, 1994). Some FMSF board members were purported to have admitted that some of their members probably were guilty as accused (Freyd, 1993). The mystery of why the FMSF chose to construct the memories of RA clients as false, and the memories of the accused as valid, was solved in the minds of the apologists, by the exposure of stake (Bloom, 1994). Apologists who had positioned themselves within a scientific ontology, therefore declared studies conducted by members of the FMSF invalid as they lacked the objective neutrality necessary for scientific validity.

The discourse of scientific theory was supported by one of *common sense*. The Lost in the Mall experiment was examined by apologists and declared invalid; it was asserted that for False Memory Syndrome to occur as described by Loftus, several unlikely possibilities must coincide. The client must trust the therapist as much as an older trusted relative, and be suggestible. The therapist must be easily able to plant wholly inaccurate criminal accounts in the client's mind (Herman, 1993) despite attachment theory's teaching of people automatically defending those close to them against attacks, such as wholly unexpected accusations of paedophilia (Bloom, 1994). It was also said that experiments in which interview questions were posed years after a mundane event to check children's memories of it (Goodman & Schaaf, 1997), in no way reproduced the context of trauma (Bloom, 1994) so could not be generalised externally to trauma cases. The very ability of the FMSF to proceed scientifically was questioned (Rockwell, 1994).

Apologists refuted allegations of unethical practice by RA therapists by again employing a discourse of common sense. It was pointed out that the notion of therapists suddenly deciding in the 1970s to implant similar RA accounts in tens of thousands of clients throughout the US, England, Canada and Europe, stretched the bounds of credibility (Barstow, 1993). The idea of suggestive techniques being used to achieve this (McFarland & Lockerbie, 1994) or the

employment of leading questions (Sakheim & Devine, 1992) or hypnosis to produce false memories (Rockwell, 1994) was discredited in the same argument.

Returning to a scientific ontology informed purely by positivist epistemology, apologists did not attempt to credit RA clients' retrospective subjective reports, which were unacceptable as scientific evidence of an objective reality. They instead concentrated on observable and measurable phenomenological evidence. Apologists cited evidence taken from ritual sites found in the US, England and Europe, of human remains, children's clothes, animal skeletons, knives, blood stained daggers, candles containing faecal matter, robes, jars of blood, masks and other ritual paraphernalia (Kelly, 1998; Ross, 1986; Weir & Wheatcroft, 1995). Pornography of children in RA scenes documented by police in various Western countries was also cited (Tamarkin, 1994; Weir & Wheatcroft, 1995). Therapists working with RA clients documented threats of violence to themselves and their families from strangers (Youngson, 1990), and dead cats or burning crosses planted on their lawns (De Mause, 1994) as further phenomenological proof of RA's facticity.

Sceptics had argued that RA remained unconvicted (De Young, 1997), so manuals for law enforcement were cited which detailed typical RA crimes, including symbols, objects, calendar dates, and advice on what constituted legal evidence for RA (Adams, 2000; Kinscherff & Barnum, 1992; Pepinsky, 2002; Perlmutter, 2004) and descriptions of RA infrastructures and organisations (Summit, 1994; Tate, 1994). Arrests and convictions involving RA crimes were documented and cited as hard evidence (Blood, 1994; Marron, 1988; Oberhardt & Keim, 2004; Rockwell, 1994). Multigenerational RA crimes resulting in conviction (Scott, 2001) were cited to validate claims that RA was intergenerational (Driscoll & Wright, 1991; Young, Sachs, Braun, & Watkins, 1991) and invalidate sceptics' claims that no evidence of generational Satanism existed.

Apologists also looked to the medical model to support their assertions. Firstly, it was attested that the increased number of diagnoses of MPD, DID and PTSD diagnosed by RA therapists were conducted in accordance with criteria standardised by the DSM-IV (Leavitt, 1994). They saw these diagnoses as to be expected (Fraser, 1990; Neswald, Gould, & Graham-Costain, 1991; Stafford, 1993; West, 1993) given that in their estimation, the extreme nature of RA produced dissociation and MPD, rather than the disorder producing the RA accounts (Gould, 1992). In

short, they accused sceptics of the *post hoc, propter hoc* fallacy, which in this case meant assuming that mental illness had produced imagined accounts of RA.

Employing a moral discourse, apologists accused sceptics of abusing their medical authority, by employing reductionist diagnoses to construct RA clients as mentally disordered alone. The medication of RA clients for Borderline Personality Disorder (BPD), Schizophrenia, or their diagnoses as Major Depressives with psychotic features, were constructed as particularly abhorrent (Martinez-Taboas, 1996). They advised clinicians to use RA symptom lists (Coleman, 1994) and exercise moral caution before dismissing RA memories as fantasy (Lloyd, 1992; Van Benschoten, 1990). The apologists continued the moral discourse by denouncing sceptics for callously ignoring a child abuse problem of considerable scope (Gould, 1995) which apologists alleged had caused ongoing physical, psychological and spiritual damage in RA clients (Langone, 1993; Schumacher & Carlson, 1999) via torture, the enforced use of drugs, and other abuses (Hudson, 1991; Scott, 2001; Snow & Sorenson, 1990; Young et al., 1991).

The associated scientific authority of a dispassionate sociological discourse employed by sceptics was also employed by apologists, with differing results. Rather than adopting the paradigm of enquiry of mainstream psychology, in which only inferential statistics of the visible received scientific credibility and RA accounts were therefore merely fears, the apologists looked at history through a social constructionist lens. In this epistemology essentialism was discounted, and people seen as historically, socially, politically and culturally situated, and informed by conflations of the same. Apologists regarded both perpetrators of RA and their victims as living under the episteme of the epoch, living with social inequalities and injustice, moving with the pivots of power and resistance. Unstable socio-economic times which disempowered the marginalised or underprivileged were seen as macrosocial determinants of behaviour, resulting in a corresponding need for personal mystical power (Ivey, 1993) and leading to a rise in Satanism in times when the church appeared powerless (Katchen, 1992; Lowney, 1995).

In summation, it can therefore be seen that the apologists vigorously opposed the claims of the FMSF, arguing that they were not neutral but biased, strongly motivated by stake, and unscientific in their methods and assumptions. The apologists also cited evidential remains of rituals, explained the rise in Satanism as a product of socio-economic conditions, and asked why thousands of responsible therapists across Western countries would start citing RA if it did not

take place. Arguing against medical reductionism, they explained that the conditions MPD, DID and PTSD were the logical result of RA trauma. To make this strong case for the facticity of RA, the apologists positioned themselves in a scientific ontology. Other therapists however softened this stance with acceptance of the possibility of doubt, without being sceptical. To examine such a construction it is necessary to consider the next group in this review, a group called the heuristics.

The heuristics

"Heuristics" here refers to a group of therapists who maintain a pragmatically open mind regarding the physical truth of RA (Greaves, 1992). The nihilists and apologists both lean heavily on purportedly objective observation as a criterion of validity for their claims, and aim to prove the existence or non-existence of RA, but for the heuristics, whether or not the memories are true or false is seen as a legal issue distinct from therapy issues (Worsnop, 1996). They prefer to utilise speculative formulation, in the form of their training, experience, and acceptance of the client's account, as a guide, while they learn alongside the client. Their theory is that RA clients engage in productive therapy more readily if they are supported, upheld, and believed. They aim to instill client confidence by affirming the "client's truth" while also privately seeking to further self educate and maybe establish validity during the process of disclosure, therapy and healing. An outstanding example of this was seen in the groundbreaking book about MPD, *Sybil* (Schreiber, 1973). The therapist chose to believe Sybil's unusual accounts early in the sixteen years of treatment, only in later years independently seeking and finding corroborating records.

Even if conclusive physical evidence is not found, the heuristics, unlike apologists and sceptics, remain unworried. They adopt the interleaved truths of social constructionism, acknowledging that the scientifically informed therapist may not have access to all truth. This concept is put into practice by attention to subject positions and agency; the client is allowed speaking rights and empowerment to construct their own account. Therapists in this group defend their middle ground between the nihilists and the apologists firstly by citing positive results. Secondly, they offer the possibility that therapists' knowledge claims customarily change over time in synchronicity with socio-cultural movements and RA is a cultural phenomenon; however unproven, therapists have an obligation to answer RA claims with therapeutic solutions.

Heuristics' lack of adherence to an exclusively scientific ontology is strongly evidenced among overseas therapists. In one survey, 75% stated that clients should be treated for what they believed they had suffered, and literal truth was not the primary concern (Bottoms & Davis, 1997); therapeutic interventions could be successfully employed regardless of what percentage of the memories were real (Ross, 1995). Others informed the client that whether their memories were true, distorted or false, they would work with the client's truth as presented (Fraser, 1997). DSM-IV diagnoses were also not necessarily seen as helpful; treating the client successfully was not dependent on classifying the abuse (Ondrovik, 1992a) which might erroneously produce accompanying prejudices (Ondrovik, 1992b).

Therapists in this group have also researched and written on related aspects of spirituality, an area not normally regarded as germane to the scientific method (Friesen, 1992; Young & Young, 1997). This includes exploring possible links between theological notions of evil, and psychopathology (Cozolino, 1990).

In short, these authors appear to be informed by social constructionism rather than a perceptual scientific ontology. However the acknowledgement of many individual truths, provides an open mindedness to research of different ontologies. The powerful, oppositional qualitative and quantitative dichotomy is ignored; the heuristics group also maintain an active interest in the findings of other therapists and clinicians, and research results. Their case studies, standpoint research (Reinharz, 1992) other idiographic research methods and therapy results and findings become the subject of enquiry for the methodologists.

The methodologists

Methodologists form the largest clinical group, of researchers, clinicians and therapists, working from a traditional scientific research perspective. They utilise psychometrics, and also rate universal themes and symptoms empirically, as found in RA clients. Their work includes studies on large numbers of RA reports and case studies which are treated as clinical data. Related issues such as those of validity, such as criticism of the lack of inter-rater liability between those reporting on RA (Noblitt, 2007) are also researched. Multiple case studies have been examined (Nurcombe & Unutzer, 1991; Weir & Wheatcroft, 1995; Young et al., 1991) to analyse clinical features and syndromes. Examples from the increasing corpus of texts are given below.

Eighty percent of RA child clients met PTSD criteria (Waterman, Kelly, Oliveri, & McCord, 1993). On the Child Behaviour Check List (CBCL) RA child clients scored significantly higher than those alleging SA (Valliere, Bybee, & Mowbray, 1988). The Word Association Test (WAT) was used to discover the effect of environmental influences on RA clients; paradoxically, less media exposure as associated with higher rates of Satanic word associations. The WAT also showed an experience base peculiar to RA clients (Leavitt & Labott, 1998). The Gudjonsson Suggestibility Scale was used to measure suggestibility in recovered Memory clients, and found them less suggestible than had been hypothesised (Leavitt, 1997). Medical evidence was documented as recorded in ritual abuse cases (Weir & Wheatcroft, 1995; Young et al., 1991).

Empirically rated reports indicated agreement between the RA accounts abuse in different locations (Los Angeles County Commission for Women, 1989). Specifically coded mind control techniques likewise matched across different cities (Neswald et al., 1991; West, 1993).

Methodologists compiled checklists for differences between SA and RA clients (Edwards, 1991). Lists of common symptoms, common experiences and standard combinations of experiences in RA clients' reports were researched and published, for adults (Coleman, 1994) and children (King & Yorker, 1996; Nurcombe & Unutzer, 1991) along with findings related to therapeutic processes in adult clients (Fraser, 1997; Sinason, 1994), and children (Gould & Graham-Costain, 1994a, 1994b; Kelley, 1988; Valente, 1992). Mind-control clients' therapies were documented (Langone, 1993) and the treatment of RA clients suffering from Multiple Personality Disorder later known as Dissociative Identity Disorder (Brown, 1996; Gould & Neswald, 1992; Young & Young, 1997).

Methodologists also conducted extensive surveys to examine whether or not mental health professionals believed RA was a physical reality. In 1991, a survey of 2709 APA clinicians revealed that 30% had seen at least one RA client since Jan 1980, and 93% of these believed their clients, on the basis of clinical symptoms of emotional trauma, without physical evidence (Bottoms, Shaver, & Goodman, 1991). In 1995, in Britain, 15% of British psychologists interviewed were found to have worked with RA clients. Of these, 80% believed their clients' experiences, despite lack of physical evidence (Andrews et al., 1995). Belief also depended on the pathology for which the patient had been diagnosed (Maddox, 1991). In California, 433

therapists showed no difference across disciplines or licences in frequency of report of RA clients, or in the presence of clusters associated with diagnoses of RA (Bucky, 1992). In Australia and Northern America it was found that those who also worked with SA clients were more likely to believe RA cases than other therapists (Noblitt, 2007; Schmuttermaier & Veno, 1999). In Australia, in 153 RA cases identified by counsellors between 1985 and 1995, no counsellors believed their clients had intentionally fabricated their stories, and 85% felt the RA accounts were an indication of genuine trauma (Schmuttermaier & Vino, 1999).

Methodologists can therefore be seen to have made substantial literary contribution to clinical findings and empirically based research on RA in the Western world. This study now takes a more localised critical focus by moving to a New Zealand context.

RA in New Zealand

The corpus of texts on RA in the Western world, therefore, can be viewed as made up of strong contributions from those who do (apologists) and those who do not (sceptics) believe in RA's existence, therapists who respect RA as the client's truth (heuristics), and those who publish clinical research from case studies and surveys (methodologists). The literature is largely from the US, Britain, Europe, and Australia. Only two noteworthy writers have become well known in New Zealand: Hill and Goodyear-Smith, both of whom write from the sceptics' perspective, echoing writers from the FMSF by utilising the sceptics' linguistic repertoire, complete with discursive resources used to formulate RA as a physical non-reality.

Hill constructs accounts of RA as unreal firstly by using the term *Satanism scare* (Hill, 1998). This implies Satanism is only a no more than a temporary scare. He terms it *imported* to New Zealand, after Australia hosted the Sixth International Conference on Child Abuse and Neglect in Sydney in 1986, which implies it did not exist here even as a concept, before 1986. He repeats these two themes, calling it the Satanic cult *scenario,* by implication something hypothesised and imagined, and *introduced* to New Zealand, by implication not previously in existence. He then re-deploys another interpretive repertoire of sceptics: social constructionism is misconstructed as merely words, which are endowed with the power to create only a physically nonexistent RA. Witches, he notes, do not exist until described in words, implying again that they, like RA, are a mental, not a physical reality. He concludes that RA was *disseminated* by New Zealand's

government agencies, implying that the verbal myth was mistakenly promulgated throughout the country to those who previously had not heard of it.

Various overseas speakers visited New Zealand to lecture on the field, for example Whitman, a strong apologist. In his article, Hill positions Whitman by citing him as a “Christian sexual abuse therapist” and omitting mention of his years as a clinical psychologist, a PhD in Psychology, a Masters degree in counselling psychology, and a total of 21 years working in the mental health field in a clinical and social capacity. These words, identified with scientific nomenclature, would have given Whitman the power to warrant voice to the reader as a credible witness, and would therefore have weakened Hill’s argument.

In 1998, Hill published his article Satan’s Excellent Adventure in the Antipodes (Hill, 1998) in *New Zealand Sceptics*, and also in the *IPT Journal*. A supporting link between sceptics and the FMSF was hinted at in IPT Journal, shown by the number of articles published which discredited recovered memories. The staff of IPT, a husband and wife team, were also active members of the FMSF, famous for their book which diminished and discredited disclosures of child abuse, and also advised that the results of paedophilia might produce no harm (Wakefield & Underwager, 1994). Public controversy erupted in 1992 after Underwager and Wakefield were interviewed for Paidika, a pro-paedophile peer reviewed Journal published in the Netherlands. In it, Underwager explained that paedophilia might not be harmful to children, God intended absolute freedom, and paedophilia was a responsible choice for individuals (Geraci, 1993).

Goodyear-Smith contacted FMSF after learning about it from Dennis Dutton, head of the NZ Sceptics. Her writings support the tenets of the FMSF, that recovered memories are confabulations. In 1994 she established COSA (Casualties Of Sexual Allegations). Her articles, like those of other sceptics mentioned previously, warrant voice by invoking the linguistic repertoires of a scientific ontology; Goodyear Smith (Goodyear-Smith, 1998) states that accusations of RA have a *low base rate probability*, but we are not told how this assumptive leap occurs. It is to be presumed that in her base rate she is acknowledging only legally conclusive empirical data regarding physical and sexual abuse, medical reports in police records, rather than unproven disclosures of RA to therapists and social workers. This line of reasoning has been said to parallel the fifties, when sexual abuse crimes were considered few, because only Police and hospital records were credited.

To the discourse analyst, such use of medical and scientific terminology in an argument, is the employment of a recognisable and reliable linguistic device for invoking traditional authority. It was termed "the empiricist repertoire" in a famous discourse analytic study by Gilbert and Mulkay (1984) in which scientists utilised an empiricist repertoire for formal occasions, but on informal occasions, used a contingent repertoire in which personal and social influences which affected scientific findings were acknowledged. This latter repertoire was also used when discounting the findings of other scientific professionals who had arrived at differing conclusions in the same research. In the overseas literature, sceptics use non-scientific words such as *panic* (De Young, 2004) *legen*d (Victor, 1993) *myth* (Loftus & Ketcham, 1994) and *pseudo* (Coons, 1994) to discredit apologists' views, but describe their theories using the scientific nomenclature of an empiricist repertoire. Hill (1998) likewise, uses the terms *pseudoscientific* and *fervent belief* to describe the claims of apologists, but utilises a scientific repertoire to support his scepticism, with words such as *findings* and a *growing body of research*.

Hill also uses humorous sarcasm to mock the notion of RA as a reality, in a linguistic repertoire revolving around a metaphor of *tourism*. The tourism metaphor associates Satan in the reader's mind with enjoyable holidays in which abuse cannot occur. Hill entitles his article "Satan's *excellent adventure* in the antipodes". The metaphor is linguistically supported with words such as *stopover*. This functions to persuade the reader not to take the claims of RA clients seriously. Hill constructs Satan's *arrival* in North America as coinciding with the claims of RA clients, which associated absurdity discredits RA claimants' claims. By use of humorous sarcasm and the tourist metaphor, RA is linguistically constructed as a myth and Satan as harmless. This functions to deny the reality of RA as an illegal or dangerous activity. Because of the action orientation of language, there are powerful consequences.

Whether or not RA is believed, overseas and in New Zealand, is the deciding factor in undertaking research, and establishing modes of treatment. The overseas literature documents MHPs who do take RA claims seriously, and therefore provide treatment and research. At the time of writing, however, despite the ongoing treatment of RA clients in this country, there are no similar studies available for New Zealand, and neither are there any published articles on symptom clusters, suggested therapies, or even counsellor reaction to such claims. In 1991 a Ritual Action Network was formed in Wellington, partly funded by the Department of Social

Welfare through the Family Violence Prevention Coordinating Committee (Hill, 1998). Its members included a police officer, a psychologist, a nurse, a lawyer, social workers and counsellors, all of whom advocated awareness of a legal and therapeutic response to RA in New Zealand. The group provided workshops rather than instigating research or publishing papers, and have since disbanded.

In summation, it can be said that from a review of the literature it would appear that the four groups mentioned have provided ample studies, which have allowed a high degree of interest in RA clients and a matching therapeutic response in the Western world overseas. There are however no studies that go beyond scepticism to investigate RA systematically in New Zealand. This gap in the literature is now looked at in the next section, Rationale and Aims.

Rationale and Aims

Rationale

> "If absolutely everything these patients tell us is false, we have stumbled onto a clinical phenomenon most worthy of study and we are honoured to study it; if anything these patients tell us is true, we have stumbled onto a phenomenon most horrible and are obliged to study it" (Young, 1990, p.10).

Out of sheer intellectual and academic curiosity if nothing else, researchers and clinicians might be interested to discover why the accounts of RA are so similar across different clients, states, and even countries. But more than this, there is also a clear moral obligation to investigate, for the benefit of the client. To benefit the client, or at least to do no harm, is an ethical cornerstone for clinicians working in the field of psychology.

Society as a whole can also be adversely affected if therapy is not offered, as RA clients manifest many documented abuse survivor symptoms: alcohol and drug addictions, panic attacks, mood disorders, suicidal thoughts, suicide, self harm, eating disorders, sleep disorders, hyper-vigilance, and high risk behaviours (Advocates for Survivors of Child Abuse, 2006). New Zealand psychologists are obliged under the Code of Ethics (New Zealand Psychological Society, 2002) to promote the welfare of society (Sec 4.1), and to speak out when they have expert knowledge

(Sec 4.1.3); however, it is impossible to offer expert knowledge on RA in New Zealand when it has not yet been researched in a New Zealand context.

This provides the rational for the research question, what do New Zealand counsellors say about RA? The answer cannot be found in the burgeoning body of overseas research into RA. The New Zealand Ritual Action Network mentioned previously is no longer in existence, and did not produce research. There is in fact a research void in this country; in the interviews, counsellors decried the lack of informative New Zealand literature on the subject. This study is a unique attempt to research the topic by investigating New Zealand counsellors' talk about RA, and providing local cultural takes on the matter in an inclusive discursive analysis.

Aims

It was proposed to invite talk from counsellors about RA, not only regarding therapeutic methods, and the interaction between RA and DSM-IV symptomology, but also integral issues such as the recovered memories debate, and "truth" as a construction. How important was hard evidence to the counsellor? Was there a universal reality, an empirically testable truth to be looked for, or did they suspend judgment? And how was this dilemma, so well recorded in the overseas literature, managed at a practical level here in New Zealand? The aim of this research was to find out and examine what New Zealand counsellors had to say about RA, using an open ended approach, and providing as broad a canvas as possible. The discursive analytic method chosen to enable this, is discussed in the next chapter, *Epistemology*.

Chapter Three

Epistemology

- Epistemological uncertainties

I have to ask myself, as I allow myself the luxury of some reflexive daydreaming, why not use traditional methods to uncover what counsellors feel about RA? Why not ask RA clients to answer questionnaires? Perhaps a carefully thought out set of pages in which unitary options were clearly delineated would actually make it easier for them both to answer. *Lots* of pages of questions would be tempting, they would yield lots of results. They could be quantitatively analysed, and the results would cause positive changes in society, due to the power of inferential statistics in the marketplace as opposed to qualitative findings (Gavey, 1989). A *solution* would be produced. Or not. My first reaction to this, from my experience of support work with women recovering from childhood sexual abuse, is that tick boxes could leave much unasked and unanswered; that the women themselves would know more than the researcher who would design the questionnaire, being the experts on their own lives. They would need a chance to frame this, to *construct* their differing ontology, in their own words. They have wept frequently, they need to express anger, pain, regret, and also joy; and what they construct will *change* as they grow. They could find a few pages of yes/no questions and Rensis Likert lines inappropriate and insulting. How can their life changing experiences be encapsulated in numbers? In reality, ethical considerations rule out interviews with clients, but the same epistemological uncertainties apply to researching counsellors who have had the privilege of briefly entering their clients' vast worlds of human experience. The counsellors' ontologies have evolved and changed with the intersubjectivity engendered by client encounters and sharing with supervisors. I sense excitement at what I have arrived at: the counsellors have a great deal more to offer than enigmatic ticks and numerical ratings, and it can only be expressed in words.

An invisibilising epistemology

It is important to consider carefully the validity of the research methods which have been employed in the past to deliver research on the broader topic of childhood sexual abuse (CSA), which RA is a part of. In empirical terms, what was the correlation between the results and the

criterion? Did the result accurately reflect the reality being investigated? One startling conclusion is that the employment of the canons of scientific research has reinforced an irrelevant epistemology which once invisibilised CSA, and today, invisibilises RA. To examine this, it is necessary to look briefly at the history, the visual ontology of traditional scientific quantitative methods, and the focus on language and context in methods informed by social constructionism, in short, to debate epistemology.

Epistemological debates were few in medieval times when the church taught absolutes, but in the mid eighteenth century scientific investigations began to be accepted as a new enlightened means by which to acquire knowledge (Burr, 1995). Rationalism and empiricism helped bring about a new Modernism, which claimed an exciting belief in observable facts and underlying structures, inspiring the structuralist movement with its grand theories of historical metanarratives and far reaching, overarching truths. The rising belief in the powers of quantitative research used in natural science led to the locking in of the positivist paradigm to social sciences; unchanging facts existed and all were discoverable using the scientific method.

Postmodernists and post-structuralists, centred not in science but in the humanities, rejected this positivist epistemology, finding no underlying truths but rather a multiplicity of situations and interacting ways of life (Gergen, 1985). They saw language and context as the key to understanding knowledges which were constructed in spoken or textual interaction between people, and socially, politically, and culturally situated (Gergen, 1985), motivated and affected by the changing world. Truth and knowledge were therefore not neutral but relative constructions. The four basic tenets of social constructionism were anti-essentialism**,** or a lack of universal truths; a questioning of scientific realism; the historical and cultural specificity of knowledge; and language as a precondition for thought, bringing practical consequences (Burr, 2003).

Despite this, researchers' use of inferential statistics and the public association of scientific research with biopower, or an undisputed access to true facts affecting life and death, continued to grant epistemic authority (Tanesini, 1999) to what was to become known as the traditional method. Within this phenomenologically dependent episteme however, some realities remained unseen, for several reasons.

The first of these was the use of categorisation. The positivist requirement for quantifiable categorisation limited the data to that which was itemised. In the case of RA in other Western countries, police and health workers who suspected RA usually only recorded the physical and sexual abuse, for which there was a set of established categories and adjacent tick boxes (King & Yorker, 1996). This also occurred in New Zealand, when a researcher researching the childhood abuse of sex workers, noted that although a participant reported that she had experienced RA involving both sexual and physical abuse, because the RA was difficult to code, the RA data was omitted from the analysis (Potter, Martin, & Romans, 1999). Algorithms, a useful tool in quantitative analysis, only produce information on the numbers in the categories supplied, and therefore become misleading when the assumption is made that because the mathematics are correct, so is the conclusion reached, in this case being that because RA is not mentioned, it does not take place.

Traditional methods also once invisibilised sexual abuse by a dependence on measurable physical evidence, which led to an underestimation of the extent of CSA beginning in the 1950s. Only medically validated police, hospital or social workers= records were regarded as quantifiable evidence of fact (Goldman & Padayachi, 2000). Unreported incidents and unsubstantiated accounts were excluded from data gathering. Even by the close of the twentieth century, traditionalists positioned in a visual ontology continued to be sceptical of figures showing that 19% of adult women gave accounts of CSA in retrospective studies (Goldstein, 1997). The spoken accounts of RA clients, and the texts of therapists who treated them, were likewise illegitimised as subjective realities.

Quantifiable physical evidence of RA was demanded even years after the event (Gonzalez, Waterman, Kelly, McCord, & Oliveri, 1993), an impractical request, which positivists nonetheless claimed denied the facticity of RA. In a continuing need for numbers, controlled studies were insisted on (De Young, 1996). Empiricists measured physiological reactions to questions (Cotton, 1994) and documented ingenious word association tests (Leavitt & Labott, 1998) without reaching scientifically satisfactory conclusion. Because unproven hypotheses are not conceded to be reality, RA was again found to be non-existent. Traditional researchers therefore turned to the attribution theory and the power of a scientific nomenclature, to diagnose RA clients with DSM-IV mental disorders. RA as a reality was invisibilised behind diagnoses, because diagnostic clinicians then claimed it was the conditions that had produced the false RA

memories. Critical psychologists argued that such universal categorisation merely reinforced the epistemic privilege of the dominant traditionalist group, ignored the accounts of the marginalised, and maintained hidden power structures.

Scientific experiments with implanted memories were also conducted (Goodman & Schaaf, 1997) to test the validity of memory recall. Such experiments were replicated and refined, and the results generalised to declare memories of RA invalid. Such experiments were roundly accused of context stripping and ignoring subjective experience (Cherry, 1995) by those informed by social constructionism. It was argued that the intensity and trauma of abuse in no way related to the research done, and raised questions as to the relevance of perfecting actuarial instruments if the data was invalid.

Controlled interviews were conducted, but RA clients marginalised in agentic settings divulged little (Cozolino, 1989). Social constructionists had documented the power relations inherent in any research interview (Lather, 1992) and the dependent and influential interaction between interviewer and subject (Gergen, 1988) but this was denied by traditionalists who claimed their methodology to be neutral. Critical psychologists also argued that epistemic partiality occurred when privileged therapists questioned, disregarded, explained, and constructed a reality different from that experienced by the client (Hare-Mustin & Marecek, 1988). RA accounts were invisibilised when reconstructed as a subconscious reaction to the generation gap and unstable relationships (Goldstein, 1997). Positioned in a traditional medical ontology, such reconstruction warranted voice with Foucauldian authority. To the Social Constructionist, this was a clear example not only of the dominance of privileged discourses, but also of the action orientation of language, with its constitutive power to evaluate, restrain, allow, and construct (Burr, 2003).

At the same time, traditional psychological research was under attack as an academically gated arena in which only results gained using a positivist scientific epistemology were allowed authority. This problem was partly addressed by the development of discourse analysis, inspired by the principles of social constructionism. Discourse analysis enabled the study of the psychological, social, and functional implications of language in all ontologies, using systematic methodologies which grounded the results in a data of language. Two outstanding analytic traditions emerged, those of Foucault (1972) (aligned with a macro orientation to facilitate

analysis of broad interpretations, and analysing how prevailing discourses were linked to social arrangements which supported and maintained powerful groups) and of Potter and Wetherell.

Potter and Wetherell's discursive psychology

Potter, Wetherell (Potter & Wetherell, 1987) and Edwards (Edwards & Potter, 1992) instead aligned their linguistic science of discourse analysis with a micro orientation in order to analyse the interactive features of talk and text of everyday life. Traditional representational views of language were challenged, because this analytic tradition attested that far from words being neutral mirrors of reality, all talk and text was active, involved, engaged, and committed to a purpose. It looked at how language was used to manage the construction of justifications and explanations, accounts and descriptions, blame, responsibility, and accountability (Tuffin, 2005). The traditional neutrality of text was also challenged, as stake and context were regarded as essential considerations in determining the meaning-making of words. Potter and Wetherell (1987) advocated the exploration of the use of interpretive repertoires. They also cited three key features of their analytic method: the discovering of construction, function, and variability.

Interpretive repertoires

Interpretive repertoires referred to linguistic options shared by those of a similar ontology, "the building blocks speakers use for constructing versions of actions….constituted out of a restricted range of terms" (Wetherell & Potter, 1988 p. 172) or "culturally available linguistic resources from which accounts may be put together" (Tuffin, 2005 p. 175). Interpretive repertoires drew on linguistic phrases, words, terms and metaphors familiar to people of that culture (Burr, 2005) which would convey understood meanings. Speakers might utilise more than one repertoire, depending on what they perceive as the requirements of the social context. Conversely the same repertoire might be used performatively by different people to achieve different functions (Burr, 2003). Certain metaphors, or figures of speech, could signal the repeated use of a repertoire. An example of this would be an interpretive repertoire of scientific reasoning, signaled by the use of phrases from a scientific nomenclature, such as *tests have proved*, or *research has indicated*.

Construction

An analysis of construction referred to looking at *how* language users assumed agency, or conveyed their argument or belief, by certain choosing words and phrases from the socially accepted linguistic repertoires of their ontology. How was their version of reality constructed? What linguistic resources were employed? How have different speakers constructed the same subject? For example, a sceptic might construct an RA client as "dangerously delusional" but a therapist construct the same client as "suffering from flashbacks". The sceptic, by choosing the word *dangerous*, has conveyed to his audience that the RA client is more in need of restraint rather than counselling. His use of the word *delusional* is part of the authoritative medical repertoire, and has added strength and credibility to the construction of incorrect memories. The client has therefore been constructed in two concisely chosen words, as being a threat to society, incorrect in memories of RA, and medically of unsound mind. In contrast the therapist, by choosing the word *suffering*, has positioned the same client as being in need of help. Like the sceptics, he has chosen a word sanctioned by its position in medical nomenclature, *flashbacks*, this time to legitimise the RA memories.

Function

Both of these highly performative constructions have consequences in practical terms, such as the allocation of responsibility to the therapist to provide therapy, or law enforcement to restrain. This is their *function*. Function refers to the business achieved by the construction, and causes the analyst to ask questions such as: What purpose did the participant have in using a certain construction? How were rhetorical or linguistic devices such as rhetorical questions, extreme case scenarios, or negative construction of disposition employed to achieve diverse purposes such as attribution, moral positioning, or justification? Why did the participant choose a repertoire with a scientific nomenclature, what did it achieve, and in terms of stake, why?

Variability

Potter and Wetherells' (1987) embracing of variability underscores another key difference between positivist and social constructionist epistemology. In discursive analysis it is acknowledged that on different occasions, the same talk may do different work, or a speaker may

offer a variable discourse. For example, an RA counsellor might conceivably discursively constitute medical categories respectfully when writing to the Accident Compensation Commission (ACC, 2009) to fund a client, critically when conferring with a colleague, and dismissively when reassuring a client. To the positivist, such inconsistencies and differences would be termed abnormalities or outliers, and normally have to be eliminated or discarded to prove or disprove a hypothesis, (Hare-Mustin & Marecek, 1988). To the discursive analyst however, contradiction, complexity, diversity, randomness, paradox and ambivalence are exciting components to be considered in context; human experience *is* diverse and contextual. Similarity and consistency in texts that draw on the same linguistic resources and cultural understandings, or that have a similar action orientation in terms of what was being achieved, would be important, but variability almost more so. Differing accounts from the same speaker might be read several times, in order to discover what functions were being served by the contrasting constructions. What were the contextual reasons for the variability? What was the functional orientation of the speaker at that point in time, and what was the consequence?

Variability may also occur in accounts given by opposing speakers, with both claiming facticity and "proof" of their viewpoint. It has been shown in the literature review that this is the situation in the field of treatment of RA clients. For the purposes of this study, it was essential to employ a form of analysis which would allow the emergence and inclusion of multiple constructions, discourses and conflicting ideas, instead of eliminating apparently contradictory concepts or outliers. It was not expected that the discourses would be few, simple, linear, or uncomplicated.

The Discursive Action Model (DAM)

The four elements of analytic method described above were extended by Edwards and Potter (1992) who developed the Discursive Action Model of analysis, which consisted of three parts: Action, Fact and Interest, and Accountability. *Action* focused on action rather than cognition; memories and attributions were constructed in talk, they became active reports to be studied, and they were situated in activity sequences to effect, for example, a refusal. *Fact and interest* looked at the dilemma of stake and self interest, the way in which reports were constructed as 'factual' and how they were organised to undermine alternative accounts. *Accountability* looked at agency and accountability in the report.

The DAM was hailed as a significant new approach to the study of memory, especially in the study of recovered memories. This becomes significant in the present context in that recovered memories have been recorded as encountered by counsellors and therapists treating RA clients, and they are the source of a great deal of academic debate. Using the DAM, it has become possible to acknowledge and analyse memory processes without the scientific necessity to first prove whether or not the memory is an infallibly factual and representative account. The scientific need to analyse memory malleability in laboratory studies, and declare memories "true" or "false" also becomes irrelevant compared to the business of acknowledging and understanding the psychology of the linguistically constructed, and culturally embedded, social process of remembering.

Towards an ethical epistemology

The fact that discourse analysis enables the contextual exploration of the psychological meaning of particpants' active language as utilised on different occasions, means that subjective accounts outside the culture, social status and politics of the researcher (Gavey, 1989) have become researchable. Using only speech as data (Edwards & Potter, 1992; Potter & Wetherell, 1987), research can also be conducted into fields invisibilised or unacknowledged in a traditional ontology. Discursive analysts are not limited by physical science; with regards to the present study, they do not need to wait for empirical proof that RA exists, before they can begin research into what is being constructed and transacted in the present, as evidenced in language. The active discourses of the language around RA are being lived out powerfully, regardless of whether RA be scientifically "proven" to be myth or substantive.

The Code of Ethics For Psychologists Working in Aotearoa/New Zealand, 2002 (Sec 4.3.5) (New Zealand Psychological Society, 2002) advises psychologists, where possible, to work to try and change practices of psychology which are not beneficial to society. It could be argued that it is important to move away, if necessary, from research methods such as scientific positivism if they have in the past invisibilised CSA, in order to research similar abuse scenarios which may as yet be likewise undiscovered and untreated in our society.

For all of the reasons discussed, discourse analysis was chosen as an epistemology capable of enabling the study of RA. The aims of this study however were to discover the influential

discourses in the talk of counsellors discussing RA, rather than to make a socio-political observation. For this reason the discourse analytic choice was the science of Potter and Wetherell (1987) and Edwards and Potter (1992) rather than that of Foucault (1972).

Reflexivity

In a traditional empirical study, there is no reflexivity; the supposed neutrality of the numerical data pre-empts the necessity. The interpretive gap, in which the researcher or participant stand to subjectively construct their differing representation of the actual things in the world, is not acknowledged. However to the social constructionist, all research is value laden (Paludi, 1992; Reinharz, 1992; Riger, 1992); knowledge is influenced and allowed through the epistemology and ontology of the researcher, and it creates its own reality (Lather, 1992), and therefore must be understood reflexively.

Burr (2003) suggests an examination of how the research reconstitutes the participants and evaluates their accounts, and also reflexivity regarding the egalitarian relationship between interviewer and participant. Burr also suggests that researchers may wish to build into their study, avenues by which participants may comment on their accounts. These concerns are attended to in Chapter Four, *Avoiding agentic control* and *Transcription and reflexivity*. Reflexivity is also encouraged in the researcher's choice of epistemology, and this is attended to in Chapter Three. Edwards & Potter (1992) look at the necessity for reflexivity on the accountability of the researcher for the "interactional consequences" (p. 166) of their study, given that research findings are part of the action orientation of language; they have function and effect, and this is addressed in Chapter Ten. Reflexivity is also attended to in "reflexivity boxes" (Edwards & Potter, 1992) throughout this study.

Importantly for stake, motivation and interest, the researcher should "explicitly acknowledge personal and political values and perspective informing the research" (Burr, 2003, p. 157). I am Pakeha, a wife and mother, and have worked professionally as a teacher and counsellor. My personal values are Christian in orientation; I attend an Anglican church, and work voluntarily on inter-denominational church teams in prisons. This perspective informs the research, firstly in that twelve years visiting prisons has caused me to be believing of hidden criminal activity, and secondly because in acknowledging the existence of good and evil, I find RA a plausible

phenomena. I would position myself as a moderate apologist for the existence of RA, one who allows that constructions of RA accounts may exhibit variability or change.

- The imponderable impingement of moral values

I realise that many times I have sat down to listen to accounts of abuse, and these have occasionally included accounts of RA. I recall a lady in a group discussion who started to describe Satanist ceremonies in which she had been victimised. When the others, although curious, could not identify with her, and the peculiarities of her abuse did not resonate, she became silent and allowed them to continue with talk about CSA. I later met another RA "survivor" in another group, whom I talked with after. I began to feel a moral obligation to explore this, to maybe give voice to a previously silenced discourse. Until now, I have never been systematic in my research on RA. I welcome the chance to look at it in a research driven way rather than as someone assuming therapeutic responsibility. But now in this study, I try to think reflexively: does the sense of moral obligation influence my research, or did it merely inform my rationale?

Chapter Four

Methodology

Participants

Participant selection

The language data for analysis was gathered from relevant interviews with New Zealand counsellors who offered talk around the topic of RA and RA clients. Twelve years of voluntary work in the prisons and voluntary and paid work co-running support groups had created goodwill with counsellors. Some voluntarily expressed interest in participating, or suggested people they knew who might be interested. The latter were contacted initially by a colleague. Participants were sent an information sheet (Appendix A) and a consent form (Appendix B) with a stamped self addressed envelope. They were contacted again a week later, and asked if there were any questions, prior to signing the consent form. They were then sent a copy of the interview questions (Appendix C). Three counsellors who currently treated or had treated RA clients declined to participate.

- Reflexivity around representation

At this point, my earlier studies in empirical psychological research kicks in with accusing vengeance. I have *skewed the data* by choosing a *non-representational* group of counsellors. Surely I should have chosen a *cross section*, counsellors whose beliefs ranged in a *continuum*? Instead, I deliberately sought out counsellors engaged in this branch of therapy. Does this mean my research is *invalid*? But I don't seek a median, and my variability will not be expressed in standard deviation but in the understanding of the realities constructed during inconsistencies in talk. That established, I reflect again, and wonder if the fact that the three counsellors who arguably knew the most about treating RA clients will not be represented, will somehow weaken my data. I have to remind myself that this is discourse analysis, and my aim is to explore what *these* participants have to say about RA. Nine accounts will produce sufficient discourses for study. I later find this is an enormous understatement.

An excursion into empirical information

As Edwards and Potter (1992) note, empiricist accounting and hypothesising "either deletes the observer entirely or treats them as a passive recipient" (p. 162). However it should be noted that no assumptive leaps or even conclusions have been made here using mathematical processes which exclude the reader. The purpose of the brief paragraph below is to further empower the reader by providing information with which to understand and assess the interviews being brought into the research and analysis which follows.

Nine counsellors gave interviews, eight women and one man, all Pakeha. Four, of whom three were ACC accredited, had treated or did still treat RA clients. Five, of whom three were ACC accredited, treated CSA clients, and had not yet treated an RA client but were willing to discuss their views with regards to that possibility in the future course of their work. Some of these felt they might have met an RA client but not received enough information from them to identify them as RA clients rather than CSA. The longest interview was 83 minutes, the shortest 28, and the rounded mean, 48 minutes.

Ethics

The research was planned and carried out with respect to the principles detailed in *Code of Ethical Conduct* (Massey University, 1999). The study was judged "low risk" and accordingly peer review for the study was sought and obtained, rather than a full review of the proposal.

Prior to the interview, participants' questions regarding the purpose of the study, their rights, and the interview process, were encouraged and answered. Transparency on the part of the interviewer was regarded as a critical and key factor. One counsellor agreed only after assurance of the interviewer's goodwill; she referred to academic studies which had so far portrayed New Zealand RA clients and their counsellors negatively (Goodyear-Smith, 1998; Hill, 1998) rather than producing helpful research findings.

The interviewer was aware of the threat to reputation that can come from treating a controversial condition. Therapists treating RA clients, regardless of the needs of those clients, have at times been publicly depicted as unskilled or gullible (Chu, 2002; Showalter, 1998), and in extreme

cases, accused of such unprofessional conduct as using mind altering techniques to create farcical confabulations in clients (Goldstein, 1997). Ritual abuse itself has been portrayed as a fabrication created by unethical, unscrupulous therapists who assume priest-like authority and manipulate clients in order to increase lucrative demands for their therapy (Ofshe & Watters, 1994; Prendergast, 1995). Therefore, although confidentiality is always an extremely important aspect of research, particular attention was given to discussing this with these participants.

Participants were assured that the researcher would make every effort possible to maintain confidentiality and anonymity. The data would be viewed only by the researcher and the thesis supervisor. Pseudonyms would be chosen at transcription, and used throughout. Identifying data such as names, gender, locations, years, relationship and workplace indicators would be edited out; participants' names and details would be kept securely and destroyed at the end of the research. The finished transcript would be emailed to the participant, to check that all identifiers had been removed. Their control over the data would be enabled by their being able also to amend their accounts at this time, if desired. These points completed, they would sign the consent for the release of tape transcripts (Appendix D) which would allow analysis to begin. The participants were given the option to have their interview tapes stored in a research archive, returned, or destroyed at the conclusion. They were informed that the data was intended primarily for use in the researcher's Masters thesis, but could be offered for publication. They were offered a summary of the completed research (Appendix E).

The researcher was mindful of and openly respectful of the counsellors' courage and compassion in treating RA clients. She did not ask for more details than the participant seemed comfortable with. The interview was opened and closed with conversation not related to RA, both to encapsulate an unsettling subject and to avoid leaving the participant still reflecting on negative or disturbing issues.

Interviews

The participants were interviewed at a time and place of their choice, the interviewer showing respect for their willingness to participate by being impartial. Their choices were their homes or place of work, or the interviewer's home.

There was an endeavour to cover the topics in the interview questions in a manner which allowed the participant to expand their ideas informally. This was facilitated by using the interviewer's known and accepted position as a volunteer worker and support group coordinator, and consequent interest in learning from other counsellors, to encourage conversational exchange. The interviews were regarded not as a means to access a veridical account, but a time to appreciate the participant's opinions and interpretive practices.

An open ended semi-structured format of interviewing was used (Potter & Wetherell, 1987) including questions, probes, and a follow up question which could be employed if a particular response was offered. Variation and diversity in response to the same question were welcomed as integral to the epistemology of DA (Potter & Wetherell, 1987). A 90 minute tape was used for each session.

Participants were reminded that there were no right or wrong answers, and also that they could if they liked turn the tape off if at any time if they so desired. A decision was made by the interviewer to be led and inspired by the accounts constructed by the participant, even if the interviewer became so engaged as to forget the original question (Reinharz, 1992). The aim was to open the boundaries of the discussion, and avoid agentic control.

Avoiding Agentic Control

Agency is always implicit when people give accounts that are motivated by day to day considerations. In interviews, it can be argued that narratives are jointly produced, and the interviewer has almost as much agency as the interviewee, by providing the questions used, commenting, and generally guiding the process. Therefore there was a concern that the importance business of facilitating ownership on the part of the interviewee regarding the interview, should be attended to, to avoid agenticism and participant marginalisation by a privileged interviewer (Riger, 1992).

Mutual respect through previous association or recommendation by mutual acquaintances facilitated freedom to disclose in a non-hegemonic, egalitarian research relationship. Any impression of researcher power (Gavey, 1989) was further dismantled by the interviewer beginning the interview with acknowledging the participant's qualifications and their years of

experience in counselling. The interviewer also avoided the controlling measure of placing a communicative distance between herself and the participant (Davidson, 2001), by exchanging laughter and using a conversational style. She gave feedback by rephrasing, and agreed with or empathised with the interviewee, to signify an acceptance of what had been offered. By these methods it was intended that the participant would feel free to give their thoughts and insights, rather than a disclosure only of what they imagined might be thought to be acceptable for the research.

Transcription

The researcher transcribed the nine audiotapes herself, verbatim, using 10-20 hours per one hour of interview (Potter & Wetherell, 1987) to emerse herself in the data. All pages were numbered and headed with the interviewee's pseudonym for reference purposes. An adapted form of Gail Jefferson's transcription notation in Atkinson & Heritage (1984) and Potter and Wetherell's adaptation of Jefferson (1987) was employed (Appendix F). Psycholinguistic evidence points to the importance of prosodic structure in auditory sentence processing (Shattuck-Hufnagel & Turk, 1996) but a simplified form of notation was used because the aim of this analysis was to explore rhetorical function and discourse.

The original tapes were listened to carefully and repeatedly while transcribing, to gain understanding of the emotion and intent revealed audibly in inflexions of speech. Lines were broken where commas, full stops and question marks might have occurred rather than where the analyst guessed an indicator of a discourse may occur (Wooffitt, 1993). It was noted that transcribed paralinguistic features could be ambiguous: for example, ((laughs)) could indicate incredulity, or humour, ((tch)) could express disapproval or sympathy, and minimal encouragers such as 'mm' and 'right' could indicate sarcasm, approval, or doubt. Indication of rising pitch could be misleading, as Pakeha New Zealanders often end sentences in this manner without implied meaning. The researcher therefore added meaning to the notation by choosing spellings (it's/its, there/their, to/too) and breaking text lines to clarify meaning which was indicated via prosody and inflexion on the audiotape, as in this example:

They might feel relieved someone's given them a diagnosis for other people(.)
I have my doubts

They might feel relieved someone's given them a diagnosis
for other people(.) I have my doubts

An ethical issue therefore developed, as the transcripted data contained my interpretation, my construction of the participant's meaning making (Potter & Wetherell, 1987; Green, Franquiz, & Dixon, (1997), even before the beginning of coding and analysis. The potential for agentic hegemony inherent in researcher privilege (Gavey, 1989; Paludi, 1992; Riger, 1992) was however partly offset by the previously described measures with regard to participant control and the requirement to sign off transcripts prior to analysis.

For ease of reading, minimal encouragers, fillers, repeated prefixes or words, and disconnected phonemes and morphemes were sometimes edited out before being quoted in the study, providing this did not alter the meaning of the utterance. Commas or full stops were also sometimes added to increase readability or to avoid ambiguity, for example, at the end of a quoted excerpt, to indicate that the speaker did not continue with qualifying discourse.

Coding

Preliminary Coding and referencing

Firstly, any instances of talk which were not related to the interview, for example conversational talk before and after the interview about general everyday topics, were eliminated. Preliminary coding was then begun using as categories the broad themes of the interview questions. This was to organise 393 pages of transcript into more manageable sections (Potter & Wetherell, 1987). The first category chosen related to the first question, *Definitions.* Working as inclusively as possible, related portions of transcript were copied and pasted to a file entitled *Definitions.* The Control Find facility in the Word programme was then used on all texts to locate all other related talk, which was then added to *Definitions.* All texts pasted were referenced with the pseudonym and page number of the participant's transcript, in order to allow the final analysis results to

remain traceable and visibly grounded in the data. After *Definitions* appeared complete, the same procedures were followed for the other categories produced by the interview questions.

Left over texts were then re-read to see if they linked to one of the existing category files. If they did not, they were re-read and their new themes allowed to emerge, for example *Funding issues*. A new file entitled *Categories outside the interview questions* was created and *Funding Issues* became the first heading. A Word search was carried out as before to collect any other texts in which the *Funding issues* theme were repeated, and all texts pasted to the file. The procedure was repeated with remaining texts, until nearly all texts had been allocated to category files.

Discrete Coding

The first category file, *Definitions*, therefore contained a large number of unsorted, copied and pasted texts. The first was read with particular attention to what it was saying, its main concern. The theme that emerged from the excerpt was *extreme*, and so this became the first heading in the Definitions file. The text was cut and pasted under this heading. A Word Find search was conducted on all texts for *extreme*, and related words such as *acute*. If these texts echoed the construction of RA as *extreme*, they were cut and pasted under the heading *extreme*. The second passage in *Definitions* was then read similarly carefully, and compared to the first; the concern that emerged was different, so a new heading was created, *power and control*, and the same procedure followed. This was continued for all texts in *Definitions*, resulting in a total of 19 headings. Any texts fitting two themes or more were copied to both or all (Potter & Wetherell, 1987). An index of these headings was compiled to allow them to be referred to. This procedure was repeated for all the interview question category files compiled during preliminary coding.

On re-reading, patterns emerged and some headings seemed to agree, and require merging, or conversely, needed separating and re-wording. Texts were sometimes re-copied and re-pasted to new headings more than once. Text which did not seem to directly answer the interview questions, and therefore could not be categorised or put under headings, was relegated to a file entitled *Categories outside the interview questions*, and headings decided as before. Later it became apparent that one of these apparently irrelevant headings, *client's account*, was in fact to be a central theme in discourses on truth: *the client's truth*. This and other discourses which appeared, are addressed in the next five chapters which form the analysis.

Chapter Five

Section One: Constructing the reality

Introduction

Constructing the reality forms the first half of this chapter. It first attends to the consequence of constructions of RA, then looks at how the counsellors in this study construct the phenomena. It is an interesting set of accounts to read, because it lays the important foundation of understanding from which the counsellors will later argue their positions. The counselors then go on to construct a prevailing New Zealand zeitgeist in relation to RA. A discourse of *RA as a reality* emerges.

Constructing the reality

Discourse is central to action. The function of any construction of RA is to involve an exercising of power, in that society will be affected by what is achieved. If RA is plausibly constructed as nonexistent, the consequence will be that no counselling need be entered into, parents need not be warned about it, police need not heed requests for the apprehension of perpetrators, and lawyers need not try to legally define the abuse. For counsellors, constructing RA as a reality rather than fantasy means they are ethically and morally obligated to offer therapeutic response, however new the ground. Six ideas emerged consistently concerning RA, all of which supported the construction of RA as an actuality, a physical reality: *extreme, spiritual, multiple abusers, power and secrecy, ritual for a purpose*.

Angela utilises the combined visual impact of a scientific metaphor and the powerful nomenclature of a scientific discourse with the word *continuum*, to establish RA as *extreme.*

Angela *If you're putting it on a continuum, I put it down as some of the worst or more extreme abuse that a person can experience?*

(Angela, 15)

Rose employs the word *abuse* five times after *extreme*, tautology which functions to emphasise. In naming first *sexual abuse*, she constructs to the reader RA as an abuse covered by ACC, which

is understood, and yet, it is more than sexual abuse. *You know* invites audience sympathy and agreement. Jennifer and others echo the multiple construction of RA, which supports *extreme.*

Rose *I would define it as(.)(hhh) um(.) well quite an extreme form of abuse(.) of a a combination of um sexual abuse emotional abuse spiritual abuse, the three(.) wrapped up together(.) over(.) you know and yeah(.) well it's a(1) yeah extreme, and um(.) it's a very damaging form of abuse*

(Rose, 1-2)

Jennifer *I would define it as psychological(.) mental(.) physical(.) emotional(.) and spiritual abuse*

(Jennifer, 1-2)

Spirituality itself, and ritual, were seen as capacities or abilities which were neutral, and capable of different expressions. Existing law abiding public churches were constructed as generally beneficial, a construction upheld in some psychiatric studies (Baetz, Bowen, Jones, & Koru-Sengul, 2006; Kohls & Walach, 2007). However, the same capacity for spirituality that engendered these, could become distorted. Satanic cults were portrayed oppositionally, in a bifurcation of spirituality, with the descriptors *good* and *bad*/*evil.* This interpretive repertoire of spiritual morality functioned to separate RA from the spirituality involved in forms of worship which were regarded as *good*. Counsellors drew on a linguistic repertoire of moral descriptors to define the difference, such as *good,* or *distorted, evil, bad, dark.*

Angela *there's still underlying I suppose protestant sort of work ethic values which have which come from sort of um (.) I don't know how to describe it, would you call it orthodox? I'm not sure what sort of orthodox religion. And so even though a lot of people may not practice Christianity(.) um there is a basis in our society in which I suppose like rules and laws are developed, and (.hh)it would seem that any ritualistic Satanic abuse somehow in my mind sits outside that. But there may be some patterns of behaviour that are similar*

I don't mean to be disre-disrespectful when I use the word religious, I think it's a distorted sort of view of some sort of ritual

(Angela, 3)

Keri *Satanic ritual abuse, which has spiritual overtones and (.)perhaps cult connotations as well- Yeah quasi spiritual I would say because I don't think of that as being spiritual I know I used the word- or maybe I'd use the word religious or allied, or something like that yeah yeah*

(Keri, 4-5)

Timothy *stuff which was Satanic(.) which wasn't - when I say Satanic it wasn't good, it wasn't to a good end. I guess looking at it one can look at it and I guess in secular terminology it's it's something that is bad, and doesn't have a good outcome, and is destructive*
ritualistic which is not of God, so it can it's got a an evil it's got an evil connotation (.hh)

(Timothy, 4, 9)

Erin *Instead of saying Satanic you could say very evil*

(Erin, 1)

Sarah *when I say anti religious I'm thinking of perhaps the the dark side of um religion or sort of Satanic dark side beliefs.*

(Sarah, 1)

A consistent discourse found among counsellors was that of multiple abusers, which was indicated by the use of words such as *multiple, group, mass, cult.* Keri uses the word *tribe* metaphorically to invoke an interpretive mental repertoire of paganism, enacted in a group setting unlike that of an individualistic Western culture, and invites audience agreement*: we know, isn't it.* The discourse is supported by her counsellor's insight into the consequence of multiple abusers. The function of this discourse is to leave no doubt in the mind of the reader as to the presence of multiple abusers in RA, and the significance of this in terms of therapy.

Jennifer *done in a group*

(Jennifer, 2)

Madeline *The most important thing about it probably is that it is a group activity*

(Madeline, 1)

Keri *one or two people I've worked with in the past described what they had experienced as ritual abuse. It took place in a like I guess a cult type setting where (.hh) um there were a number of people.*

Maybe some of the hardest things to(.) recover from are those where(.) there have been multiple abusers.

It's a the power of the group(.) and a mass behaviour and we know how shockingly humans can behave en masse, in ways they might not necessarily behave individually. It's one of the worst things isn't it, having the tribe turn against you

(Keri, 1-2, 40-41)

Using linguistically similar constructions, counsellors also constructed a discourse of *power* and *secrecy*. The linguistic repertoire for *power* included emotive words such as *victim, inflicted, control, intimidated, dominated, overpowered, trapped*. These functioned to resonate with the audience, and establish the seriousness, in human terms, of what was being transacted between perpetrator and victim. *Secrecy* drew on a linguistic repertoire of *collude, silent, covert, hidden, shrouded*. Keri gives the discourse credibility by calling it *fact*, and citing professional experience.

Keri *the fact that that's group knowledge(.) you know most of the abuse that I deal with it's two individuals in a room somewhere(.) but for this there's a there's a code of secrecy as well(.) so there's a lot of people who have this knowledge and who collude to keep it silent*

(Keri, 13)

Sarah *they are abusive practices because they are(.hh) um utilising a particular form of POWER over those people(.hh)*

It maintains um secrecy. It's one of the ah effects um of the abuse is the secrecy that helps to kind of maintain its power

(Sarah, 2, 13)

Erin *Abuse inflicted on another person in a covert manner, that is a hidden manner*

(Erin, 1)

Rose *very hidden….hidden and secretive*

(Rose, 1)

Keri *dominated overpowered controlled used trapped, all of that stuff.*

(Keri, 40)

Jennifer *controlled and intimidated and all that*

(Jennifer, 32)

Timothy *lo::::t of power and control stuff*

(Timothy, 10)

Erin *secret societies and organisations*

(Erin, 10)

Erin *And also there are those individuals who(1) would lose a great deal(.) if they were uncovered. um(3) well sometimes there are people in power?*

(Erin, 23)

The counsellors were consistent in constructing RA as a ritual, shown in a linguistic repertoire of *ritualised, repeated, pattern, regular, systems, procedures.* A discourse of *ritual for a purpose* emerged as counselors talked about ideology driving the rituals.

Angela *an on going pattern, a ritualised pattern of behaviour, ritualised because it's repeated behaviour.*

(Angela, 2)

Timothy *it's (.hh)((clears throat)) ritualistic. it's um form it's ceremonies it's(.) it's ah it's processes it's systems it's procedures(.hh)*

(Timothy,3, 11)

Timothy *a regular pattern, or a set pattern(.) based on the ideology or the views of (.) whoever's doing it*

(Timothy,3)

Angela *there's some sort of brainwashing.*

(Angela, 15)

Participants also constructed their abhorrence of RA. Angela uses the phrase *down the other end* metaphorically, to distance herself. The function of this device is to show by implication that normal humanity is at one end of a scale, and RA perpetrators at the other.

Angela *Down the other end, where I put Satanic ritual abuse*

(Angela, 15)

After much re-reading of the transcripts, an underlying discourse of *RA as a reality* emerged in the participants' talk. The participants were consistent in their construction of RA as an existing form of abuse taking place today, whether overseas or in New Zealand. This discourse was well argued, a notion backed up with contextual sensitivity in the form of explanations, and the recounting of real life counselling episodes which confirmed the speakers' account. Madeline was an exception, who constructed RA as a reality happening somewhere but maybe not in New Zealand. Her texts and others relating to this topic are looked at next in *Constructing RA in New Zealand*.

Constructing RA in New Zealand.

Having constructed RA *per se*, it then became necessary to know if all the participants believed it happened only overseas, or in New Zealand aswell. Eight of the nine counselors constructed the presence of RA overseas as logical proof that it can also happen here. This borrowed from the traditional idea of universal essential truth, which Angela supported with a scientific vocabulary: *dynamics, text books*.

Angela 21 *very similar dynamics regardless of where, so - I know it was in overseas text*

books, but I also(.) felt like what was described had um(.) there was similarities between what the person I worked with and what was in the textbook

(Angela, 21)

Rachel *it's something that could happen(.) <u>anywhere</u> in <u>any</u> country. because the::re are um(.) ((tch)) occult practices that happen in all countries.*

(Rachel, 2)

Erin *secret societies and organisations certainly are in New Zealand the same as they are everywhere else.*

(Erin, 11)

Madeline provided variability by doubting, using the positivist word *fact* to imply that her doubt was reasonable if she was not *sure.*

Madeline *I don't actually feel sure that it's a fact in New Zealand(.) I'm <u>quite</u> sure it's happened in countries with much larger populations, like England (.hh)and America.*

(Madeline, 1)

Her discourse is unwittingly critically examined by the other counselors, who attempt to construct current New Zealand beliefs regarding RA. Timothy constitutes Pakeha New Zealanders as unaware of RA in New Zealand because of a lack of spiritual awareness, compared to Maori. This is an interesting overall construction and evaluation of Pakeha, showcased as it is in a rhetorical device of contrast. He moves from generalised documentation to the specific, in which he underscores his assumption by talking of a need for training.

Timothy *I think that it happens in New Zealand but we (.hh)are not spiritually <u>sensitive</u> . We do not <u>recognise</u> because we've not (.hh)either been <u>made aware</u> or trained into it*

(Timothy, 13-14)

Timothy *MAORIDOM(.) have seen this a lot(.) (.hh) the spirit world(.) - they're very conscious of the spirit world and I've been recently (.hh)looking at Maori models of counselling to impart to the students, to say it's time you looked at them,*

(Timothy, 8-9)

Keri and Angela construct New Zealanders as having an essential disinclination to believe in unusual abuse such as RA, and then cite New Zealand instances they feel parallel the issue. This is an interesting instance of the combined use of two epistemologies to establish a point. Positivist concepts are declared linguistically in terms which denote first universality, *a general rule* and then essentialism, *a bit of an attitude*. The speakers then move to a constructionist stance by contextualising their assumption, and backing it up with examples of discourse in action. Angela says "when people started *to talk* about sexual abuse" "*called her* really rude names" "*negative connotations* about women came out" and by this acknowledge the power of language in action, to create social knowledge. The unexpected discursive achievement of the latter, in Angela's excerpt, is to prove her hypothesis: that New Zealanders as a whole are unlikely to believe unusual abuse, and this is therefore generalisable to instances in which RA might be required to be believed. A metaphor is introduced by the counsellor to describe the process, *backlash*. This is a powerful linguistic device which encourages the audience's defence of the victims of abuse, whose plight is compounded by an unsympathetic public. The descriptor *had to endure* supports the metaphor.

Keri *I do remember there's a bit of an attitude around it. You know it's like(.)too far fetched or unbelievable. Or too weird or unlikely or that that sort of feeling around it.*

(Keri, 54)

Angela *I think as a general rule, society would(.) find it to believe(.) Satanic ritual abuse, because it is out of the ordinary. And then um (.hh)if it came out in the media which I don't think it ha::s um there'd be a backlash possibly. Like if you look at other (.hh)issues or movements like you look at um(.) example feminism um you know when women started to take(.) personal power there was a backlash. You look at um when people started to talk about sexual abuse and family violence, there was a backlash against those (.)and it's only like recently like with*

s:::::exual abuse with the [name] case for example, she spoke out but she also said that people (.hh) um on talkback shows actually um(.) doubted her, called her(.) really rude names . You kno(.)w the usual stereotypical um(.) I call them right wing in some ways. Negative connotations about women came out and so she had to endure that as well so I think you know if something like that Satanic ritual <u>abuse</u> came out , you know that would have that whole raft Now we've had this backlash(.) partly cause of I think [name], but and(1) yeah(1) again it's partly against women and abuse , I mean I think that might work against people(.) speaking out about something that's (1) more extreme possibly.

(Angela, 25)

RA as evolving knowledge

Another construction of why New Zealanders might find RA difficult to believe, was built around the notion that RA was now positioned malignantly, even as CSA was in the 1950s. The 1950s were seen as a time when CSA was not only unacknowledged, but accounts were generally not believed, even as some New Zealand sceptics, and the general public, might not believe RA today. The lack of belief in the physical reality of RA became therefore a historical or contextual issue. An interpretive repertoire based around the discourse of *evolving knowledge* draws on a linguistic repertoire in which years are mentioned numerically, and words such as *decades* and *years* and *ago* used to signify the need for the physical passing of time before New Zealand can position unusual abuse more positively, as a phenomena for concern. Rachel makes this construction plausible by giving an account in which an RA client is nervous of not being believed, as CSA would once not have been, and positions her as needing audience sympathy, by the use of descriptors such as *vulnerable, feeling,* and *horrific.*

Angela *I think was the early 19(.)80s – people still didn't want to <u>believe</u> it but they were starting – they <u>were</u> believing it more so that's what twenty five to thirty years ago*

(Angela, 24-25)

Rose *I was just thinking that um(.) the reality in New Zealand like(.) some decades ago(.) I dunno in the 50s 60s(.) um was that people wouldn't have thought that sexual abuse was a reality and discounted that, yet <u>now</u> the evidence says yes this*

is this is a true(.) occurrence, it occurs in our society. And I think that in the years TO COME that people will view like ritual abuse will have a much better acceptance and understanding? As the same progression that's occurred with sexual abuse and the understanding that's occurred around sexual abuse?

(Rose, 25)

Rachel *So her feeling that people might not believe what she was going to tell them implies that it wasn't(.) just sexual abuse which we now do accept, yeah (.hh) because(.) um(.) the de:tails are so horrific that(.) yeah it was like well who could(.) ever believe that anybody would have ever gone through this. And she'd be left feeling(1) oh my goodness(.) so vulnerable.*

(Rachel, 8-10)

Constructing a New Zealand reality

The counsellors expressed their view first in unambiguous short statements, which contained the word *believe*. *Belief* as a descriptor, could be construed to imply a possible lack of actual facticity, so the belief is made rational and credible by practical or scientific justification, by referring to phenomenological, quantifiable data. The use of strong traditional linguistics from a visual ontology is even used when describing words, as in Rose's *evidence* which was *seen*; it transpires that this is actually not what she has literally seen, but what she has heard trusted colleagues say. This is an interesting use of a traditional linguistic repertoire to justify a social constructionist belief in the powerful ability of the spoken word to create reality. Erin cites Youthline, a reputable agency, to give credibility.

Timothy *I checked out locations(.hh), and I checked out situations and I talk-checked out the descriptions that he'd given so I CHECKED OUT(1) and that it all fitted in*

(Timothy, 18)

Rose *I(.) believe(.) the evidence that I've seen tells me that it's real,*

(Rose, 2)

Rose *because I've heard accounts of from other people, of it occurring in New Zealand. I've heard other people's um(2) yeah accounts of that. And two people I know(.) of have had clients ah I think who have experienced that kind of (.) abuse.*

(Rose, 5)

Erin *I absolutely believe it is ((laughs))*

(Erin, 7)

Erin *I have had anonymous um calls, which(.) um come to us through say(.) through the Samaritans, through <u>Youthline</u>*

(Erin, 8-9)

Keri uses the extrematisation *absolutely* to indicate the firmness of her belief that RA does in fact take place in New Zealand. She then positions herself within a powerful scientific ontology by using an empiricist or traditional essentialist repertoire to explain why. She refers to the existence of other abusive cults in New Zealand, and refers to this as a *principle*, a principle which implies that is an acknowledged likelihood for some people to abuse others in a cult-like setting, whether it be Satanic or otherwise. Such abuses are all produced by *the same mechanism*. The rhetorical *isn't it* invites audience agreement with the notion of universal themes. After citing many examples of the principle, she concludes by re-answering the question: *there has to be a certain amount of that wherever you are.*

Keri *<u>Absolutely</u> yeah absolutely yeah yeah. Well so I was thinking straight away about Burt Potter. There are communities down the South Island. I've worked with people in Exclusive Brethren sects who were utterly victimised. Yeah(.) And you know who had all of their thinking had been formed around(.) brethren m m beliefs(.) politics values Yeah (.) and often you know, one or two men usually up the top um(.) men who who were <u>very</u> happy to have a harem of willing devotees um(1) I wouldn't call that <u>Satanic</u> because it would be coming in a di-different format altogether ((laughs)) but it's the same principle. Yeah(.) yeah it's the same mechanism everywhere isn't it mm Now I mean maybe it's just (.)statistically there has to be a certain <u>amount</u> of that <u>wherever</u> you are.*

(Keri, 36-37)

Of course people could do it, there's {multiple examples} we've already cited. U:::m(.) Ah(.) yeah(.) I'm sure they've happened in New Zealand

(Keri, 52-53)

The unspoken dilemma of why RA isn't public knowledge, if it is fact, is managed first by use of a metaphor, then explained by being attributed to several factors.

Angela *It carries on under the radar.*

(Angela, 13-14)

Timothy *it's there. And it's under the mat.*

(Timothy, 15)

Angela *there's still a lot of factors that um would make it s:::: that(.) actually prevent people from talking about it yeah you know children who speak out or adults and there's a fear of retribution and I think in something like this there's possibly(.) even greater fear and possibly because of the nature of it where it's more extreme*

(Angela, 19-20)

Power and secrecy, mentioned earlier, and drugs, are revisited. Perpetrator denial is introduced.

Sarah *It would be difficult to understand what the prevalence was, because of the extreme secrecy um and the secrecy is enforced by um particular (.hh)um*

(Sarah, 13)

Erin *the perpetrators have gone to great lengths to cover it up and bury it, by drugs, by threats. The person is so(.)traumatised or fearful that they just lock it out.*

(Erin, 8-9)

Keri *most people who are taken to court(.) Deny(.) that they did anything {Even when they're in bloomin' jail you know}*

(Keri, 25)

Client's fears that authorities are ignorant of RA, and the ACC funding requirements relating to sexual abuse but not RA, are also cited. The latter provides an example of epistemological invisibilising by use of an empirical methodology, in which a lack of "tick boxes" for RA may occur.

Angela *a person would think they wouldn't actually be believed, and wouldn't go to authority. they'll tell you <u>part</u> of what happened um(.) sometimes that's to meet the requirements of ACC so they can get counselling.*

(Angela, 16-17)

Variability

The counselor most informed by a scientific epistemology, Madeline, a psychologist, who had also constructed RA as mainly an overseas phenomena, provided interesting variability among the other counsellors' accounts. Her discourse is a scientific one, in which an unknown counsellor is subtly criticised for believing their clients' RA accounts without proof. The words *belief* and *proof* function to emphasise that anything not proven by science requires a step of faith, or belief, because it may or may not exist. *Proof* implies quantifiable facts. The word *colluded* further downgrades the believing counsellor.

Madeline *it had been turned into an example of(.) Satanic - ritual abuse =(.hh) I thought her <u>previous</u> counsellor had(1)(.hh) <u>colluded</u> if I can use that with her wanting to believe that had been a ritually abusive situation, and there was no proo- other proof she could have(.) given that it had been(.) a ritual(.) situation*

(Madeline 17-18)

Summary

Eight participants constructed RA as a deeply concerning reality occurring in New Zealand, with variability shown by one who found it hard to believe. New Zealanders were constructed as finding it hard to accept that RA took place in New Zealand, and positioning RA in the same unknown area which CSA had occupied in the 1950s. The counsellors emerged as being informed by language, giving weight to the constructionist tenet of language's action orientation.

However, when it seemed that their arguments might produce uncertainty in an audience, they sometimes used a traditional empiricist linguistic repertoire involving visual or quantifiable accounts. The need for counsellors to speak from a traditional scientific ontology in order to warrant voice, while remaining unspokenly informed by social constructionism and qualitative research, is looked at next in *Stake, positioning, and warranting voice*.

- The impact effected by inner acceptance

When people ask me if I think RA happens in New Zealand, I try to put aside the emotive and disturbing aspects of the topic, and to think logically. As I see it, adherence to a deity involves trying to emulate and please the object of worship, and it's therefore logical to assume that Christians will try to follow the goodness of Christ, and Satanists the evil of Satan. At this point, my mind rebels at the thought of New Zealanders (Godzone, after all!) being interested in evil per se. I looked online in January 2009, and googled Satanists New Zealand. The first of a staggering 162,000 sites to appear facilitated meetups for those interested in Satanism, in more than 270 New Zealand towns.

New Zealand media has made known to the public, over the last few years, almost unbelievably shocking cases of child abuse. My time spent visiting New Zealand prisons, and observing the likeable, innocent persona of convicted paedophiles, has made me aware that the CSA for which they were eventually jailed usually went undetected for years, if not decades. It seems reasonable to me to assume that RA could similarly be taking place undetected in this country.

Reflexively, I ponder how my belief in the phenomena of RA has impacted on this research. Was there a conflict of interest in the interview definition questions? No, because the participants also constructed RA as at least a probable reality, at most a reality in this country. Later when I endeavoured to let discourses emerge from the transcripts, was I attempting an impossible neutrality, or reading with my own bias in mind? I concede that someone who is sceptical of RA might have produced a different analysis of the same data.

Section Two: Stake, positioning, and warranting voice

Introduction

In this the second half of the chapter, two features of the counsellors' talk, which recur throughout the following analyses regardless of topic, are examined. The first is the counsellor's moral stake in their profession, which is seen in the counsellors' reasonings, arguments and assumptions. Secondly the context in which the participants linguistically construct their arguments and ideas is examined, to show a recursive positioning participants employ agentically in order to warrant voice (Burr, 2003).

A moral stake in counselling

Keri *I have felt I guess protective of my clients*

(Keri 23)

Jennifer *my first um (.) concern(.)is to keep the person safe(.) Safe inside the session(.) and safe outside of the session.*

(Jennifer, 24-25)

Timothy *my aim was to help my client(.)*

(Timothy, 22)

Counsellors have a professional moral stake in counselling which can be described as a need to know that they are causing benefit rather than harm, their efforts are successful, their training put to good use, their work producing good results. It is revealed in a concern that whatever they decide will benefit the client, and has been shortened in this study to the term *concern for the client*. Its presence is an integral feature in counsellor credibility, and contributes to the respect necessary in a professional-client relationship (Gibson, 2006). It is professional but also unavoidably personal because it is a reflection of the ethical self. Concern for the client is a precursor to assuming agency; in the examples above, the counsellors take agency in the progress of their client, by the use of the words *I* and *my*. However, this must be managed within the parameters of professional counseling practice. The stake is generally not mentioned as clearly as

in the above. It has no feature metaphors, and no recurring linguistic repertoire common to all examples. An example is when Erin, before agreeing that the traditionally approved DSM-IV diagnoses are useful, instead asks a question; will this benefit my client?

Erin *(.) is the label any better than the abuse(1) or is that further abuse?*

(Erin, 13)

A superficial observation could be made, that the counsellors interviewed have no self regulating moral stake which must be managed in all decision making regarding clients, but show a concern for the client because it is in their professional interests to do so. However it became apparent in the texts that follow that the moral stake is managed on an internal level which is self monitoring rather than self serving.

The need to manage this moral stake of *concern for the client*, in this case the RA client, was however inexorably accompanied, in terms of professional requirements, by an equally important stake of a different nature, that of government funding. The counsellors did not talk directly about a conflict between these two interests. However, a possible conflict appeared in the juxtaposition of government funding, informed by traditional epistemologies, and the counsellors' need to treat RA clients, whose controversial and subjective experiences were not scientifically proven. The counselors had a moral stake in the successful progress of their RA clients, but also a professional stake in government funding, as most received funding from government bodies. The counsellors managed this dilemma by positioning themselves in a scientific ontology to warrant voice.

Warranting voice: a discourse of government backing

Counsellors live and move in a world in which the action orientation of language is unquestioned. They are positioned in a linguistic ontology rather than a visual one. Through talk, counselling and therapy, roads of healing are explored, addictions conquered, relationships restructured, life changing decisions arrived at. Freud's famous "talking cure", echoing through from more than a century previous, resonates in a post-structuralist era where psychological beliefs and knowledges have changed, but the power of speech remains: linguistically and without physical intervention, entire lives are changed. Worlds are understood, relativity encountered and contextual truths constructed, through engaging in talk.

How then, do counsellors who are arguably mostly informed by an unspokenly social constructionist, post-positivist epistemology, warrant voice in a market place funded by a government which is aligned with the powerful traditions of medical knowledge informed by a scientific epistemology? In a symbiotic relationship between counsellors and government, the discourses of the latter episteme or cultural domain, specify the rules by which concepts and perceptions must be formed, and in the rules of positivist empiricism, the evidence of the senses takes pride of place. In New Zealand at least, RA has not been phenomenologically proven to exist, and yet ACC counsellors are funded by the government to treat RA clients. Counsellors were positioned in a different ontology to a government informed by traditional medical and scientific ontologies. How this dilemma was managed in the counsellors' talk was then looked at.

The analyst was first alerted to the participants' way around this dilemma by an anomaly discovered in the interviews. At no time during interviews were participants asked about their experience or qualifications; in fact, the interviewer made a point of acknowledging the experience and qualified nature of the participants in such a way that clearly indicated that no further validation was needed, as noted in Chapter Four, *Avoiding agentic control*. Despite this, and for no apparent reason, nearly all participants volunteered their credentials at some stage of the interview, often reinserting them or adding to them at various points. The first two pages of Timothy's transcript were entirely dedicated to the topic. It seemed to emerge, after several readings, that these personal citations were being used as necessary evidence of the counsellors' ability to warrant voice within a traditional ontology. The personal validation they cited was drawn from a traditional repertoire used in the field of government funded counselling, and used a linguistic toolbox which enabled the construction of an otherwise unnamed discourse of *government backing*.

This powerful linguistic repertoire included words and phrases which implied knowledge of, and acceptance within, a traditional MHP ontology. *ACC, funded, doctor, medical, training, psychologist, member, DAPANZ, New Zealand Association of Counsellors, certificate, clinical, lecturing in social welfare, police, social worker, seminar, lectures, conference, research, spectrum,* and the names of various government funded workplaces which, if the participant was employed there, in the interests of anonymity were cited in the transcripts as *identifiers*. DSM-IV categories not mentioned in the interview questions but an essential consideration in government

funding and the medical establishment, were also named and functioned as a part of this repertoire, as did medical nomenclature. The functional work of this repertoire was to position the participant within a traditional and powerful scientific ontology, so that before they tentatively challenged traditional claims to factual knowledge such as the DSM-IV system of categorisation, their voice would have been established as viable. After the construction of the discourse *government backing* was completed, the phrase *in my experience* was spoken or implied. It formed an acceptable adjunct to the repertoire, because it indicated that the speaker had been further informed during the legitimate practical application of their cited situatedness. Burr (2003, p. 204), describes such deployment of subject positioning as "implied position within a particular discourse which may be occupied or taken up by a person, providing basis for their identity and experience". The discourse of *government backing*, a subtly constructed government approved employment platform with implied alignment to medical theory and scientific epistemology, became an allowable stepping off point from which to express critical thinking. Some examples are provided below.

Sarah *I've looked at that {quite extensively in my} ((laughs)) {in my research} Science does try to sort of sell us the idea that they know the truth as well but (.hh)um <u>again</u> I sort of think that these are grey, you know*

(Sarah, 28, 37)

Madeline *went to a conference. Don't ask me the name of it 'cause it's so long ago, I've been to so many….worked in settings where there are people who I suppose are mainly medical you must be a little bit more open minded than just get <u>stuck</u> on the ah on the diagnosis itself*

(Madeline, 5, 10)

Timothy *I'm the ((clears throat)) coordinator of a counselling course in [location] I work two days a week there ah lecturing principles and theories(.) of counselling and <u>skills</u> of counselling and group work(.) ah and I supervise the second years, that's two three days a week, got a degree from [institution] I've got a diploma in soc-counselling, I've got a certificate of qualification in social work, (.hh) ACC sexual abuse counsellor u:::m, Member of of DAPANZ that's ah drug and alcohol, U::m*

I'm a member of New Zealand Association of Counsellors, I supervise(.) five counsellors

(Timothy, 1-2)

Timothy *a therapist that I kind of relate well with or to is Dr William Glasson (.hh)who trained as a psychiatrist and he comes back and says well (.hh)sometimes I question(.) this whole thing of the DSM four*

(Timothy, 26)

Angela *I have done training(.) DSAC Doctors for Sexual Abuse Care Training. So how helpful is DSM four for (.)clients(.) um I didn't(.) I mean some of it in my experience it wasn't really useful*

(Angela, 27, 30)

Their credibility was therefore constructed through the use of category entitlements (Potter, 1996), which were validated and prescribed within the discourse of *government backing*, positioning them as knowledgeable and entitled to produce their account. The credible self was thus achieved, and deployed in order to contest traditional empirical findings. Without engaging in quantiphrenia, it can be said that throughout the transcripts, examples of this discourse preceded, and correlated positively with, examples of expressed critical thinking or resistance to the scientific discourse. Other examples are noted throughout the study.

Summary

The moral stake in counselling, evidenced in *concern for the client*, and the discourse of *government backing*, are recurrrent in the constructions, arguments and explanations that follow, and are mentioned throughout the analysis. A tension emerges, when the participants, who work within a structure informed by positivist epistemologies, must resist, at times, the scientific discourses which accompany it, in order to support ideas which are informed by social constructionism. The participants position themselves in a powerful scientific ontology in order to warrant voice, or choose a social constructionist, linguistically informed ontology to construct their knowledge, and at times employ both. Stake and positioning continue throughout the three main areas of talk, which are next explored: truth, recovered memories, and labelling.

Chapter Six

Truth

Introduction

Whether or not individual accounts of RA are veridical, is not for the analyst to determine. "Discourse work remains agnostic about the actual truth of the matter. As analysts, we are not in a position to know" (Tuffin, 2005 p. 97). This study rather sets about investigating how, in the absence of empirically validated phenomenological evidence, the counsellors arrived at their understanding of the possibly putative RA as reality, and why. By what epistemologies were they informed, before they declared propositional or declarative knowledge fact? Was a certain rationalism employed, whereby they reasoned their way to a knowledge of the truth of RA, without regard to experience? Maybe a critical realism, in which it was acknowledged that although they could not be directly aware of RA, nonetheless, their perceptions did give some kind of knowledge, albeit second hand? Or, knowing that RA was a nomological possibility, was an abstract RA reified by counsellors? Was RA regarded as a metaphysical problem, only solvable by an *a priori* speculation because it was unanswerable to scientific observation? Or was their knowledge of RA acquired through externalisation, a process Berger and Luckmann (1966) describe as a way of thinking about the world which becomes externalised, then becomes an object, then acquires a sense of pre-givenness and becomes part of the thinking of the members of that group?

However informed, the counsellors made clear in Chapter Five, their construction of RA as reality as in a physical occurrence. Potter and Wetherell (1987) introduce the idea of justification in talk; how was the counsellors' construction of RA as reality, justified, given the lack of phenomenological evidence? Were the participants assuming a universal truth? Interesting questions remained, regarding how their counselling world, in which RA clients existed and RA was accounted for as truth, was organised in talk.

On rereading the transcripts, it was seen that several strong discourses emerged, as the participants managed their answering of the much debated question of the truth of RA. The participants constructed not one truth, but three, all relevant to context: *legal truth, the counsellor's truth,* and *the client's truth.* Accepting the client's truth became a *moral* discourse.

But before these truths were constructed and explained, the counsellors justified their belief, stated previously in Chapter Five Constructing the reality, that RA was a physical reality which all but one of them were sure also occurred in New Zealand. They now justify this construction reality with the *credible client* discourse.

The credible client

The participants explain their belief in the reality of RA in the following discourse of *the credible client*, which has several aspects. The discourse is supported by a linguistic repertoire which includes the words *detailed, information, specifics, consistency, trauma, credible, integrity*. Their belief in the credibility of the RA client justifies their construction of RA as reality, and also their counselling such clients.

The *credible client* discourse was constructed in several ways. Firstly, counsellors asked the question why anyone would make up such stories. In the first two examples, the counsellors appeal to their audience by invoking common sense, and asking rhetorical questions. Rose also invokes common sense, then supports this with a first person account.

Erin *I personally don't think that a person would <u>want</u> to make it up. I mean what would be gained by <u>making it up</u>? Why would anybody want to be deluded in that way? And why would they want their life to be ruined? Why would they want to be lonely and outcast and (.hh)<u>ostracised</u>? I mean it makes no sense ((laughs))*

(Erin, 5-6 and 23)

Jennifer *I mean {who could make up stories like that really} ((laughs)) and their symptoms.*

(Jennifer, 37)

Rose *um(.) not the kind of(.) things that people would make up. It takes enormous courage(.) to come in to begin to talk about it(.) and um(1) yeah, I haven't encountered someone who's come and made things up.*

(Rose, 4, 15)

Counsellors also recounted being convinced by demeanour, detail, and consistency between accounts. Erin uses first person authority: *I don't believe*, then positions her RA client in the world of reality by contrasting it to the world of movies. Angela and Rose again invite the audience to agree; common sense is subtly invoked, and the question mark indicates the voice rising at the end of the sentence in a manner of a rhetorical question. Rose uses consensus to enhance facticity (Potter & Wetherell, 1996).

Erin *an::::d(4) the level of trauma(.) and fear in the voice of the person, you can't put it on, you CANNOT act it(.) you can't act it. I mean you can do stuff to get attention but(1) you can't act out real(.) terror. I don't believe that you can act out real terror(.) even on a screen it's not(.)like in movies(.) it's not like the reality.*

(Erin, 9)

Angela *It was definitely (.hh)um quite detailed and a lot of information and I don't think it would be possible for somebody to have actually (.hh) made made that up? Because of the as I said earlier the specifics that were able to be shared and the length of time it had gone on for and the detail that was able to be provided…… I don't think it's possible that somebody(.) could have planted that (indistinct), or that they could have made that up in any way*

(Angela, 5, 11-12)

Rose *I think consistency between um peoples' experiences(.) suggests there's something going on?*
the stories that are told by people that(.) that match up with each other.

(Rose, 3, 4)

Secondly, counsellors talked about being able to believe the abused, as opposed to believing the perpetrator. Erin first uses contrast to promote facticity (Edwards & Potter, 1992) then appeals to the audience by the use of the personal pronoun *you*. She then engages in attributional negotiation, in which the perpetrators are reasonably constructed as liars, because of their vested interest, and this is followed by strong negative judgement which has thus been pre-constructed as reasonable. Angela portrays her RA client as credible, then manages the so far unspoken problem of an RA client presenting with severe problems; she would *still* find them credible. She

manages this by constructing the symptoms as reasonable, and inviting audience sympathy. The powerful linguistic repertoire includes *debilitating, vulnerable, ongoing abuse, traumatised*. The first person account from a counsellor gives her argument force.

Erin *you cannot call all these people liars. Somebody is really telling lies, and since there is only something in it for the ones who are trying to cover it up? to gain by covering it up and discrediting those individuals(.) that they've um(.) ritualised - then it becomes quite heinous really.*

(Erin, 6)

Angela *I felt the client was managing well and was credible that helped me to um kind of get my head that this actually did happen and does happen. And there was something about this story and how things fitted together and the details so that yeah, I think the integrity of the client helped, but (.hh)even if somebody came and they were um(.) - and they've had um you know symptoms that have been really debilitating, and they haven't been able to hold a job down, they haven't been able to go out of their house, have good relationships um(.) with people, either of the same or opposite sex um - and then I mean that often makes people vulnerable to ongoing abuse, throughout their life, and other like addictions issues aswell - um so I know people that can be really traumatised(.) um so I don't think I would probably disbelieve somebody either in that situation, if they talked about ritual abuse. Because(.) I felt the CLIENT was credible that made it easier to believe it. But I probably would still(.,) depending on what a person told me, believe people in that situation as well, that I just described*

(Angela, 36-7)

Counsellors here constructed the possibility of risk factors regarding perpetrators as something they took seriously. The function of this is to further construct the client as credible.

Angela *I think at the time I there was for me kind of like almost a scary feeling about it because of what I heard it's like (.hhhh)ohhh wo:::ah are these is could my safety be at risk too was something that came to me um I'm remembering. It did seem that there was a lot of(.) there would have had to be a high level of secrecy around*

it for it to happen, and a lot of coercion um(.) occurred from memory and so (.hh)I felt that I would need to just be careful for myself aswell in terms of how I (.)took care of my own safety

(Angela, 33-34)

Sarah *Safety for the client I think is really really important(.) I mean that's kind of like the first place to be y'know, is this client safe. um(.) and then if they're safe if there is (.hh)ah possibility that other people might not be safe the group does not want to be exposed, um the group definitely want to keep um(.hh) the secret*

(Sarah, 52)

The counsellors also noted that the symptomology of RA clients matched those of other survivors of severe sexual trauma. Although all signs can be regarded as polysemic, the range of meanings possible from the symptoms narrowed down contextually to RA when an RA client presented with these. In doing this, the counsellors invoked the authority of a scientific ontology, in which symptomology is known. Angela talks of Post Traumatic Stress Disorder (PTSD), and also of her New Zealand client *matching* descriptions in overseas texts on RA.

Erin *Most of them are missing time in their childhood. They're ve:::ry timid(.) individuals(.) fearful, um(.) would have not much confidence. They feel unworthy(.) dirty. They feel shameful(1) um they feel like they've had part of their life robbed from them. Those would be the common elements. And, have difficulty with(1) um the opposite sex relationships, because of the sexual nature(.) of a lot of the abuse. They feel they feel like they're worthless. Many of them feel like it was their fault, they did something that caused this to happen.*

(Erin, 11-12)

Jennifer *ah it's a trauma(.) and anybody who's had a trauma tends to(.) whether it's physical mental sexual whatever(.) they tend to have the same long term effects.*

(Jennifer, 9)

Keri *Feeling(.) dominated, overpowered, controlled, used, trapped, all of that stuff.*

(Keri, 40)

Rose *I think it becomes more um(2) the dissociation becomes more(.) - I mean there's a spectrum for dissociation and I think it becomes more extreme. More complex? Yeah.*

(Rose 7)

Angela *I mean there's a whole raft of different responses. But for some people it affects their self esteem(.) their confidence(.) A lot of people experience traits of(.) Um Post Traumatic Stress Disorder*
I know it was in overseas text books there was similarities between what the person I worked with and what was in the textbook

(Angela, 23, 21)

In summing up, the counsellors managed their justification of their construction of RA as reality, or "truth", by the credible client discourse. They explained that no-one would want to make RA up, there was convincing detail and consistency in the clients' narratives, a common symptomology, and believable risk. However, further reasons for belief despite the lack of physical evidence might be required by some audiences. To address this, participants moved past the *credible client* discourse and into the empirical war zone, and at the same time the constructionist world, of relative truths. Truth was not necessarily singular and universal, but multiple, and relative to its context. What was truth for the client, and the counsellor, was not necessarily truth to a jury; the counsellors therefore constructed *legal truth*. They provided insight into how reflexivity allowed their own doubts to be managed, in the section on the *counsellor's truth*. Here it is explained that although they had constructed RA as reality, this did not mean that all doubts were eliminated, as might be expected in a *legal* truth. Finally, they discussed the significance of another equally truth constructed by the client, *the client's truth.*

A Legal Truth

Legal truth was constructed as truth generally supported by physical evidence; as a discourse it was furnished with a linguistic repertoire of *legal, lawyer, court case, actually true, proof, evidence, clinical.* Legal truth was also termed *clinical* truth, by Keri, indicating that the legal system and the medical establishment were both informed by positivist epistemologies. Madeline talks about the need for physical evidence behind legal truth, but Timothy talks about the way

legal truth can also be constructed linguistically in such a way that the powerful consequences of language in action are made to occur even without physical evidence. Keri ends with a response echoed by most of the counsellors, by positioning herself outside the legal world, and expressing a preference not to have to investigate legal truth; the client's subjective experience, valued in social constructionism but outside the bounds of scientific empiricism, is what is important. Madeline also expresses this, using extrematisation for emphasis: she would *always* work with someone according to what they *believed*, *unless* they needed proof for legal purposes.

Keri *I'm not a lawyer(.) and my purpose is other than proving someone right or wrong(.) It's not my purpose or my focus, to determine what is clinically true or not clinically true 'cause CLINICALLY true is what they're presenting*

Sylvia *(.hh) that's a legal issue isn't it*

Keri *Yeah yes actually true mm you know*

(Keri, 18-21)

Madeline *It's very hard to find evidence.*
I would always work with someone according to what she or he (.)believed and how that affected them now, and help them in that way, unless that person needed proof (.)I mean some people come along and then want to find out who did it and prosecute them or whatever.

(Madeline, 2, 14-15)

Timothy *The evidential interviewing type stuff. It becomes a legal issue. And I think(.) this is one of the complexities of the human mind. If you really want to be wanted and you don't like your stepfather, you can make a story and someone might tell you a story (.hh)or(.) and you can crucify them. And if they automatically believe the kid and then they can feed the kid and these leading questions and (.hh)we know where psychologists have been in leading questions and um(.hh)(hhh) I teach this(.) - open questions but not leading questions, and I see this in the court*

(Timothy, 59-60)

Keri *I'm just really glad that I don't have to prove anything you know in my work, and ACC doesn't require me to prove anything. All it requires is that um I s:: I report the client's experience.*

(Keri, 24)

The people who have taken things through to court I've absolutely believed.

(Keri, 24-25)

The counsellor's truth

The counsellors, having constructed RA as reality in Chapter Five, also acknowledged that it was not always easy to believe the accounts. Most presented a consistent two step response to the doubts: the first was a period of personal reflexivity, regarding their subjective response to another's claim of *truth*. A scientifically neutral stance, from which one might judge facticity, was not entertained.

Sarah *if they're telling me (.hh)something that um(.) I'm thinking it's unbelievable, then I need to be doing some (.hh)reflection myself to think what is it about this that's unbelievable and why am I feeling this way.*

(Sarah, 48)

Angela *It didn't seem real and yet - I knew that it probably was? but there's part of me(.) that um(.) - like I was examining my own response, which you're supposed to do as a counsellor*

(Angela, 40)

Rachel *so if there was a(.) if there was a little question mark in there I would need to be(.) um(.) (.hh)doing my own process at that point. (.hh)I would need to be looking at me::: and who I am in this and why is there a question mark? What's happening inside of me that is creating this question mark, is this story just too difficult for me (.)to be listening to? Am I trying to minimise (.hh)what they're saying (.hh)because it's too difficult for me to listen to what has happened, is this about*

the CLIENT, is this about me(.) (2)is it a crossover of both(.) And that would require(.) um(.)((tch)) a lot of soul searching in in me.

(Rachel 27-29)

The second step was to confer with their supervisor, who generally confirmed for them that RA was a physical reality, and sometimes encouraged them to ask questions of the client in order to make sense of, or check out, the narrative. The words *confirm*, *check*, *inconsistency*, and *question*, featured in this linguistic discourse of *checking*. To an outsider, this recourse to supervision would seem to be a normal and expected step. However the moral stake of *concern for the client* created an unexpected dilemmic tension for the counsellors; it transformed supervision from a neutral response, into a value laden judgement call. Out of concern for the client, counsellors did not want to appear to be doubting the client (the reason why is explained in *the client's truth*), yet the consultations with supervisors were for the very purpose of acknowledging and exploring such doubts.

Sarah, Angela and Rachel talk about their doubts of RA below, and their recourse to supervision. Rachel justifies her consultation by explaining it would not be fair on the client to counsel them while doubting. Sarah emphasises that even while she has questions, this does not mean that she doubts the client's integrity.

Rachel *taking that to supervision, 'cause I certainly don't think that it would be helpful(1) (.hh)um(2) if(1) I am(.) closing down the client by my own doubts*

(Rachel, 29)

Sarah *we would reflect upon that and um think about some particular questions we'd go through (.hh)um probably between us and then perhaps some questions that I could go back and (.hh)talk to the client and when I say questions I'm not going back to question their integrity*

(Sarah, 48-49)

The supervisor often provided confirmation of RA, a strong factor in the construction of *the counsellors' truth.* Timothy found it necessary to warrant voice for his supervisor when she

confirms the reality of RA, by drawing from the linguistic repertoire of the *government backing* discourse.

Angela *That supervision session kind of confirmed for me that yes this does happen that it's real?*

(Angela, 39)

Timothy *When I(.) related the story, and then related what I was doing and how I was doing it(.hh) .)she would say(2) I know that(.)situation. And so she kind of or know that person or that rings a bell for me. And as I talked and shared with my supervisor, (.hh)(hhh)she checked out my authenticity my:::: saneness {my} ((laughs)) all those things, (.hh)to make me believe and realise that yes my supervisor (.hh) who was a M:::::ember of New Zealand Psychotherapists and New Zealand Association of Counsellors and had psychiatric background in training as well, so I believe it's there I believe it's (hhh)(2) there but it's not overt*

(Timothy, 17-19)

The moral need to justify going to the supervisor with doubts, when they were also treating the client's account as true, was dealt with in such a way that also took care of what Potter and Wetherell (1987) call *self presentation* or *impression management*. The counsellors accounted for their need to gain confirmation from their supervisors, in a way that evaluated themselves as responsible counsellors.

Sarah *And so then I need to per-perhaps (.hh)um take that to supervision? um (.)and I think that would fit with the code of ethics*

(Sarah, 48)

Timothy *I believe my responsibility as a (.)counsellor was to(.hh) to::: make sure that it was authentic, and not to come and say this(.) say to the client I don't believe what you're talking about. I needed to know (.hh) because it wouldn't have been fair on the client*

(Timothy, 22-23)

The texts in which Timothy explains the way in which he sought to justify his own *counsellor's truth,* show interesting variation to the consistency. Surprisingly to the reader, his reasonable desire to assuage his doubts conflicted with the unspoken ongoing moral stake of concern for the client. Assuaging doubts involved checking up on the client's narrative, with the accompanying moral dilemma; the counsellor must trust the client. An example of the management of this dilemma is in these imperative sentences: *I had to do it for me to make sure that I was professional* and *it was so: horrific, that I needed to.* The discursive achievement of these texts was to offer an explanation and what to the reader was a maybe unnecessary excuse for his actions, but one which answered his personal moral dilemma. The need to appear to believe the client led to the variability in the form of contradiction in these two lines: *not that I didn't believe him but I thought(.hh)(hh) this is incredibly big stuff* and *why don't you believe this, and I said it's not that I don't believe it.* His belief in *the client's truth* conflicted with *the counsellor's truth*. Timothy's desire to safeguard the client from knowing he had his doubts, is constructed in *I never told him, I never said what I did*; and *it's just walking step by step with a person (.hh) helping them* gives a final positive evaluation of his actions as a counsellor.

Timothy *and when the client said it happened at such and such a place, what I did (.)is during the week I would go around and see if there was such a place. So I checked out locations and I checked out situations and I checked out the descriptions that he'd given. I thought for me::::(.) (.hh) because it was so: horrific, that I needed to(.) (.hh) confirm for me - not that I didn't believe him but I thought(.hh)(hh) this is incredibly big stuff here, and(.(.hh)(hh) am I(.) being fooled or and I want to be genuine and I don't want to be taken for a ride so to speak. And so I CHECKED OUT(1) that it all fitted in. I checked out his story, I had to do that for me::: (.hh)(.)to make sure that I(.) was professional*

(Timothy 17-18)

Timothy *I would talk to my supervisor about it, and she says why do you think it's uncertain, why do you think it's not clear, or why don't you believe this, and I said it's not that I don't believe it, I don't want my time wasted(.) I'm very strong on reality(.) and we talked about watching for inconsistencies in the stories.*
I never told him, I never said what I did. I did it for me::::. ((clears throat))(2) if ritual abuse happened, when it's like sexual abuse, it's like any abuse - (.hh)you

listen to the consistencies you listen for the inconsistencies. And so it's just walking step by step with a person (.hh) helping them.

(Timothy 21, 34)

The counsellors therefore while constructing RA as a reality, or *truth*, at the same time resisted being positioned in a scientific ontology of absolutes. They maintained the right to entertain and investigate their own doubts. Their *counsellor's truth* was a working device, necessary in therapy, and subject to change and discussion. It was held separate from *legal truth*, and also from *the client's truth*, which is looked at next. The counsellors' views once again reflected a social constructionist framework, in which truth was contextual, subjective and many facetted, rather than singular, neutral, and fixed. This concept is explored further in the *client's truth*.

The client's truth

Although relative truth is a tenet of social constructionism, only one participant talked about how the epistemological underpinnings of social constructionism affected her view of the RA *client's truth*. Sarah constructs the representational meaning of the word *truth* as *a very religious notion, fixed, only one*, and therefore limiting. She uses pictorial metaphors, *standing back* and *stepping away*, to illustrate her feelings towards the word. Instead of *truth*, she prefers the word *ideas*, which again she illustrates metaphorically: ideas are not finite, they have *movement.*

Sarah *I don't think I'd sort of go with your word of truths, 'cause I yeah I tend to stand back from that, and I probably use the word ideas because I think ideas has movement available in it and I like the idea of there being movement. And it also allows there's multi stories, there's many stories there's not just one story of um a person(.) yeah(3)*

(Sarah, 40-41)

The metaphor of *multi stories* provides us clearly with the constructionist discourse of *constructed truth*. It is therefore something implicitly available to the client also; her use of the word *people* is inclusive. Truth is something all people construct, they may construct more than one truth, and these may change depending on their situatedness. She goes on to talk about the way this very openness to change is a necessary part of the therapeutic process. Again speaking

metaphorically, in the areas of building a construction, she explains that the many constructions of truth provide *room to work* and *room to move*.

Sarah *I STEP AWAY from saying the word truth because I keep it that it is their experience and their understanding and what makes sense to them, and that gives me room to work with what it is. I think that um(.) people can construct things in(.)various ways. It can be constructed depending on your (.hh)um particular outlook, your position that you're in, um what other discourses are intercepting with what's going on for you, um how you're positioned in those discourses, and the kind of discursive type practices that you engage in um(.hh) So I think that um truth per se is probably a um I think of it more as a very religious in some respects, a very religious notion, and I think it's an idea but I don't give it a sort of a um(.hh) - I sort of step away from it being fixed, you know, that there is a fixed truth to what there is because as I said, that doesn't give me a lot of room to move or to work with. Because if there's only one truth, if there's only that truth about that situation, then I'm not(.) I'm stepping away from the idea, we're multi storied. We are constructed, we're socially constructed.*

(Sarah, 35-36)

Other counsellors echoed the *multi storied* metaphor that a *client's truth* should be something which allowed *room*, or *space*, in which the client could *grow*. Rachel talks about *what's real for them*, and calls it a *freedom*. Keri talks about working with *whatever someone presents*. The latter referred to what the client constructed, or *the client's truth.*

Rachel *I wouldn't want to get in the way of that, I wouldn't want to to start digging around and asking things that is ahead of where the client wants to be? just staying(.) alongside them and looking with them , where they are. . It's what's real for them(.) yeah allowing them the space(.) to grow in the freedom*
Go with the client's truth and work with their truth and work with them in their process and allow that(.) to unfold however, whatever way

(Rachel, 25,37)

Keri *I will work with whatever someone presents? whether that's for um(.) you know the symbolic value to the person of presenting something in a particular way I think is really important because if that's how they see and experience something , I'm not going to argue them out of it(.hh)*

(Keri, 6)

Accepting the client's truth: a moral discourse

Sarah constructs responsibility by employing a strong first person account. In a subjective account of her experience nursing in a hospital, she constructs the need for a therapist to believe their client's truth, as similar to the need to believe a patient's physical pain. Her patient, she believed, was the expert on their pain levels, and in the same way, the client was the expert on their life, constructed as *the client's truth*.

Sarah *I guess that's part of my philosophy n(.) you know, that people are the experts in their own lives, and um that who am I to decide whether you know I would con-consider that an extreme (abuse?) of my position as a counsellor to um suggest that that memory is not true.*
When I was working in a hospital I remember saying to a doctor I said look , could you just chart her some IV morphine(.) and um we can provide her with the pain relief (.hh) it never occurred to me to DOUBT what that person was saying, they had had all this surgery and they were in this pain. That was recognising(.) that person knew what was going on for them. Who was I (.)to be saying oh gee I don't want to give this person any morphine.

(Sarah, 11, 44)

As well as accepting the right for the client to declare truth from their standpoint, the counsellors also declared their respect for that right. This strong moral discourse drew on an interpretive repertoire of *respect for the client,* which was supported by an interpretive repertoire rich in easily understood colloquialisms from the culturally available linguistic resources: *it's not my place, it's not up to me, I'm not a lawyer, sit in judgement, believe, honour, respect.*

Rose *a client's truth is always their interpretation of what's happened to them. um(.) but I would take the stance that I would believe them, unless I had evidence to suggest that what they're telling me was untrue. Yeah I think that would be disrespectful to(.)come from a place of not believing a client that came to talk. A part of establishing trust is(.) to trust what - I will honour them and respect them.*

(Rose, 14-15)

Rachel *it's not(.) my place(.) to go (.hh)and say HEY(1) this is cha::::nged(.) you can't be telling the tru::th. (.hh)and it isn't it isn't my pla::::ce to go(.) um(.) and sit in judgement. I don't need to be(.) (hhh)poking around(.) and(.) with a with a um ((tch)) I feel(.) a::h(.) a doubting mind (inaudible).*

(Rachel, 25, 36)

Sarah *(.hh) um(hhh) I think again it's um(.) it's not up to(.) me to(.) say to the person it's not believable*

(Sarah, 48)

Keri *I mean I s::till will work with whatever someone presents? I'm not going to argue them out of it(.hh) (.) ahm and I'm not a lawyer either ((laughter)), so they don't have to prove it to me.*
Who am I to say it(.) didn't happen

(Keri, 6, 51)

The moral imperative to believe *the client's truth* can be seen as part of the ongoing guidance provided by the moral stake of *concern for the client*. This ongoing orientation on the part of the counsellors ruled that the *client's truth* should not be doubted or challenged, because this might be harmful to the client. The participants in this study also drew in their audience, and gave the audience agency, and thus responsibility, by a personal pronoun: Jennifer's use of *you* in *y'know*, and Timothy's use of the word *you* throughout his text. There is evaluative moral force in the words *impact, abusing* and *bigger problem,* which construct voicing doubt, to the client, as unethical and morally unjustifiable.

Keri *I'm aware of the(.) impact on the person, of having probably <u>lots</u> of people not believe them, if that was their reality.*

(Keri, 51)

Jennifer *there's a(.) a thing about(.) um(.) an ethical principle of doing no harm. So if I(.) disbelieved or said " I want to get your police records or(.)" It's not my right really. Y'know I've got to um(.) value and respect that client <u>where they are</u>.*

(Jennifer, 23-24)

Rachel *Um I I wouldn't see myself as being an effective or <u>helpful</u>(.) person? if I'm(.) disbelieving them. I would feel like I was(.) am abusing them(.) actually by sitting there and going(.)((tch)) hmm? not sure that this is true.*

(Rachel, 25)

Timothy *there are risks. (2) because it can be so unbelievable(1) that you don't believe it (.)and therefore I think you can easily portray that. (.hh) (1) you can <u>soft pedal it</u> or <u>minimise</u> it (1) to the extent that it doesn't help(.) it just leaves a bigger problem*

(Timothy, 37-38)

Variability

Overall then, the client's truth was constructed by the counsellors as an account to be respected, and worked with in the therapeutic process of healing. It was not to be doubted or questioned, firstly out of respect for the client, and secondly because it could cause harm to the client. Three interesting exceptions emerge, and even these are carefully managed so that the client's truth is challenged subtly or constructively, and the client respected. In the first, Madeline says if she thought the client's truth was *mistaken*, she would not challenge their truth by saying *this is the truth,* but she would suggest alternative accounts.

Madeline *I would always work with someone according to what she or he (.)believed and how that affected them <u>now</u>, and help them in <u>that</u> way. and that's <u>their</u> truth that's right. (.hh)Um again I'm thinking of the two that I did know(.) um(2) I*

don't think I ever got to the point with either of them that I believed it had happened, I think they may be mistaken about what happened to them um and she came round to thinking about it(.) quite differently(.), because of the questions I raised. (.hh)I wasn't saying this is the truth, I was just saying have you considered the alternatives.

(Madeline, 19-20)

In the second, Timothy felt a strong personal need for some phenomenological verification for his *counsellor's truth*, but would not allow this to compromise the moral stake, the need to avoid voicing doubts to the client. In this short text of his on this topic, the linguistic repertoire is anchored by two metaphors with strong pictorial impact: the differentiation between reality and fantasy is *where the rubber hits the road* and *a great big game.* Equally powerful supporting words are *wasted, genuineness, strong, reality.*

Timothy *I don't want my time wasted(.) (.hh)um and when I work with this person we're working in a place of genuineness and reality, we're not just playing a great big game. And I'm very strong on reality(.) it's (.hh)I've got to work with people where the rubber hits the road and that's my expression*

(Timothy, 21)

In the third example, Keri broaches the topic of the client who has *made something up*. This is respectfully reconstructed as *kind of embellished;* once again the moral stake of *concern for the client* means that rather than challenging the client's truth, she looks at the client's problem.

Keri *Even when people have you know made something up(.) and I know that(1) people have kind of embellished things at times over the years(.) but I would say it's not y'know it's(.) um oh there's a few that I've thought no that doesn't ring true(.)um(.) but there's still a problem you know and the fact that they have told it like that is part of the bigger problem. So I'm interested in the problem they're actually presenting with.*

(Keri, 24-25)

Summary

The three exceptions noted in *Variability* are part of the larger collage, in which the discourse *the credible client* plays a strong role. All counsellors maintained their right to investigate doubts about *the client's truth* with their supervisors, but remained sanguine about the need for hard evidence, as might be required for a *legal truth*. They were in varying degrees, reluctant to judge the facticity of *the client's truth*, which decision was subject to both a moral discourse and concern for working with the client. Their *counsellor's truth* was arrived at with their supervisor. Timothy and Madeline expressed something more forceful regarding truth, a "need to know" for their own and mostly unacknowledged *counsellor's truth*, regarding whether or not *the client's truth* did indeed represent a physical happening. Did RA really occur as the client explained, or not? Such "outliers" might be omitted from a scientific experiment, but they are to be included in discourse analysis because they are part of a whole, and because they raise important questions which throw further light on the discussion. In this study, Timothy and Madeline's doubts are representative of those who find the horrors of RA hard to credit in an age of civilisation. These doubts link the talk to another contentious area of unproven veracity in which there is ongoing debate; recovered memories, which is looked at in the following chapter.

Chapter Seven

Recovered memories

Introduction

Abuse memories, whether of RA, CSA, or SA, when forgotten then remembered, are termed *recovered memories*. The polemical debate over their usefulness and veracity has produced strongly conflicting research in the world of psychological research, where it is fuelled by the dyadic but often irreconcilable drives for sound therapeutic practice and legal justice. Recovered memories are constructed differently by various professional groups, all of whom are informed by different conflations of stake, interest, epistemology, and subjective experience. Two main groups emerge, sceptics and heuristics, as described in the literature review. The participants reflect the pragmatic qualities of the heuristics' group. This chapter looks at the participants' construction of recovered memories, and also their assessment of scientific findings on recovered memory by such groups as the False Memory Syndrome Foundation.

Scepticism and heuristics

As shown in the literature review, the group named "sceptics" align themselves with the aims of the FMSF; they may also have a moral and/or financial interest, or stake, in producing the scientific and medical backing needed to combat RA claims. The aim of their research is to produce cognitive evidence to be used in court, to exonerate those accused, on the basis of recovered memories, of perpetrating childhood sexual abuse (Bloom, 1994; FMSF, 2008). They are therefore concerned with constructing a *legal truth.* They allege that the ability of the mind to receive implanted memories, or to remember incorrectly things temporarily forgotten, invalidates recovered memories. The group called heuristics, in contrast, represents counsellors who remain uncommitted to such a universal and singular truth; they contend that common sense dictates that some of the memories will be correct, and in the interests of therapy, recovered memories are a part of *the client's truth,* to be honoured and worked with.

When examining recovered memories *per se*, the participants in this study were not generally concerned with a scientific or *legal truth*, but having invested in a moral stake of concern for the

client, tended to be pragmatic about the dual possibility of recovered memories being valid and/or representationally correct. Their aim was to provide effective therapy for their clients, rather than generate research findings on the factual nature or otherwise of recovered memories. Their working approach to recovered memories was more social constructionist in orientation than essentialist or cognitive, and had some similarities to the DAM described in Chapter Three.

In this analytic model, there is no need to make a decision regarding scientific fact and proof, such as would be required in a legal setting. Therapeutic work takes place linguistically rather than empirically, so for counsellors there is an emphasis on the external construction of recounted memories rather than the internal intrapsychic functions of the mind. In the first stage, the action section, the memory is constructed in talk, rather than cognitively summoned. This external linguistic construction is able to be examined by the counsellor for stake and interest; the memories can be worked with to establish the interests of the perpetrator and victim, which may be unclear to the client. Accountability and agency can also be looked at, and the therapist can examine the constructions given by the client is to help the client re-assign accountability and agency to the perpetrator rather than the abused, on the basis of the recovered memories. The therapist is working with memories that are linguistically constructed, and the psychology of healing is engaged with through this same external linguistic medium.

Participants avoided the supposedly conclusive true/false findings of cognitive memory evaluation, the results of scientific experiment or laboratory evaluation. Instead, they constructed recovered memories in a variety of ways, most of which resisted a scientific epistemology by privileging contextual constructions. Memory was constructed as a *twilight zone*, affected by context, in which anyone might remember correctly or incorrectly, much as moving images can be clear or varyingly vague in twilight. Memory repression was constructed as a coping mechanism, which permitted traumatic childhood memories to be forgotten until triggered into the conscious mind in adulthood. The memories might become fragmented or change during this process, and some might or might not be remembered correctly, by the same person. This became the main discourse for this section: *memory is a twilight zone*.

The first excerpts in the counsellors' discursive work introduce the discourse *memory is a twilight zone,* by constructing memory as not always clear.

Memory is a twilight zone

Participants concurred that sometimes memory was clear, but it was not necessarily always so; in Rachel's example, she used the authority of a first person account, and invoked common sense, to establish this discursively. The implication that she had not been traumatised like an RA client, yet still sometimes remembered wrongly, allowed RA clients to also remember incorrectly. Keri gives a visual metaphor of a *twilight zone*, with the words *hazy* and *doubt*, conveyed the blurring that might occur naturally, then be increased by perpetrators' denial of abuse. The discursive achievement of such excerpts was to construct the reality that memory may be both clear and unclear, depending on the person's context. This lays a foundation which enables the later construction of memories as fragmented or missing.

Rachel *I MEAN FOR ME it's not as clear? and as sharp? as it would have been(.) as of (.)yes:terday?*

(Rachel, 36)

Keri *Like some people their memories are unequivocal,there's not a question of a doubt, but for other people(1) mmm - Y'know especially if they haven't spoken about something for a long time - if they're starting to speak about something and it's been more than ten years maybe, or more than twenty, um it becomes very hazy and(.) once again, oh to me, a real strong twilight zone feeling. Particularly if their context has(.) ah(.) denied any(.) denied their experience, like "no that didn't happen to you" um "you shouldn't be feeling like this thinking like this"…. and well often the abuser you know(.) is presenting it as something else "well it was just a game or y'know just fun" 'n all that stuff "you gave con- you wanted it anyway and you started it" you know until people doubt themselves so much that they have no idea whether they're making it all up.*

(Keri, 18-20)

Memory repression is a coping mechanism

Repressed memory after childhood abuse was constructed in definite terms, firstly as a coping mechanism, then as a possible indication of childhood abuse. In both cases, the participants

warranted voice before pronouncing on this controversial issue. They drew from the linguistic repertoire which is a part of the *government backing* discourse, Angela by using the medical term *coping mechanisms*, and Sarah by mentioning again her work in sexual abuse, which the interviewer knew was government funded.

Angela *Sometimes even with abuse that's not even Satanic um people develop just develop coping mechanisms to help them get on with their life . Sometimes um they're able to block out the memories for quite some time.*

(Angela, 5)

Sarah *I'm probably thinking a little about um my understanding of and working in sexual abuse(.hh) I should say that(.hh) for some people um that(.) there's not a lot of memory for them about their childhood and that sometimes that's quite indicative that there's been abuse in their childhood.*

(Sarah, 10)

Triggered memories

The well known metaphor of a trigger was used to construct the notion that memories forgotten in childhood could later be *triggered* into being consciously known, in adulthood. This was a consistent finding across all participants. The metaphor implied that something of quite enormous impact would follow, in this case, the memories of abuse. The accompanying linguistic repertoire included more metaphors containing vivid imagery, to emphasise the force of the event: *locked in, bang, the floodgates open, away they go, panic attacks.*

Angela *and it's not until um something happens or they see or hear something or watch a TV programme that it can actually trigger um (.)some of the abuse.*

(Angela, 5)

Erin *I think the older a person gets(.) the more difficult it is for them to control(.) the subconscious.*

In the clients I have seen they really do(.) range in age(1) from say(2) thirty up to(.) sixty five? And smell might trigger, or a tone of voice? (.hh)Voice that's(.) u::m like the perpetrator's?(1) would trigger off a memory that's been locked(.) in

(Erin, 4-6)

Jennifer *Sometimes the memories get triggered by something that happens in their life? Twenty years or thirty years down the track? See something on television(.) meet a person again or some and bang the floodgates open and away they go(.) And then they're getting the having the flashbacks and the intrusive memories and the(.) nightmares and you know the whole lot(.) panic attacks and mm*

Sylvia *(.hh) So you feel it is possible for some people who have been through trauma to block it out and then later remember it*

Jennifer *yeah YES Well I've se- I I've worked with people who have had their memories(.) triggered mm mm(1) after many years. Adults adults ADULTS! and it happened to them a long time ago, you know yeah, thirty years or thirty or forty years previously*

(Jennifer, 37-39)

Constructing fragmentation and change

How these recovered memories might present in adulthood was constructed around a discourse of *fragmentation and change*, supported by a linguistic repertoire of *images, picture, jigsaw,* and *collage*, implying separated pieces which did not *hang together*. The image of *change* was sustained in the words *journey*, *evolution.* The visual repertoire borrowed mildly from a scientific epistemology, giving the construction positivistic power. The function of Keri's word *haunting* was to remind the reader that the client was not fabricating the memories, but rather being followed independently by them, adding to the construction of recovered memories as a reality resulting from memory repression.

Keri *I'm just thinking about that first woman that I saw(3) I had(.) fragmentary images of things that she referred to(.) so I could not get any clear picture. Because I was still new to the field(1) I was also sceptical as I said(1) but now like I have a different view about fragmentation too and why memory is fragmented like that*

'cause a lot of things ah traumatic things happen(1)many people ah have fragmentary memories - you know things don't hang together it's(.) it's um part of the healing(.)a being able to have narrative about what happened(.) and people have got this sort of fractured zigsaw out there(.) it's like a a haunting collage I guess(.)

(Keri, 16-17)

Timothy *They can often remember the feeling, but may not remember the experience. Or they may remember the experience but they kind of have no feelings*

(Timothy, 34)

Rachel *they're going to start remembering things and associating things with all <u>different</u> things along(.) the way and that's just(.) I see it as a <u>process</u>, a growth almo- an evolution? a journey for <u>them</u>(.)*

(Rachel, 37)

Objective and subjective validation for recovered memories

Angela positions herself within an "objective" scientific ontology to suggest age limits to recovered memories. Rather than weaken the construction of memories as recoverable, the suggestion that it might not be possible to remember events from below a very young age, functions rather to reinforce the notion of recovered memories. It implies that it is still possible to remember repressed memories, albeit at a later age. Because she has cited clinical findings, her observation implies scientific backing. She talks about *looking objectively*, *frequency*, *levels*, *ages*, using a positivist linguistic toolkit in which phenomena is measurable and observed, and such observations are presumed to be made objectively.

Timothy, highly trained and aware of medical findings on the inability to remember before the age of three, deliberately steps away from the dominant discourse in his argument. Instead he speaks about recovered memories from within what can be seen as a social constructionist ontology, where subjective contextual experience is regarded as worthy of study, and may be constructed linguistically. He grounds his knowledge claims in the authority of personal experience, using detailed and vivid description, as if the experience were being relived, which

categorises him as a credible witness (Edwards & Potter, 1992). He recounts a subjective experience of his own which involves recovered memories. His account is challenging to an empirical argument, partly because of the authority of the first-person account, and also because he has deliberately used words which although unquantifiable, are powerful enough to undermine scientific findings: *homesick, crying, rejected, experience, wanted.* The function of this combination is to offer resistance to the power of the scientific discourse which disputes recovered memories.

Angela *If I was like looking at this objectively I'd have to say that I would it would depend a lot on the age of the child or person that was abused, like when it happened. The frequency of it because if it happened over a long period of time and was um (.)ongoing, I think it's possible that um (.)it would depend on um like the developmental levels of the child and the ages. But, I think it's possible that a child or a young person would have um(.)memories of that as an adult.*

(Angela, 4-5)

Timothy *Repressed memories, recovered memories, I find that in myself. For example I'm always I'm I get very homesick(.) I'm terrible. I'm really terrible and I never knew why(.) and ((clears throat))one night when I was only about when I was twenty six, saying "I've got to go away why do I have to go away" and crying (1) and I just lay there(.) and I went right back. And at eighteen months old(.) I was put in the [location] hospital with polio and put in complete isolation. I remembered that as if it happened yesterday(.) I worked through that and I thought my parents never wanted me (.hh). I felt rejected (.) But what I did is I thought about it in my adult mind, and I went back to my childhood and I cried and cried. I've been back to that hospital. Someone said "you don't remember it". I took people. I went back and I said to wife "see that window there in the hospital? That's the room I was in, that's the window I looked out of(.) and I can remember being in a cot and I can remember standing with my feet in a cot. I can remember being strung up(.) I remember what I was dressed i(.) I can remember what I was fed. It was such a traumatic experience at eighteen months(.)to be put into hospital and I thought my parents never wanted me. The reason why, that they lived [location], visiting was two days a week, a Tuesday and a Thursday from two to three, they had to*

[occupation] and they had there were three other [relatives](.) older than me so they couldn't come and see me(.) But you see it goes way back and then so the memories that were there that have just come out. And now when I go away now I say I don't want to go away, so I get into my rational adult mind and I think about it and say [name] hey(.) you're coming home. I should stay in [location of work] over night - I don't I come back home every night ((laughs)) and that's what I want, and that works for me.

So from experience(.) repressed memories (.hh) and recovered memories.

(Timothy, 54-59)

Having constructed recovered memories as possible, the participants then turned to another part of this study, which was to discuss cognitive and experimental studies which supposedly disprove recovered memories, such as the *Lost in the mall* experiment.

Lost in the Mall

The participants were given the opportunity to talk about a famous experiment conducted by a member of the False Memory Syndrome Foundation, Elizabeth Loftus (Loftus & Ketcham, 1994). Loftus hypothesised that false memories could be implanted, then adopted by the recipient as their own, and achieved this in her experiment *Lost in the mall*. In the experiment, trusted family members told a younger relative anecdotes of their childhood, and included a fictitious time in which the younger relative was lost in a shopping mall, and delivered safely back by an elderly woman. Twenty five percent of participants said they remembered the false memory. The recovered implanted memories of the subject in the experiment were then shown to be invalid, and the findings generalised to discredit all recovered memories.

Loftus subsequently constituted all recovered and repressed memories as fraudulent myth (Loftus & Ketcham, 1994) in various publications, including a book she co-authored with Ketcham, entitled *The myth of false memory: False memories and allegations of sexual abuse* (Loftus & Ketcham, 1994). She later talks of the need to cause non-scientists to comply with her findings (Loftus, 1993), and urged all therapists to reject recovered memories that are scientifically unsubstantiated. The participants in this New Zealand study discussed whether or not such experiments disproved recovered memories. Participants constructed the Lost in the Mall

experiment, firstly as motivated by stake, then as insubstantial, and finally as inconclusive. The counsellors strongly resisted the notion of a universal truth being drawn from the study, in this case the universal truth being Loftus' generalisation, that all recovered memories were invalid.

Investigating stake

In a scientific world, stake and interest are presumed not to exist; neutrality is assumed to be established by the methodology used. However, in the understandings of social constructionism, and in discourse analysis, no study is neutral, but recognised as contextually embedded and value laden. Stake and interest are therefore significant. Sarah, professedly social constructionist, assumes that there will be a stake of some sort for the experimenters; Erin's discourse goes further by excoriating the experimenters' interests, which she strongly implies are, that they themselves are involved as perpetrators, and therefore have a stake in discrediting RA clients. She gives strong negative judgement.

Sarah *Well hearing that they're a foundation suggests to me that they have a vested well some kind of interest in um perhaps um proving that there isn't such a thing as a memory that can be brought back.*

(Sarah, 8)

Erin *My question would be that if the people set that up in such a way(.) um(.) what was their purpose for doing it?*
There is only something (in it) for the ones who are trying to cover it up? to gain by covering it up and discrediting those individuals(.) that they've um(.) ritualised - then it becomes quite heinous really.
Sylvia *you're looking at the motives of the people who =*
[ ]
Erin *yes I am*
Sylvia *=are conducting these experiments(.) mm*
Erin *I don't know that they're all ((laughs)) start out as experiments. We:::ll(1) probably a highly organised one to discredit individuals who have had this done to them probably.*

(Erin, 3, 6)

Constructing insubstantiality

The counsellors were consistent in their dissatisfaction with the Lost in the Mall experiment; they constructed it as *insubstantial*. The linguistic repertoire for this purpose included *doesn't begin to address, tweaked*, not *robust, doesn't go to the heart of things*. Sarah, who has stated her social constructionist epistemology, says *as we understand more about memory* implying that the scientific findings are only a small and debatable part of a changing knowledge about memory. Rachel implies that the lack of substance is partly caused by scientists measuring what they have created.

Rose *I think that um the experiment doesn't(.) begin to(3) to address the stories that are told by people that(.) that match up with each other. I think when people(.) I I think people's memories are VALID, it would be their own interpretation of what happened to them(.), um(2) you know I don't think that experiment(.) is a basis to(.) discard(.) um peoples' stories, and peoples' memories.*

(Rose, 3-4)

Sarah *No I don't think it tends to provide a lot of evidence, I don't think that it decides anything on a general basis, and I think that as we understand more about memory, and I'm reading more about memory, I don't think that um this really from just reading those few details, doesn't tend to go to the heart of things for me.*

(Sarah, 8-9)

Rachel *mmmmm it just seems a bit(.) not qui:te substa::ntial or(1) research I think. For me(.) I'm just thinking um(1) you know research can be(.) tweaked in ways you know? They can researchers can often get(.) what they're looking for, you know the end result of what they're looking for u:::m(.) and yeah just that study(.) of the {the combination of it having}(.) you know the relative(1) and it just doesn't se::em yeah like a robust(.) sort of yeah study(.) to me? Mm pa:rtly because it's a relative, ye::ah and it is o::ne(1) piece of research. So it just(.) yeah(.) NO.*

(Rachel, 3-4)

Questioning science

Madeline and Keri both position themselves scientifically to counter the Lost in the Mall experiment. They cite an equally famous study (Yoder, 1999) which contradicts it. In the study, women who had been hospitalised for abuse in childhood, were asked in adulthood if they could recall their abuse. Despite the hospital records, 38% of the women either could not recall, or had difficulty recalling, their early abuse, thus proving the possibility of repressed memories of abuse in childhood. Because science tends to look for a single universal truth, the Lost in the Mall study is effectively reduced to an epiphenomenon. Both use scientific nomenclature to construct their arguments: *prove, proof, generalise, experiment, hosptialised, significant, denial, repression.* Erin and Jennifer also question the ethicality of the scientific method used.

Madeline *Doesn't prove anything either way. I think a memory is much too complicated, and yes it's possible for (.hh)especially children to be convinced that something happened, but there's equally research about things that DID happened, and that there's PROOF that they happened. There's one (.hh)particularly famous study and the adults who for whom there's proof they were abused don't remember it(.) until it's brought up. So it works both ways and you can't generalise (.hh)so it doesn't prove that it didn't happen ((laughs))*

(Madeline, 3)

Keri *I remember that um experiment I heard about really earlier where(.) some people I think they had been hospitalised ah for I think it was for battering(.) Some of it may have been for sexual abuse as well. See I can't even remember now ((laughs))*

Sylvia *I can't remember what I did last week to be honest ((laughter))*

Keri *((laughter)) Um and they had been hospitalised so there were records. Yes, and they were interviewed some time a- in their forties and a significant number of people had no recollection of anything happening at all…..*
Yeah and whether that's you know denial repression or whatever, 'cause of course people can successfully forget (.)something.

(Keri, 20-21)

Erin *(.hh)the individuals that they used , were they already familiar with them (.hh)and were those particular people(.) compliant to participate to prove their point?*

(Erin, 3)

Jennifer *And so I suppose that False Memory Syndrome came up there, when they the children were being interviewed. Were they(.) swayed in some way by the interviewee or their parents or whatever.*

(Jennifer, 37)

Constructing an epiphenomenon

The counsellors therefore eschewed a study which generated from its hypothesis a single universal answer which provided no ground for their moral stake, concern for the client, and disallowed their experience, both personal and professional. Jennifer refutes the generalisation. Keri challenges the limitation of constructing memory as simply true or false.

Jennifer *I'm sure that some children are susceptible, but that doesn't mean to say that they all are. Mm(.) so so although possibly(.) some people do have false memory(.) syndrome then - but you couldn't say that a hundred percent of people(.) are like that.*

(Jennifer, 4-5)

Keri *I think memory is incredibly plastic. You know I've seen lots of experiments like that on TV I've read about them. You know I've studied them.*
I think memory is far from being fixed. I know my - like I've been talking about my own memories, flowing in and out of books movies(.)
Yes memories can be implanted, absolutely they can, and they can be distorted and they can congeal and you know it's a a really creative and quite fluid function I think that we have, and that's fantastic.

(Keri, 18, 21, 24)

Sarah *I think that um(1) there is the possibility I guess that you can um create memory - I think I've seen that from studying- but I also think that um before we just decide*

this disproves the possibility of people being able to recover something they haven't thought of in a long time, well I don't think that I'd be wanting to disprove or disbelieve that

(Sarah 9-11)

Rachel, like Timothy, avoided a scientific ontology when responding to the Lost in the Mall experiment. Instead she invoked the authority of personal experience (Potter & Wetherell, 1996) by giving an account of her own in which a recovered memory *changed, evolved,* had *movement*. As she explains, this did not invalidate recovered memories for her. She constructs both clear memories, and their changing, as valid; she uses extreme case formulation, *forever*, *always*, and *absolute clear*, firstly to emphasise the definite nature of the recovered memories. Later she uses *always* again, this time to stress the changeable nature of memory. The discursive function of the text is to offer a reason for her disregard for cognitive experiments on the malleability of memory; they are constructed as an epiphenomenon, an unnecessary and irrelevant addition to what is already known from experience. Her reaction, as a counsellor, to the scientific finding that recovered memories can change, is summed up in the evocative phrase *so what*. The scientific finding is an epiphenomenon, irrelevant to her work with clients.

Rachel *I had(.) FOREVER(.) thought that - I had one memory of [identifier] who(.) rejected me by flicking my hand off(.) when I was a little girl, flicking(.) I went to hold their hand(.) they flicked it off(.)now(.)((tch)) that was(.) my memory, and(.) so I've always associated [identifier](.) with they rejected me(.)whsssssshh that's it rejected me didn't give any physical touch(.) I had that memory. But on the weekend I was in [location](.) it came back to me this absolute clear memory of when I had [illness](.) as a little girl(.) and I slept in their bed for two nights and they had their arm around me because I shook all the time? They had their arm around me(.) Now that has changed now, there's been a movement(.) in(.) my memory(.) and how I now(.) am looking at [identifier](.) so I believe that(.) things keep o::::::n(.) coming up and it's always evolving (.hh)and the things that (.hh)things that. Say something happened(.) something happened? and I might have(.) added in a little bit? or left out a little bit? But so what(.)if (.) something something did happen yeah(.) so that's how I would see the client(.) so what?*

(Rachel, 35-36)

Exceptions

Not all counsellors were as sanguine regarding sceptical cognitive studies of recovered memory; Keri believed that harm was done to abused clients who were confronted with the FMS research belief that their scientifically proven hypotheses, that all recovered memories were wrong, applied to all. Her discourse creates attribution by placing blame and responsibility on the FMSF members.

Keri *I can't remember that guy's name, the famous proponent of false memory syndrome that came out here. But both of those people at times I have felt incredibly reactive about and I guess protective of my clients, because for those people who(1) doubt their own experience, for the reasons that I mentioned previously they were told this didn't happen(.) and you know(.) you're making it up and you're just making trouble(.) by abuser and family, um then it just com– made things much worse you know so that means I'm mad you know? This didn't happen you know all this other stuff, all my PTSD symptoms are totally inhibiting but it's just 'cause I'm crazy bad and <u>wrong</u>. So you know that's where why I've got really, <u>annoyed</u>.*

(Keri, 22-23)

Summary

Within the discourse *memory is a twilight zone*, the participants constructed recovered memories in several ways. Traumatic childhood memories could be repressed as a coping or defence mechanism, then recalled or triggered, later in life, and termed recovered memories. Those memories might be correct or incorrect, or both, for the same person, at different times. The ability of the mind to recall memory clearly at certain times, and hazily at others, was acknowledged. The plasticity of memory, its vulnerability to context, and the ability of experimenters to implant memories, was not disputed. However, participants resisted the findings of sceptics who claimed that this "proved" that all recovered memories were false.

The participants' construction of recovered memories was in fact a dual construction, in which both correct and incorrect memories were possible and allowable, with neither excluding the

other. Both were expected parts of the memory process. This dual construction embraced the diversity of ways in which memories could be recovered, with or without error, as a noteworthy human achievement, to be worked with in therapy. The acknowledging of a multiplicity of truths and contextual influences in the construction of recovered memories reflected an epistemology informed by social constructionism, rather than a scientific epistemology which could produce decontextualised results with experiments on the truth or falsity of recovered memories.

Anger was aroused when cognitive researchers from the FMSF assumed that there was only one answer for all, and that RA clients should denounce their recovered memories because they had been “disproved” by the scientific method. The reaction of the counsellors to medical assumptions are explored further in the next chapter, *Labelling*, which looks at DSM-IV categorisation.

Chapter Eight

Labelling

Introduction

The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, is a categorical classification system for the purpose of diagnosing mental disorders. It has at times been accused of being a flagship for the reductionist approach, and of being used erroneously in place of therapy. In such a scenario, symptoms are matched to a coded disorder, and the client medicated, in a powerful system backed by traditional discourses, and spuriously maintained by influential and profiteering drug companies (Sharfstein, 2005). For the RA client and therapist, three main issues arise; is reductionist coding valid for RA clients, and will they benefit from medication? Are accounts of RA symptomatic of essential disorders, or does RA produce DSM-IV symptoms?

The analysis begins with talk around the need for DSM-IV categorisation in the work of therapy, then moves to the participants' use of the metaphor *labelling*. The advantages of the system are examined. *Essential and external disorder* looks at cause and effect; is RA part of an essential disorder, or caused by external abuse? This is followed by *I don't like labelling*, in which participants talk about their misgivings. A *discourse of ambivalence* emerges as participants attempt to reconcile their many constructions of labelling, and the chapter closes with the participants constructing possible alternatives.

ACC and government funding: a discourse of power

The need to engage with the topic was brought about by the fact that most of the participants' work was government funded, and the government generally preferred a DSM-IV category on applications for funding clients. Counselors lodge claims using an ACC45 Injury Claim form, on which they must state they "believe the claimant has a mental injury arising from an incident of sexual abuse" (ACC, 2006, p.3).

Jennifer opens this topic by drawing attention to the increasing need for counsellors to use the DSM-IV categorisations when they apply for funding to treat clients. The slight irritation or resentment at the requirement for labels is heard in the tone of the recording but less clearly revealed in the transcripted excerpt; it is shown by her two constructions of the requirement to label. Firstly, she says they *like you to,* but this is amended to *you have to*. This also speaks to the power relationships between government and counsellors. Because she is talking about an insistence on labelling for funding, and in doing so possibly implicitly questioning a scientifically informed requirement of the traditional establishment, she first positions herself within the discourse of *government backing*, by mentioning her years in counselling with its category entitlement, and her interaction with doctors. Angela, in a discussion about why RA goes undetected, points out that clients may only divulge enough of the abuse to satisfy ACC funding, which results in RA not going on record. Sarah offers insight informed by Foucauldian discourse: DSM-IV categories are the means by which funding for counselling is made available, because they position clients within a discourse of *legitimate illness*, for which healing must be provided. Material power is being exercised within the scientific discourse; the position of *legitimate illness* is being offered to the clients, but the position of being medically well, yet also in need of funded counselling, is denied.

Jennifer *the lo::nger that I'm counselling the more I'm finding that (.)doctors and that are more you know when you're writing to ACC(.) about something(.) They like you to put a(.) you have to put a label on someone (2)*

(Jennifer, 17)

Angela *with adults, they'll tell you part of what happened um(.) sometimes that's to meet the requirements of ACC so they can get counselling*

(Angela, 17)

Sarah *it puts them in the position to be able to go to the doctor and have a legitimate illness, and I say that in parentheses - to get some treatment and for some people, that may be the only way to get um some help and support. So I don't want to dismiss the fact that you know, there are things that are useful and helpful, (.hh)and um that provide benefits for people, in having(1)(.hh) labels.*

(Sarah, 28)

Sarah also looks more closely at the structure of traditional power, and asks who is achieving what, and why. While not suggesting totalitarianism, she nevertheless asks who benefits from the use of DSM-IV categorisation, and constructs an economic discourse in which traditional funding bodies also fund other traditionally trained personnel to create a closed system.

Sarah *Providing a <u>medical model</u> type scenario for people who have been um(.) traumatised um there's a lot of kind of <u>different ideas</u> that come into that, I think one of the really strong ideas is an economic discourse of (.hh) you know "who's going to pay to treat this person and I think there's also ideas of (.hh)you know how in having these kind of <u>diagnoses</u> for <u>mental</u> type illnesses, we provide (.hh)um jobs and um reasons for people to be (.hh) further trained, you know to train further psychologists and psychiatrists and counsellors I guess as well.*

(Sarah, 27)

- You know and I know

The strategic deployment of pronouns is significant in discourse analysis, but they "do not form perfectly neat divisons" (Tuffin, 2005, p. 101). As I reread Sarah's excerpt and notice the frequent use of *you know*, I started to assume that she was trying to draw in a wider audience, to establish her knowledge as part of something universal, or invite supportive audience identification. *You* has a broad reference; it reaches out to include, and is representative of a whole. *You* means everyone, or at least everyone in your culture, in your world. *You know* implies that the speaker is simply pronouncing something that everyone knows already, and it gives their argument cogent force. However, the subjective nature of all analysis, and especially discourse analysis, requires that the analyst think reflexively, and acknowledge subjectivity and intersubjectivity. I acknowledge that Sarah is someone I have known for some years, and funding is something we have talked about previously. Our views coincide, our conclusions have been constructed intersubjectively over numerous coffees. Reluctantly (because I would very much like to analytically deduce that the entire world is aware of the significance of funding issues) I must conclude that her use of *you know* is probably meant as a *you* singular, part of her conversation with a friend. In a conversational analysis, it could be considered her way of handling the noncommittal stance I have adopted as interviewer, as I try not to interrupt her exegesis by appearing to disagree or agree.

Labelling

Resistance to the scientific discourse of categorisation was constructed linguistically in a discourse which made itself apparent early in the interviews by the use of a powerful one word metaphor: *labelling*.

The word *label* was not given as a part of the interview questions; the phrase *DSM-IV diagnoses* was used. One might have expected the counsellors, especially the psychologist, to also use this phrase, or similar that expressed a philosophical alignment with the DSM-IV, linguistic constructions that affirmed it such as "correct diagnosis" "definitive symptomology" but instead, for the most part a single evocative metaphor was used to give an immediate distinct and vivid physical image: *label*. The linguistic repertoire supporting this device included phrases which recurred throughout, such as: *attaching, stuck with it, in a box, boxed in, hard to shake, remove.* The interpretive repertoire surrounding this metaphor implied that although a label has its usage, it provided only a limited amount of information, and an item could be relabelled by someone with a different opinion. It was not a permanent or an intrinsic part of the item, and was imposed by someone external to the object. Notably, when the participants constructed DSM labelling positively, the term *labelling* was omitted in favour of *diagnosis* or the name of the condition.

A discourse of mental disorder

The counsellors were nonetheless careful to construct *mental disorders* as valid medical conditions which they would seek medical help for. This was constructed as the responsible and ethical response. The discourse was supported by a linguistic repertoire of *trained, psychiatric, mental health, abnormal, assessments,* and named DSM-IV categories.

Keri *I'm working at [institution] with someone that I was told about before I worked with him(.) you know, paranoid schizophrenia(.) that one <u>terrified</u> the <u>hell</u> out of me(1) at [place of occupation] so obviously [possibly identifying statement] which was as a result of that disorder, so it's not something I would take lightly atall.*

(Keri, 45)

Timothy *If this the client (.hh)was showing a mental disorder of some kind, by taking it to my supervisor who was trained in psychiatric m:::::ental ah health etcetera, she would be able to help me pick it up and recognise it. (.hh)and things when was this beyo:nd me:::, and to be guided by my supervisor to say this is too big for you [name] or hey(.) this is who you should go to - or I would ring a psychiatrist(.hh), I would suggest you go there. So it was to using all the resources to make sure that I wasn't coming across as an arrogant(.) self righteous person(.) who thought he knew everything, and so it was ethical(.) professional(.) (.hh)um being ethical and being professional in what I did.*

(Timothy 23-24)

Certainly I use it and I teach it and and we do abnormal psychology and we::: teach assessments(.) um(.) I think DSM four is a good guideline.

(Timothy, 30)

The advantages of labelling

In what will later become a *discourse of ambivalence*, variability immediately contradicts the consistent construction of DSM-IV labels as only for the mentally disordered. Some counsellors construct an apparently contradictory use for label: ironically, they say DSM-IV labels can be used to reassure their clients that they are *not* insane. Madness is constructed as something outside the scientifically ordered world of DSM-IV labels.

Jennifer *Sometimes I think that it's quite useful for somebody to know(.) "okay so I'm not mad" 'cause quite often clients think that they are, that's the thing that they're afraid that they are, "a bit loopy" you might say to them, "Oh so do you have you been thinking that you might be a bit mad(.) or a bit loopy and they'll say yes yes yes you know, and so then you can sort of reassure them that they're not.*

(Jennifer, 15)

Erin *It might(.) give them(4) a sort of validation that there is something wrong - like they know something's wrong.*

(Erin, 13)

Rachel *For some people I'm sure it could be really helpful(.) and it could(.)(.hh)be(.) really quite liberating for them, to be given a label(.) which could explain their symptoms. And they could have a sense of freedom because of that, "been living with that for so many years and finally someone's told me what's happening".*

(Rachel, 15)

Sarah *I don't want to dismiss the fact that some people like to have something sort of written down concrete that they can (.hh)hold onto for a short time or a long time.*

(Sarah, 27-28)

Keri *Some people find it a helpful diagnosis for themselves to have 'cause it explains something*

(Keri, 45)

Labelling was also constructed as something that could help the therapist. Jennifer uses the metaphor of a *handle*, one which could, if the metaphor were extended, draw up a basket of *broad understanding of the different signs and symptoms, some idea* of *what I'm dealing with.* Like Keri, she says she would not label a client *I'm not a diagnostician*; but then, in another example of ambivalence, she talks about distinguishing between Generalised Anxiety Disorder and phobias in her client.

Jennifer *I find it quite helpful to have(.)in my own mind a bit of a handle ah(.) on what I think's going on. And the DSM DSM categories(.)they sort of give you a um a broad understanding of the different signs and symptoms that go in different - You know like if it's a somatoform disorder, Or Post Traumatic Stress or d- or Anxiety Disorder or whatever it is. I wouldn't be(.) personally(1) la- ah putting a diagnosis on them 'cause that's not my role, you know I'm not a diagnostician.*

(Jennifer, 16)

Jennifer *when I've(.hh) seen them a few times I'll talk to them about you know(.) anx- anxious, that. And you've got to work out, is this a generalised anx- anxiety or is it a phobia - I actually find it's quite helpful. I know lots of counsellors don't.*

(Jennifer, 18)

Rose *I think there's a validation in acknowledging (.) some of the things that occur in that they - they're not unique to one individual, they're common to people who have experienced the same kind of trauma. So it's useful to have that commonality Um(1) in the way it presents in an adult.*

(Rose, 8)

Essential and external disorder

Whether or not RA could produce symptoms that paralleled those of the DSM-IV, such as those of PTSD, BPD, DID, and even psychosis, was argued strongly by the participants. This moved the discussion to the heart of the exogenic-endonymic debate, and also challenged attribution theory: were the diagnostic symptoms the result of essentialist, internal disorder? Or were the symptoms the logical product of ordered minds that had been affected by external disorder, in this case, an RA perpetrator? Was the RA client being pathologised? The participants were largely consistent, in constructing the DSM-IV symptoms of their clients as the result of the abuse, and did not give credence to a bio-medical causative aspect.

Because the symptoms were constructed as a reaction to external context, the symptoms were positioned as temporal rather than biomedical, something which had been imposed and could therefore be helped through therapy. This discourse challenges the medical model and instead draws on a social constructionist ontology in which reality is constructed externally and changeably. In the following texts, Jennifer's use of the word *result* indicates RA as a cause and the DSM-IV symptomology the effect. Timothy's *can come* also positions the symptoms as coming after the abuse.

Jennifer *I mean it might turn out in the end that they are completely psychotic(.)But that doesn't mean to say that they haven't been ritually abused, just means that they're psychotic, could've been a RESULT of the ritual abuse.*

(Jennifer, 24)

Timothy *And I believe that oh not only w::::Satan-Satanic ritual abuse but ordinary abuse - often (.hh)um a mental disorder can come, like a dissociative disorder or*

schizophrenia, (.hh) u:::::m (.) where people have split personalities in order to cope

(Timothy, 23)

Post Traumatic Stress Disorder, the DSM-IV category most commonly cited on ACC applications for funding to counsel SA survivors, was already constructed exogenically in the manual. Participants constructed RA clients as displaying an increased symptomology due to the nature of their abuse; a linguistic repertoire of *even greater, heightened, torture, trauma*, functioned to underscore the construction RA as an extreme form of abuse.

Angela *A lot of people experience traits of(.) Um Post Traumatic Stress Disorder, so like- re-reoccurring(.) mem::ories , feeling hyper vigilant or(.) easily aroused, um(.) feeling like having dreams nightmares, actually(.) Difficulty sleeping, yes. I think there'd be um similarities there, that whole safety thing could be ah even greater, being watchful not being able to relax in your own environment, I think that could be heightened with ritualised abuse.*

(Angela, 23-24)

Jennifer *IT'S A BIT LIKE a torture or a prisoner of war(.) or someone like that(.) you know - and and sexual abuse comes under that. Rape, you know. In my opinion it would be(.) um(.) fairly on the high spectrum of trauma symptomology*

(Jennifer, 11)

The controversial condition Dissociative Identity Disorder (once termed Multiple Personality Disorder) was a category which counsellors consistently constructed as the result of abuse rather than being an essential internal disorder. The discourse is one of dissociation being a rational choice to counter abuse, and the ability to produce different personalities was constructed as a natural, and intelligent way of coping with severe childhood abuse, reflected in words such as *brave, smart, extremely creative.* Timothy uses the metaphor *float out of your body,* to construct a conscious act, echoed by Angela *move out of their bodies* and *separate themselves*. Other counsellors support this with a linguistic repertoire of *dissociation, switching.* Forms of the personal pronoun *you,* and accounts of professional experience which carry the authority of first person experience, are utilised by counselors to establish credibility with the audience.

Sarah *well what a good idea to um have diff-different personalities to help you (.hh)get by God what a brave idea and what a smart idea is what I think about that um, yes extremely creative*

(Sarah, 26-27)

Angela *Sometimes with some of the children I interviewed they talked about actually like (.hh)being in the room but actually being out of their body and watching themselves, a dissociation but actually knowing that it kind of that it did happen but actually that was one of their coping mechanisms?*
Move out of their bodies or somehow(.) separate themselves out from what was happening to their body at the time, so that would be dissociation yeah.

(Angela, 12-15)

Timothy *they go into the state(.hh)(hhh) in order to cope with it because it's so traumatic. And so sometimes the only wa:y is to(.) is to float out of your body so to speak, or to go into another person.*

(Timothy 25-26)

Erin *you KNOW from trying to talk to them, that something is definitely not right and there is switching(.) within the conversation.*

(Erin, 9-10)

Madeline provided variability by being the only participant to construct the relevant DSM-IV categories as both essentialist and also as resulting from RA. This interesting duality was discursively achieved by constructing the symptoms as proceeding from neurological changes incurred during childhood abuse; the symptoms were thereafter essential. This scientific construction was linguistically supported by a traditional repertoire. Nomenclature such as n*eurological literature* and *dysfunction* give the concept both medical and academic credibility. The words *as you probably know*, have the function of making the knowledge seem universal and accepted. *All the neurological stuff that's pouring out now* is a metaphorical way of suggesting that there is a vast reservoir of universal and finite knowledge on the topic, which has recently

been tapped. The words *proves* and *physical effect* serve to underscore the strength of her scientific discourse to construct an undeniable reality.

Madeline *Some of those so called Borderline Personality people are(.) survivors of all kinds of abuse which could include(.) ritual for sure yeah yeah. .hh)and that can be a WIDE range of things. I mean it can be the most(.) - the things that are written about most - are (.hh)the people who have been from an early age neglected and abused. And as you probably know there's a lot of ah (.hh)neurological literature now about that too, about how the brain and the endocrine system and everything is affected from a very early age (.hh)so that those kids then become adults who are highly(.) dysfunctional because of what happened to them early (.hh) I find all the neurological stuff that's pouring out now absolutely fascinating 'cause it just proves what people have been believing about the effects of early trauma on kids that that's actually having a physical effect on them.*

(Madeline, 11-12)

I don't like labelling

Rachel's evocative phrase *I don't like labelling* is the discourse that emerges from the following excerpts, in which the counsellors explain the negative results that they argue can easily accompany the issuing of a DSM-IV a diagnosis. The moral stake of *concern for the client* continues to guide the reasoning. Madeline says *they're not really looking at how they can help,* and Timothy notes *they're not getting any better*. Madeline and Erin both observe that it is easy to give a diagnosis, and then ignore the client, rather than provide the therapy needed. Rose and Madeline employs the *labels* linguistic repertoire with *box,* and *stuck.* Labels have limits: the moral stake of *concern for the client* determines that they are *only useful if they lead to a solution.* Timothy condemns the practice of issuing first the DSM-IV diagnosis, then the drugs that accompany the condition, then forgetting the client. He does this by using ironic rhetoric to win the reader, rather than directly criticising labelling. He turns the argument back on the opposition, by ironically constructing their actions as beneficial: *{hey what a relief} you can give them a label* then cites negative results. Again, he chooses the authority of the first person account, one which also positions him as entitled to warrant voice.

Madeline *they're only useful if they lead to something a solution, and if they're just there to then put people in a box, where you can ignore them - Borderline Personality Disorder's the classic example - Then you're STUCK you know people say "ah well what d'you expect of course she's going to be like that, because she's a Borderline Personality" and they're not really looking at how they can help that person get out of the rut that they're in.*

(Madeline, 9-11)

Rose *putting people um (.) into the box of having a DSM label I find I ss have difficulty with that.*

(Rose, 8)

Erin *It is just the easy thing to diagnose(.) , and get the person out of your hair(.) because then when you do spend the time with the client it is(.) a long term commitment*

(Erin, 16)

Timothy *(.hh)and um(.) so so(.hh) I think some people label people(.) because either they don't have time, or don't know(.) how to deal with the issue .*
And so if you can give them a label(.) {hey what a relief} {you didn't have to work so hard} because (.hh)he's got this problem and therefore give him some tablets sort of stuff, and it's very easy.
A simple label, give 'em some medication, that's where it is, you'll be like this for life ((clears throat)) and it it saddens me when I see some people that have been(.) I'm working with people now saying how long have you been on your medication? (.) fifteen years. You've been on your medication for fifteen years? Have you gone back and sat down with your psychiatrist? No, they don't want to see me. I say well have you been back to your doctor? No(1)And they're not getting any better.

(Timothy 26-27, 30)

The participants supply more justification for the discourse *I don't like labelling*, in the following excerpts. The labels metaphor is extended to show a client who is *limited* by the definition, and

boxed in. The implied transmogrification of the sane client into a mentally disordered medicated patient is then constructed by Rachel, who argues that *they become the label.* Erin describes the possibility of wrongfully committing an RA client to a mental institution, and asks if a label causes *further abuse*. Her statement *they're crying out for help and … they get another label* again refers to the moral stake of *concern for the client*. Erin's talk involves accountability and responsibility, and because agency is given to the mental health professionals, *they put them in the psych unit*, blame is assigned to them for harm to the client. The function of these constructions is to downgrade the resource, and to provide resistance to a scientific discourse with respect to treating RA clients, which in turn has a later function, the legitimising of alternative ideas. Timothy and Erin assert that the now negatively constructed label will *never* leave the client but follow him *the rest of his life*. The urgency of the extreme case scenarios function to make the reader aware that alternatives are necessary; the reader is assigned moral agency by the inclusive use of *we, you* and *you know*.

Angela *When we move into the area of putting a definition on something, I think it can sometimes limit, or perhaps get in the way of a relationship. That's important in counselling.*

(Angela, 1)

Rachel *I don't like labels(2). That to me just creates such a reaction straight off, because I feel it keeps a person boxed in.*

(Rachel, 14)

Rachel *They become(.) the label. They can become the label.*
While you know may be it could be helpful for the counsellor o::::r the therapist to (.hh)to have that perhaps tucked away SOME WHERE, does the client really need to know that? (.) and start living accordingly, to that label "oh yes I'm um(.) I'm borderline" "hey I'm I'm such and such and I've got borderline" or "and I or I'm such and such and I'm schizophrenic"

(Rachel, 15, 19)

Erin *but then you label it, and(.) is the label any better than the abuse(1) or is that further abuse. If they have an epoisode(.) where just say someone is a um*

(.hh)ritual abuse survivor and they are triggered into an event and they maybe are(.) extremely fearful and terrorised by the memories(.) they put them in the psych unit because they already have a record of being(.) (.hh)maybe psychotic or having bipolar or manic depressive or (.hh) the previous label OR(.) is the diagnosis correct? If you don't(.) believe that there is(.) ritual abuse perpetrated with purpose(1) then(.) you would never(.) entertain that, you would just give them a label(.) of oh you're bipo:::lar you're manic depre:::ssive (.hh)you're psycho::::tic you're (.) whatever. And(.) here they are trying to cope the best way they know how, and they're crying out for help and they're not getting the help they get another label. Is that a further abuse? You give them then a stigma(.) in society. Well if it's on their medical records it would never go away.

(Erin, 13)

Timothy *This is one of the hard things. I saw this, (.hh) When writing a report and it said that this kid has got a behavioral disorder, and you (indistinct) and the psychologist says this and so you write it in your report, and that follows the kid for the rest of his life, because(.hh) um he's(.) you know this and you know.*

(Timothy 27)

A discourse of ambivalence

A discourse of ambivalence therefore emerges, supported on either side by sub-discourses of both negative and positive argument. The discourse of ambivalence itself is signaled by a single word, *but*. All of the following examples contained the word *but*, and followed on from excerpts which downgraded the resource. A linguistic repertoire of *useful, framework, understanding, diagnosis,* indicates favourable construction of DSM categorization; usually the term *labelling* is not used in these constructions, but is returned to in the negative, as in Keri's excerpt.

Angela *But on the other hand, it is useful to have a framework*

(Angela, 1)

Angela *but…Post Traumatic Stress Disorder, so <u>that</u> was useful, yeah that was useful in that sense, in terms of <u>understanding</u>(.) or more about ritual abuse, or(.) ah <u>treating</u> it(.)*

(Angela, 30-31)

Rose *but…. it's useful to have that commonality Um(1) in in the way it presents in an adult.*

(Rose, 8)

Keri *Some people find it a helpful diagnosis for <u>themselves</u> to have 'cause it explains something, but it's not something I would label(.) people atall. In fact(1) I don't(.)*

(Keri, 45)

Constructing alternatives

The DSM-IV is part of a largely undisputed, powerful scientific discourse. In order to allow alternative therapeutic ideas to be privileged, it was necessary for participants first to show how the DSM-IV system could be repositioned within the ontology of therapy. They do not reduce it to a second order phenomenon, but reduce its power by positioning it as one of many possible ideas. Keri and Timothy cause us to consider their discursive construction of relative positioning by using two different means. Keri questions the exclusivity of the DSM-IV labelling system, and Timothy uses humour to challenge the notion of scientific correctness. The function is to position the DSM-IV alongside other therapeutic methods, rather than in a separate discourse.

Keri achieves this discursively by using metaphors: the labels are *frames*, or a *lens*. The implication is that they are but one way of seeing the client. They are *not the whole story*; the indefinite article *a* implies they are one of several or many. This shifting of the DSM-IV from a discourse of universal power relative to other knowledges, is achieved by the use of a qualifying word, *just: just a lens*.

Timothy employs humour, in the form of ironic rhetoric, to achieve a similar result: *you can give everyone a (.hh)psychiatric label*. The implication is that if everyone can have a DSM-IV label, then the entire world is mentally disordered. He positions himself in the discourse of

government backing in order to warrant voice, by identifying with a psychiatrist. Because the psychiatrist is more highly trained, and therefore more credible when questioning medical findings, he allows him to question the DSM-IV, and also to pose a humerous challenge. In invoking this corroboration, Timothy's argument is strengthened (Edwards & Potter, 1992). The discursive achievement is to permit Timothy to follow this line of reasoning; because the doctor has questioned the DSM-IV, he may also.

Keri *It's like I've got all different frames to hold up against what's happening, to try and to understand.*
- it's not the whole story. It's just <u>a lens</u>(.) through which you can(.) think about(.) y'know, someone's experience.

(Keri, 44, 51)

Timothy *A therapist that I I kind of relate well with or to is Dr [name], (.hh)who trained as a psychiatrist, and he comes back and says "well (.hh)sometimes I question(.) this whole thing of the DSM four". He said you know you kind of - if you can give everyone a (.hh)psychiatric label, you've <u>got it</u>(.) you know and you're <u>RIGHT</u>.*

(Timothy, 26-27)

Keri strengthens the argument by providing evaluative assessment, bringing the discussion back to the unavoidable moral stake of *concern for the client*, reminding the reader of the participants' primary orientation. Is the client being helped? She warrants voice by using the *government backing* discourse, in this case by giving the name of her place of work as a government funded mental health establishment. Rose repeats her theme.

Keri *the people I work with(1) I don't generally(1) see that their diagnoses helps them much, and that's what I'm more interested in*

(Keri, 50)

Rose *doesn't allow room for healing and (.hh)<u>change?</u> Um Yeah and I think that can become unhelpful.*

(Rose, 9)

Here and earlier in this chapters, it emerged that the counsellors were subtly downgrading labelling as a resource, and providing resistance to a scientific discourse which required RA clients to be treated as DSM-IV studies. The collective function of these discursive challenges can be seen as providing an enabling contrast; if the labels are not working, then by contrast, the construction of alternative ideas becomes ethical, responsible and necessary. Sarah and Keri here construct two possible alternatives: Sarah suggests asking clients what positions are being made available or denied through the current discourse of labels, and what the alternatives could be, while Keri suggests working with clients' alters, or inner parts, rather than labelling them with the DSM-III label MPD.

Sarah *I think talking to the people and asking them about (.hh)um(.)what that might be like for them and what that means for them, and what um(.) what becomes possible (.hh)what does it open up what does it shut down, um do they have any other ideas about how they'd like(.hh) um people to know what's been going on for them and in the traumas.*

(Sarah, 28-29)

Keri *I work with some people who are probably(.) on the(.) threshold of(.) multiple personality, but I don't use that frame, and I discourage them from using that lens as well. Not actively(.) probably but more subtly. I would tend(.) to think of it as working with parts, which it is of course, you know, Multiple Personality is when parts are absolutely fragmented and don't know each other. But many of the people I work with have um(.) extremely ah(.) powerful parts, um particularly enraged(.) children inside them, or internalised persecutors, you know like get vicious, parts that attack themselves. Um and I've read, heard, thought about lots of different ways of explaining that, that I find more palatable than thinking of them as Multiple Personality.*

Yeah, I think any part that you deny or disown can build up quite an outrageous will, and that can manifest as Multi Personality Disorder. But I don't - I wouldn't I wouldn't call it that. I'd rather think of it as lots of people who had similar experiences, rather than(.) the diagnoses which becomes(.) kind of fixed.

(Keri, 45, 48-49)

Summary

From this it can be seen that the participants, who used DSM-IV categories in their funding reports to government bodies, constructed the system as one which had both advantages and disadvantages. They did however use a one word metaphor which had a subtle downgrading effect on the resource: *labelling*. Other discourses which emerged were *ambivalence*, and *I don't like labels*. The traditionally privileged position of scientific epistemologies was resisted and challenged as participants, motivated by a moral stake of concern for the client, warranted voice by positioning themselves within a discourse of government backing employing authoritative first hand accounts.

Sceptics of RA suggest that the accounts of RA clients are the symptoms of an essential DSM-IV disorder. The counsellors in this study resisted this scientific discourse by naming only two DSM-IV category as significant for therapy. The first was PTSD, in which the RA client's symptoms were constructed as being the result of trauma and not symptoms of a mental disorder. DID was also considered possible, for the same reasons. Although there was ambivalence, there was a general reluctance to label RA clients with DSM-IV categorisations; alternative therapeutic approaches were suggested, which are discussed further in the following chapter, in a discourse of *preparedness*.

Chapter Nine

Constructing preparedness

Introduction

In the last chapter, *Labelling*, the participants talked about issues surrounding the diagnosis and treatment of RA clients, and suggested some alternative therapeutic approaches. It is interesting to return to the literature review, in which four overseas groups who responded to RA clients' needs and claims were described: sceptics, apologists, methodologists, and heuristics. The group called heuristics was comprised of therapists and counsellors who maintained a therapeutically pragmatic approach to RA. They did not construct themselves as apologists, or methodologists, or sceptics. They utilised speculative formulation, based on their training, experience, and acceptance of the client's account, as a guide, while they learned alongside the client. The notion of the overseas group was that RA clients engage in productive therapy more readily if they are supported, upheld, and believed. As shown in previous chapters, this notion was generally supported by the New Zealand counsellors interviewed for this study.

In this chapter, the participants construct *preparedness*, or a readiness to provide therapy for RA clients. Preparedness was constructed in three stages; firstly the need for *adequate supervision* was talked about, and secondly the need for counsellors to be aware of the *risk factors* involved, for both client and therapist. Thirdly, the participants constructed therapeutic ideas in *counselling the RA client*. The discursive function achieved overall is the construction of the New Zealand counsellors as ready and able to counsel RA clients; however, there is variability in the consistency of this discourse which is explored at the end of the chapter.

Adequate Supervision

The first function of the constructions below is to show that the counsellor would not expect to work alone, but to work in a team with a supervisor. The recourse to a supervisor is constructed as an automatic and immediate response; Rachel uses the descriptor *definitely*, and Rose *straight to*. Timothy says he *couldn't have done it without* his supervisor.

Rachel *definitely taking it to my supervisor*

(Rachel, 26)

Rose *straight to my supervisor to say look, this is - and seek her advice? about whether to refer um(.) and(1) yeah and trust what what she said*

(Rose, 18)

Timothy *I couldn't have done it without my supervisor helping me and supporting me and standing with me.*

(Timothy, 37, 39)

Secondly, there is a construction of the supervisor as more knowledgeable. Angela *knew it* (RA) *existed*, but her supervisor had the authority of personal knowledge as well as category entitlement: she was *very experienced*, she was a *psychologist* and had *worked with people who had been ritually abused*. Timothy's supervisor had *done a lot of training*. Angela calls it a *specialist kind of area.*

Angela *I knew it existed …. but I actually hadn't (.)phys- heard the details. So um just for me to actually um manage that, I went and met um with a very experienced person who was a psychologist, who'd worked with people who had been ritually abused. I already had a supervisor and I cleared it with my normal supervisor so it was a one off kind of (.)specialist session, because it was a specialist kind of area*

(Angela, 10-11)

Timothy *I had a person who was - my supervisor, was so::: um(.) good to help me. I <u>trusted</u> her because she(.) had I had known her for a long time and a <u>lot</u> of people went to her for supervision, and she had done a <u>lot of</u> training*

(Timothy, 37, 39)

Risk factors

Three types of risk were constructed; firstly the threat to the counsellor's equanimity, secondly risks within the counsellor client relationship, and thirdly risk to the counsellor from those

outside this relationship. In the first, the counsellors construct some of their reality of feeling unnerved by the negative spiritual nature of RA accounts, while maintaining their professional approach. This construction is supported by a strong descriptor; Keri talks of being *totally freaked out,* an interpretive repertoire with clear metaphors: *creepy overtones,* and *shrouded in mist.* Angela mentions *shock* and *disbelief*. Timothy also uses *freaked out*, and says he told his supervisor he was *scared*. He says he *took the risk to be really honest with her*, implying that as a professional, taking agency for feeling *scared* was not something he would have expected to have to do. He also uses a metaphor, saying he wasn't just *{doing Hollywood}*, the curly brackets indicating "laughing the talk" in a way which underscores the implication of a contrasting reality.

Keri *I (hhh) remember [name] was in- initially into Alistair Crowley who I highly {{disapproved of(.) have to say an totally freaked out by}}so(.) yeah and the whole area of of ritual abuse for me has got really creepy overtones, um it's kind of shrouded in mist*

(Keri, 2-3)

Angela *for me as the counsellor um because of the <u>shock</u> and disbelief like shock as in um that I hadn't - I'd sort of read about this stuff*

(Angela, 8)

Timothy *I took the risk to be really honest with her and said [name] (.hh)I feel a bit scared I feel scared. Now what's going on(.) what's the <u>scariness</u> all about? And so there was a protection and a help(1) and it wasn't just(.){doing Hollywood} ((laughs))*

(Timothy, 39)

Timothy goes further to construct the spiritual risks as reality, which he terms *evil*. He gives this the authority of a first person account by citing an occasion where he could not break professional confidentiality to his wife regarding the sessions, but asked for her prayers.

Timothy *You leave yourself very vulnerable to the spirit world if you're not conscious of it yourself. Um(1)at <u>times</u>(1) I after I'd finished some of the sessions I was quite freaked out, and I felt(1) I felt the <u>evil</u> I felt the <u>horribleness</u> of it, and I would(.)*

say to my wife "would you pray for me just - (.)and I can't tell you what went on - but just pray for me".

(Timothy, 38)

The second area of risk participants constructed was that of the RA client counsellor relationship. There are two parts to this. Firstly, the participants were consistent in their construction of this situation as one which needed care, because the RA client could become suicidal as they brought into the present the trauma of the past; Rachel describes a client's experience as *very alive in her*. Jennifer and Madeline construct it as to be expected, people *do get stirred up*; Madeline employs the metaphor *over the edge*, extrematisation *always*, and tautology *very very* for emphasis.

Rachel *I think it's very(.) (.hh)um I(.) think very alive in her, in her experience(.) of(.) what she went through(.) as a child yeah.*
So I think re-truamatisation is(.) is(.) um really important for the counsellor to be very aware of

(Rachel, 10, 30)

Jennifer *people do get stirred up - things get worse before they get better quite often with people - so they might become suicidal.*

(Jennifer, 30)

Madeline *There's always a risk to the client with working like that, because you have to be very very delicate not to tip the balance of whatever the balance is you know, not to push people over an edge*

(Madeline, 21-22)

Secondly, the participants construct the risk of too close a relationship with the client, occurring during what might of necessity be a long term counselling relationship, in which the idealisation of the therapist by the client, and the responsibility felt by the counsellor, lead to a codependency. Erin warns that RA clients can be long term, but guided by the moral stake of *concern for the client*, gives an imperative in *you have to be willing to spend the time*.

Erin *And with um severely(.) ah abused individuals, ah you have to be willing to spend the time that it could take to see them walking forward in victory or walking forward and becoming(.) productive a person in society.*

(Erin, 22)

Timothy talks of the risk of feeling responsible for the client. Because he mentions it, it is implied that this went beyond the normal therapeutic care. This risk is also constructed around the moral stake of concern for the client, with an alternative suggested, to *get someone else*. Erin constructs another alternative, using the metaphor of *strong boundaries* for the *safety* of client and counsellor.

Timothy *I felt the seriousness of it I felt the(.) I felt the responsibility as a counsellor I felt the responsibility of the need of the client but any time I was {{quite willing to say}} get someone else or bring someone else along side of me because I felt I felt um I felt the responsibility of the need of the client.*

(Timothy, 39-40)

Erin *you can have codependency develop, where you need to be needed ((laughs))and the other person needs to need you and I think you have to be a very strong person, and have(.) strong boundaries put up, for your own safety and for the safety of the person.*

(Erin, 21-22)

Jennifer constructs the process of idealisation by the client, who starts with *a huge lack of trust* but idealises the therapist. The word *false* alerts us to the risk, which is metaphorically described as *falling off a pedestal*, the word *bang* implying sudden disaster. Her deployment of the extreme case formulation *completely* functions to further emphasise the seriousness of the risk.

Jennifer *Um(1) they may get get extremely attached to you, if they haven't had other people in their life that they've ever had a really good relationship with. There may be a huge lack of trust but there's also maybe an idealisation of the therapist? So I don't trust anybody but I'll trust - it's a sort in a way a false idealisation, so that*

at some stage(.) if the therapist does puts a foot wrong, then bang they fall off the pedestal and(.) you lose the client completely.

(Jennifer, 30)

The final risk constructed was that of possibly physical or other risk from people outside the therapy, being perpetrators who feared conviction, and the general public. In Madeline's, some variability occurred; she constructs the risk as something *believed*, which implies that it is not a physical threat, and she uses this word four times in the short excerpt. Her denial of risk is argued as *I certainly don't believe it*. Sarah constructs a risk which was a *possibility*, her unstated reasoning being that a group involved in illegal activities might want to silence both the discloser and the disclosee. Her construction of the risk appeals to the audience with logic.

Madeline *I did know people who believed that. At the time there was a particular person (.hh)who had an accident (.hh) ah believed that the accident had been caused by people who were(.) abusers who knew that she was part of the Ritual Action Group. Part of the group that was um(.) investigating it and they wanted to get rid of her(.) so then it's a risk . I don't believe that(.) um any m- well I never did - I certainly don't believe it. I don't feel any personal danger? no no*

(Madeline, 21, 22)

Sarah *I think my understanding was that (.hh)there could well be risks, from the perspective that(.hh)if there is a sort of um group(.) who are(.) um(.) (.hh)could possibly be ex- you know sort of(.) feel under threat of being exposed and um are aware that somebody's coming to talk to somebody about ritual abuse- and I think that it's important to be aware of that possibility and not discount that.*

(Sarah, 50)

Angela constructs risks of a *backlash* from the public if counsellors make public the accounts of RA by putting together a story. Strong linguistic resources are harnessed to make this account work and let us know it is reasonable and plausible. The first is the employment of a vivid metaphor to describe the risk, *backlash*, which is used three times for emphasis. She then builds her case by referring to other groups who have "gone public" and have experienced a *backlash*; feminist campaigners for equal rights, those who stood against family violence, and a well known

sexual abuse case. The groups who administer the backlash are described as the *usual stereotypical right wing*, which carries a recognisable interpretive repertoire of oppression, and *negative connotations;* their victim had to *endure*. The reader is invited to respond by the use of the pronoun *you*, and respond affirmatively to *you know*. Having shown a consensus in her examples, she builds an extreme case scenario for making public statements regarding RA; it would invoke *the whole raft*. She concludes by employing the words *safety issues* which are from a professional nomenclature, and an understatement of what has been cited before, and therefore function to create credibility.

Angela *(.hh)if it came out in the media which I don't think it ha::s um there'd be a backlash possibly like if you look at other (.hh)issues or movements like you look at um(.) for example feminism um you know when women started to take(.) personal power there was a backlash you look at um when people started to talk about sexual abuse and family violence(.) people come there was a backlash against those (.) and it's only like recently like with s:::::exual abuse with the [name] case for example (.hh) she spoke out but she also um I didn't hear it but she said that people (.hh) um on talkback shows actually um(.) doubted her called her(.) really rude names you know the (.) usual stereotypical um(.) I call them right wing in some ways(.) negative connotations about women came out and so she had to endure that as well. You know if something like Satanic ritual abuse came out you know that would have that whole raft and possibly (.) down the other end of even disbelief you know (.) yeah so for somebody to publicly(.) (.hh)um to make statements to the police and to talk about it I think there's also um possibly(hhh) like safety issues .*

(Angela, 18-19)

Counselling the RA client

Safety

A discourse of keeping the client safe, based around the stake of moral concern for the client, emerged as a precursor to the actual counselling. A linguistic repertoire supporting this discourse included *suicidal, safe, risk of harm, at risk, mentally safe, physical danger, threatened*. The risk

of suicide as the client relives their trauma has already been covered. Timothy, who consistently constructed the system of labelling as licence to medicate then leave a client anomic and unattended, here shows variability by stressing the importance of medication. This apparent contradiction is explained by the moral stake of concern for the client; the medication is to alleviate suicidal depression, and the modification is that it is *reviewed*, *changed*, or taken *off*. He justifies his account by citing knowledge gained professionally, which also unstatedly speaks of employment, in the *government backing* discourse: *I've come to realise over the years*

Timothy *If a person's suffering from say from what, from incredible depression to being <u>suicidal</u>, (.)you might need to give them some medication to <u>balance</u> them(.) they can become a bit more <u>rational</u> (.hh)and get out of that <u>down</u> side.*
I've come to realise over the years(.) with medication um(.hh) it needs to be reviewed(.) (.hh)and sometimes it needs to be changed or even to take them <u>off</u> it.
(Timothy, 27-28, 31)

Sarah uses category entitlement to give safety mandatory importance:

Sarah *…I am required under the Code of Ethics um (.hh)to um do something about that (.hh) and I'm not only talking about <u>mentally safe</u>, I'm thinking of physical danger*
(Sarah, 52)

Symptomology

Having constructed a therapeutic scene in which risks were understood and safety ensured, the participants then constructed a therapeutic road for their RA clients. They began with constructing a non-essentialist idea of what to expect.

The participants constructed some possible symptomology for RA clients which built loosely on the DSM-IV category Post Traumatic Stress Disorder. In Chapter Eight, *Labelling*, this category was accepted as it did not imply that RA was a result of internal mental disorder, but gave symptoms that could be considered a result of trauma. Although such schema are generally a part of a scientific repertoire, resistance was provided in that rather than basing the findings on empirical testing, Angela used her experience in this area to grant entitlement. Sarah speaks

entirely from this perspective. Rachel then modifies this by stressing individuality, using the word *different* twice, and the pauses when saying *in their(.) way(.)*for emphasis. This construction functions to undermine the universality presumed by a scientific epistemology.

Angela *Um Post Traumatic Stress Disorder, reoccurring(.) mem::ories, hyper vigilance, easily aroused, dreams nightmares, Difficulty sleeping, being watchful not being able to relax in your own environment, I think that could be heightened with ritualised abuse. Yeah I think there'd be very similar traits that maybe(.) with s-some of those other ones could be more (.hh)extreme, um like often peoples' thinking patterns, about how they view themselves or the world, can be um(.hh) distorted or different to people who may not have experienced abuse. So there could be the possibility that that you know the self doubt may be even greater*

(Angela, 23-24)

Sarah *if people have some particular fear about how they speak to me about you know if they're sort of really quite concerned about being able to speak about anything, and who I might be wanting who I might talk to about my work*

(Sarah, 15)

Rachel *I think(.) trauma is trauma(.) for for people, and how they(.) how they deal with that(.) um can be quite different. I think everybody is so different as to how they they cope, in their (.) way(.)*

(Rachel, 13)

Remembering

Individuality is again privileged over universality, in a discourse of *when they're ready*, referring to allowing the client to disclose in their own time. Angela constructs several possibilities, all informed by the moral stake of *concern for the client*. She employs a linguistic repertoire of *hurt, damaged, support* and the metaphor *flooded* which implies disaster.

Angela *When they're ready(.) or feel safe they will talk about it? and I think that's pretty much what counselling is like with individual people too? and why I I think it's*

about trusting that the person knows(.) often in themselves when it's the right time to um(.) and it's they like it's yeah like they cause they have to feel resourced - because they're so hurt and so damaged and haven't got a lot of boundaries um (.hh)it all comes out all atonce but often then they need a lot more support too?

(Angela, 41-43)

you know they could actually become flooded themselves , and feel a loss of control and that would be really scary, and often counsellors will try and pace work anyway so that um it doesn't happen that people are flooded with memories.

(Angela, 17)

The counsellors constructed remembering as a process. Their construction resisted the scientific discourse in which memory is purely cognitive. In a discourse of *explore the experience*, different types of memory and ways of remembering are constructed. Rachel talks about *a range of things that could be happening* in the process of remembering: *body* memories, *headaches*, *anxiety*, and *depression* are a part of the process. Again, a universal experience is resisted by the inclusion of individual differences in the construction.

Rachel *I mean I'm really am a strong believer in the body remembers things? so I'm sure that(.) in many ways while it might not be exactly the same for each person, but their body would be remembering something, there would be something going in their body some where. Whether it be in the form of anxiety, some sort of(.) you know just u:::m depression, headaches u:::::::::::m yeah(.) maybe fla::shba::cks::, oh a range of(.) things that could be happening(.) But some people might have it stronger in one way(.) than another.*

(Rachel, 11-12)

Timothy takes the non-cognitive construction further, but also warrants voice for this non-scientific construction by citing his academic and employment category entitlement from the *government backing* discourse, which is grounded in a scientific ontology: *I've seen from my studies at university, counselling, reading the psychotherapies.* He constructs a separation of memories of *feeling* and memories of *experience.*

Timothy *They can often remember the feeling, but may not remember the experience. Or they may remember the experience but they kind of have no feelings and then (.hh) I've seen from my studies at [university] and (.hh)and in my things, in counselling and reading the psychotherapies(.hh) I believe it can happen either wa:::y*

(Timothy, 34-36)

Acceptance

Timothy talked in Chapter Six, *Truth*, about his need as a counsellor to be able to accept the the client's account of RA. Here Angela constructs the client's therapeutic need to *progress* to *it happened to me*. An acceptance of "reality" is constructed as necessary.

Angela *they talked about actually like (.hh)being in the room but actually being out of their body and watching themselves, a dissociation but actually knowing that it kind of that it did happen but actually that was one of their coping mechanisms? I think as they progress in counselling or therapy they've sort of been able to come um to terms more with yes it actually(.) happened and it happened to me::*

(Angela, 14-15)

Alternative stories

A discourse of *alternative stories* is represented in the following texts from Sarah and Erin. In both, the powerful action orientation of language is assumed, and the counsellor brings about a therapeutic change in the RA client's construction of their abuse. The linguistic repertoire included *total lie, shame, blame, low self worth, fault.* Erin asks a rhetorical question of the audience to support her argument.

Sarah *I would work more on(.) looking at you know work more on um the response from them and(.)an alternative story to the shame and the blame and the(.) um the low self worth*

(Sarah, 22)

Erin *Many of them feel like it was their fault, they did something that caused this to happen. And of course(.)the perpetrator(.) tells them(.)that it is their fault (.) which is a total lie. You can't have {a four or five year old} (.) how can it be their fault?*

(Erin, 2-3, 12)

Participants talked about stories of *resistance* and *strength* they would encourage, alternative stories to ones that might be constructed from a position as a victim of abuse. Sarah constructs the spoken word as a powerful tool in therapy, and explains the tenet of social constructionism in which realities can be constructed and changed in language.

Sarah *Working with the philosophies of social constructionism, and postmodernism or post-structuralism perhaps and (.hh)and also in working with um (.hh)the techniques of um(.) therapy that are based in um how we are constructed the discursive practices that we engage in (.hh) the and that is um very evident in the conversations and how we speak so it's tied very much to language ?*

(Sarah, 62)

Sarah *offering them some ways of speaking about those perhaps more of (.hh)that speak of um resilience and protest. And they may be very little things, which may be just that the person closed their eyes and would not look um(.hh) and that was that was the resistance that they made at the time.*

(Sarah, 18)

Rachel makes the importance of alternative stories into public knowledge with *you know* and then emphasises its importance with an extrematisation: *all of these people*.

Rachel *stories of strength yeah(.)the stories of (.)of how did they survive ,what have they what other things have they done with their life. You know positive stories. There would be things that they would have, coping mechanisms that they would have put in place that(.) to help them get through. I mean all of these people are incredible*

(Rachel, 20, 13)

The spiritual component

The spiritual component is regarded as integral to the process of counselling an RA client counselling. Keri introduces this with a problem RA clients sometimes recount, one which has challenged theologians and philosophers, and been constructed in many ways: spiritual betrayal, the awesome why, the dark night of the soul, or, why do bad things happen to good people? It is constructed as a classified category in the DSM-IV's: V-Code 62.89 Religious or Spiritual Problem, such as loss of faith, or a questioning of spirituality.

Keri *A betrayal of your of the of sort of like universal betrayal. A bit like(.) abuse generally you know why didn't anyone save me. You know there is no God because God wouldn't have let me endure this.*

(Keri, 35)

Counsellors talk about a need for spiritual counseling, but Jennifer, paradoxically, says it was something she could not talk to other counsellors about. Timothy legitimizes it by invoking the *government backing* discourse for spiritual counselling with the words *work holistically*. Erin likewise cites *Youthline and Samaritan,* accepted organisations, who referred clients to her.

Jennifer *I wouldn't talk about it with a secular counsellor ((laughs)) who didn't have any belief in the spiritual aspect of life(.) of God in God God(.) well in Jesus really.*

(Jennifer, 33)

Erin *I have had anonymous um calls, which(.) um come to us through say(.) um(.) through the Samaritans, through <u>Youthline</u>, where they're not equipped to deal(.) with this kind of stuff.*

(Erin, 8-9)

Timothy *If we're going to work holistically (.hh)we need to <u>work</u> in the person's <u>spiritual component</u>, not just the body and soul and feeling and psyche (.hh)but there's a <u>spiritual</u> side*

(Timothy, 7)

They go on to construct spiritual needs as separate to other; Jennifer differentiates between a DSM-IV condition and a spiritual problem. Erin constructs spiritual peace as separate to mental and emotional needs. She achieves this by first positioning herself in a Christian ontology.

Jennifer *Somebody who has(1) unhealthy spirits around(.) might hear words(.) voices in their head(.) things being said(1) that(.) from a secular perspective might be considered to be psychosis(1) from a Christian perspective it might be "a bit of spiritual warfare needs to go on here".*

(Jennifer, 13)

Erin *My experience is because I'm a Christian is that(.) Jesus came to bring peace. (1)and what He does when you sit and work with clients (.hh)and they're willing to look at the spiritual nature , and look at(.) who has the answer(.) who is the Prince of Peace, and allow Him to bring that ministry into your life(.)those(.) issues(.) have(.) peace brought into them. Then you can't have the spiritual torment again because the peace there*
You're trying to give the person a place where they can(.hh) go (h:::::::::h) they can fi::nally(.) have the qui::etness, the peace of mind

(Erin, 16-18)

Spiritual counselling was also constructed as conditional to consent. Timothy and Jennifer both use the word *if* to achieve this. The moral stake of concern for the client precluded the counsellor imposing their beliefs on the client.

Timothy *If I've got a relationship, I then will explore their spirituality (.hh)and knowing scriptures and explore it and then saying - hang on there's something wrong here (indistinct) tell me about it(.hh) giving them the opportunity that ah to explore it*

(Timothy, 47)

Jennifer *If it's not a Christian who is um aware of such things and wanting ministry in that area, I don't go down that. I might I might have a suspicion, that the - it's not that - actually what's going on is a demonic thing. But I don't necessarily do anything.*

(Jennifer, 13-14)

Walking with the client

The moral stake of concern for the client precluded impositioning, and this occurs again in the following excerpts, in which Rose and Rachel construct a discourse around a metaphor of *walking beside* their client. This was supported by a linguistic repertoire of *honour, respect, story, listen, hear, journey, space, grow*. The discursive achievement was an impression of accompanying the client as they worked out their own healing.

Rose *they're telling their own unique story, so you're hearing something new, even though there may be(.) um(.) parallels with other(.) clients' stories - so I I would listen and hear what they're saying, and that's their(.) and and honour their story? and respect what they're saying.*

(Rose, 14)

Sarah *offer them(.hh) a um acknowledgement of what has been said, an open space for them to speak more about what's been said.*

(Sarah, 38)

Rachel *I'm there(1) listening, and(.) walking with that clie:::nt(.) walking(.) beside that client. So what they present with? what they come in with? (.)is where I am for them so we're working together(.) (.hh)on their(.) story(.) their(.)what they're bringing.*

It's part of that journey. and it's part of(.) cha:::::nge. and it's(.) part of just working in the moment:: and working(.) with that client:: and allowing them the space(.) to grow in the freedom.

(Rachel, 23, 38-39)

Constructing counsellor satisfaction

There were no interview questions regarding this, however some of the participants volunteered a construction of the rewards of their efforts. Like the moral stake, these were non-material, but powerful; the linguistic repertoire is a positive one including *joy, healing, demeanour change, forward, peace, confidence*. The reward also seemed related to the counsellors allowing

themselves, at the end of the therapeutic journey, to take some agency for the healing process, constructed in phrases and words such as *I could contribute towards the healing process*, a *privilege*.

Rachel *yeah(.) yeah(.) I just see(.) ah so much more to people I just think um people are are amazing, what they WHAT they cope with and how they learn to cope with that it is so fascinating and I and I get great(.) (.hh)ah joy out of hearing that of how people do cope.*

(Rachel, 21)

Timothy *I was actually able to see this guy become more at peace with himself. I saw this guy actually able to (.hh)where I {(indistinct) all over the place} at least become a bit more focused and I couldn't take away the experience (.)b:::ut I could contribute towards the healing process that he would get into (.hh)and and it would um(.)reflect right around and and and infiltrate the whole infrastructure of the whole family(.) to bring him to a a place of (.)peace*

(Timothy, 63-64)

Erin *Seeing their demeanour change - you can actually see the peace of (.hh)when they get the peace of mind and peace of soul, their face changes. A:::nd they go on and sometimes you know you might see them for (.hh)five six months and then you don't ever you don't see them again, or sometimes you might see them in passing and they say they look like a totally different person, and they've got a job and they're going forward and they've got their confidence and they've (.)chosen*

(Erin, 25-26)

Sarah *you know in in offering people the space to um(.) reclaim their lives from the problems and the traumas that (.hh)um they have been(.) you know the traumas they have been subjected to is for me um(1) I don't know I just find that just um a great privilege to be involved in that yeah*

(Sarah, 63)

Variability in the discourse of preparedness

In a scientific analysis, the quantitatively large *n* representing accounts of preparedness and the very small *n* of texts referring to unpreparedness due to a lack of literature and training, would lead to a conclusion of preparedness, and the very small *n* could be regarded as a non-representational outlier. However in discourse analysis, exceptions to the main discourse must be included, because they raise important questions. How has the participant's orientation caused them to present preparedness, or a lack of preparedness, in this way? Why was there a large number of texts on preparedness, and very few on unpreparedness? Was there an unspoken interest guiding what was constructed? How did the context affect the data?

The participants' accounts were therefore looked at in the context of a counselling service which is funded by the government, often through the ACC. RA clients are referred to ACC counsellors by medical practitioners for counselling to counter the effects of traumatic sexual abuse. The participants in this study were experienced, government employed counsellors, either ACC accredited or in the process of becoming so. They therefore rightly positioned themselves as qualified, capable and informed. They also positioned themselves as *prepared*, by referring to their training, and experience, and by talking about the process of counselling. This choice solved the first requirement, which was to position themselves as professionally prepared. However it also created a new problem; their construction of preparedness invisibilised any unpreparedness, and precluded any suggestions that training was lacking, or more resources are needed. There was an apparent contradiction in stating both; they could not be both prepared, and also lacking. They managed this dilemma in the text by spending a comparatively large amount of time discussing preparedness, and a very small time mentioning the need for resources separately, in what can be seen as self contained areas outside the preparedness text. These function as addendums which augment, but leave the main body of the *preparedness* texts unchanged.

In these "addendums" both a lack of literature and a lack of training were mentioned. Even participants such as Angela, who had counselled RA clients, felt that they did not know enough. Others, despite describing their therapeutic methods, were cautious in stating their preparedness, which was achieved by the use of the conditional conjunction *if*; Rose says *I'd only be prepared to do it if.* This variability, found in an otherwise consistent discourse of preparedness, was expressed first in a discourse of *lack of resources*, which was supported by a linguistic repertoire

of *need, very limited, want, haven't, search, only, few,* and the singular indefinite article *a*, indicating the paucity of literature. Keri uses humour to communicate the lack of literature.

Angela *I don't feel I know a lot*
I remember at the time going and reading(.) a text book, and it was the only text book that I could find um(.)

(Angela, 1-2)

Jennifer *I think that if I wanted it(.) I'd have to go and specifically search it out.*

(Jennifer, 7-8)

Rose *for a counsellor that hasn't worked with with such a case before(.) (.hh)um need really good support and good you know access to good um information good resources. I've (.) I've read just a couple of articles Um(3) yeah so like my reading is very limited and I'd want to and(.) yeah I'd want to find a counsellor that had worked with abuse and consult with them? as a counsellor I'd want - I'd only be prepared to do it actually if I had those resources available to me.*

(Rose, 19)

Keri *Yes no no I haven't read any read any oh yeh I probably have read some papers in the past but I don't recall what they were. Could be a false memory you know*
Sylvia *((laughter))*
[ ]
Keri *((laughter))*

(Keri, 54)

Jennifer is representative of participants who did not recall RA being mentioned during training. Rachel speaks loudly for emphasis, and uses extrematisation to give cogent force to her construction of lack of training as an omission: *never, no-one*. Timothy implies it is not taught today, by contrasting reference to the past.

Jennifer *nothing was mentioned during our training*

(Jennifer, 8)

Rachel *In my training it was just(.) never talked about, which leaves me a big question. Like I'd want to do that segment of my training AGAIN and say HEY(.) (.hh)HOW COME IT WASN'T MENTIONED. And NO-ONE in the class actually(.) brought it up UM(.)*

(Rachel, 32)

Timothy *I did work with a tutor who (.hh)who believed this was happening many years ago*

(Timothy, 15)

Summary

The participants constructed themselves as prepared to counsel RA clients, by talking about the counselling process. They constructed firstly a counselling situation in which adequate supervision was available, the counsellor had assessed the risks, and the client's safety been prioritised. Counselling the RA client was then explained as a process in which the client was helped through a journey of remembering, accepting, and repositioning in alternative stories of courage and resilience. A spiritual component, usually not included in counselling, was also explored, and the whole finished on a positive note as some counsellors described the sense of satisfaction that accompanied positive results. In a much smaller body of text, which could be likened almost to an addendum, counsellors expressed a contradiction, by constructing themselves as less well informed than they would hope to be. Opportunities for the practical and beneficial application of taking seriously these small but extremely significant texts, are looked at later in Chapter Ten, *Application and implications for future research*.

Chapter Ten

Discussion

Analysis summary

The aim of this study was to conduct a discourse analysis on the talk of New Zealand counsellors who were interviewed about RA. Eight of the nine participants constructed RA as a reality in New Zealand, and justified this using *the credible client* discourse. The participants generally constructed their arguments, ideas and experiences with respect to the epistemology of social constructionism, employing the social constructionist tenet of language's constitutive powers and action orientation. When warranting voice, however, a discourse of *government backing* was employed, which drew from a traditional empiricist linguistic repertoire including scientific nomenclature, category entitlement, and visual or quantifiable accounts. A moral stake in counselling termed *concern for the client*, was found to be considered in most accounts.

Strong discourses emerged around three main topics relating to RA.. In the first one, "truth", the participants constructed three contextual truths; a *legal truth*, a *counsellors' truth*, and the *client's truth*. In general, with regards to "truth", the counsellors emerged as epistemologically informed by a constructionist view of relative truth, or truth relative to context, rather than positivist epistemologies such as might be required to provide a *legal truth*. While not denying the existence of a reality beyond discourse (Gergen, 2001), they were pragmatic in their therapeutic approach, and worked with what the RA client presented, *the client's truth*.

The second topic, the recovered memory debate, allowed the emergence of a discourse *memory is a twilight zone*. In this discourse, repression, fragmentation, and change, were constructed as all part of the memory process, in which the dual possibility of correct and incorrect recall did not discount the purpose or possible validity of recovered memories. Experiments such as *Lost in the mall* were critically examined, and not accepted as revealing finite or universal truths regarding recovered memories.

In the third topic, DSM-IV categorisation, a powerful discourse emerged: *labelling*, which had negative connotations. At the same time, the participants maintained respect for essential mental

disorders, and also saw advantages to labelling, in a discourse of *ambivalence*. Counsellors constructed mental disorders as resulting from RA, rather than RA accounts being the result of mental disorder.

In a discourse of *preparedness*, the participants constructed the therapeutic and counselling skills needed to provide therapy to RA clients. A paradox appeared, an antinomy of preparedness along with talk of lack of training or relevant literature. This created an interesting variation because of what it signified, and is looked at next in *Application and implications for future research.*

Applications and implications for future research

As shown in the Chapter Two, *Rationale and aims*, it is important for society as a whole that the therapeutic needs of RA clients are met. But whether or not adequate therapy is taking place in New Zealand, has yet to be determined. Timothy, one of the ACC-accredited participants who counsels RA clients, speaks metaphorically

Timothy *it's <u>there</u>. And it's under the mat*

(Timothy, 15)

This statement, and the texts of other counsellors who have treated RA clients, provide a question fuelled by moral obligation and engendered by accounts, arguments and their frequent use of *you*; how do we get RA out from "under the mat?" The implications and applications arising from this study, with regard to this question, are considered first at a macro then a micro level.

Timothy's metaphor speaks to the invisibilising of RA which was discussed in Chapter Three, *Epistemology.* The maintenance of invisibility at a macro level comes with a scientific epistemology. While sceptics continue to demand scientific proof of RA, and claim that cognitive laboratory experiments alone will decide whether memories are true or false, RA remains as undiscovered as CSA was in the 1950s, when retrospective studies in which adults recalled CSA, were discredited as unproven. Discursive psychology however, is philosophically opposed to more traditional scientific approaches; it focuses on material from real life situations, exploring material in context, and this has already proved useful in many forms of counselling, including relational and child protection. It is therefore argued from the results of this analysis and the

literature review, that discourse analytic studies, or other qualitative studies, of accounts of both RA clients and their therapists could be employed to bring RA to public notice.

With regards to stake, participants suggested that the "Lost in the Mall" experimenters' stake and interest caused them to discredit RA accounts. Possibly discourse analysis, or other qualitative research, could be employed to research the findings of New Zealand therapists who have a moral stake in the successful counselling of RA clients.

Categorisation, as shown in Chapter Three, *Epistemology*, also invisibilises. It is suggested that discourse analysis of RA clients' accounts be required of researchers aswell as empirical studies. The linguistic focus of discursive psychology would avoid the problem of the positivist requirement for categorisation, and the subsequent omission of RA tick boxes in favour of the more familiar sexual or physical abuse categories in police and hospital reports. Algorithms cannot pick up RA if it is not allocated a category; however in the form of inferential statistics the results of such collective studies (however erroneous) gain ready access to the marketplace (Gavey, 1989; Wilkinson, 2001). Via the availability heuristic, the public assumes that CSA does not include RA, and therefore RA does not exist. This problematises disclosure for RA clients.

Timothy *A lot of people would say that's just <u>rubbish</u> it doesn't happen.*

(Timothy, 13)

On a micro level, counselors showed a willingness to accept RA clients' accounts, but noted that there was a climate of silence.

Jennifer *I think it's something that's(.) not really talked about?*

(Jennifer, 6)

Secondly, in this study, participants highlighted the need for specialised training to counsel RA. As shown in the literature review, only a few sceptical articles have been written in this country. Jennifer and Rachel stated in Chapter Nine, *Constructing preparedness*, that it had not been mentioned in their training. Timothy mentions the need for this as part of a holistic approach.

Timothy *I don't believe we(.hh)we are(.) have been trained <u>enough</u>.*

hey whether we like it or not the New Zealand [association] is saying we've got to address people holistically (.hh) and you've got to address the spiritual now

(Timothy, 47, 49)

Timothy draws particular attention to the need to include spiritual awareness in training, by the use of contrast; he suggests that Pakeha New Zealanders are not aware.

Timothy *When you go to an an Asian culture(.) or another culture(.hh) MAORIDOM straight away would say: no, that's evil(.) that's not of God. But we in a European framework have explained it away in humanistic terms. I've been recently (.hh)looking at Maori models of counselling to impart to the the students to say it's time you looked at them*

Sylvia *mm te Tapa Wha*

Timothy *yeah because then you can come and recognise - but then you've still got to have a plumb line to know what is truth so you can recognise what is (.hh)ritual abuse.*

(Timothy, 47, 8-9)

Timothy's metaphor of a plumbline is in fact a reference to the idea that there is no New Zealand literature to explicate what exactly RA is; he explains in his texts that he learnt as he counselled, with the help of his supervisor. There is a gap in the literature. This gap affects those treating RA clients, and also those wishing to speak out. In *Rationale and aims,* in Chapter Two, it was shown that because of this lack, New Zealand psychologists do not have access to expert knowledge on RA in New Zealand, and are therefore unable to give public voice. However as covered in the literature review, there is an abundance of overseas literature. Madeline cited reading material on RA by an *English journalist***,** Rose says the articles she read were from *overseas,* she thought *American based*. Jennifer talks about *differences.*

Jennifer *We we we(.) assume that it's relevant(2), but there will be differences(.) think of the books that we(.) assume to be relevant to New Zealand. A lot of them are a lot of them are produced in America.*

(Jennifer, 9)

This study has argued in Chapter Two, *Aims and rationale,* that society benefits from meeting the therapeutic needs of RA clients, and therefore argues against the invisibilising of RA through a scientific epistemology. It is suggested that categorisation for RA be provided in reports which normally only record physical or sexual abuse. It has argued that qualitative studies of linguistic accounts of both RA clients and their therapists could be more useful than quantitative or cognitive studies. A need for specialised training for counsellors treating RA clients, including a spiritual component, has been shown in the texts of the participants, and also the need for literature on the phenomena of RA in New Zealand.

Validation and criticism

Validation

Reliability and validity are terms traditionally used when assessing scientific research; would the procedures produce the same mathematical result if replicated, did the study measured what it was intended to measure? Confounding variables, history, maturation, experimenter bias, all vitally interesting to the discourse analyst but anathema to the positivist, could invalidate the universal truth discovered. Discourse analysis however, informed by social constructionism, does not look for a finite truth, rather knowledge constituted through intersubjectivity, and constructed varyingly in language. There is no final arrival at individual timeless facts, because the knowledge or discourse discovered is situated in and part of the changing course of political and cultural histories (Burr, 2003). Criteria applied to empirical research is not applicable, and rather than a set of universal laws, there is instead an evolving set of criteria for evaluating discourse analysis. Some famous authors have observed the following ideas, which this researcher endeavoured to employ. The first of these is systematic transparency.

Potter & Wetherell (1987) talk about research validity in terms of systematic transparency. In this study, this first meant that the researcher avoided a neutral stance by stating her situatedness, values, epistemological underpinnings, cultural embeddedness, her bias. The participants' orientations were also acknowledged, as much as they were known, and as far as anonymity would permit.

Transparency was also demonstrated in a full description of the methodological processes, with the sequential analytic procedure outlined (Burr, 2003). Exceptions and variations were included, and new questions they brought to the study acknowledged (Taylor, 2001) for example when participants felt unprepared as well as prepared. Transparency also involved basing all findings in the data, which was offered alongside conclusions made, to enable the reader to evaluate the arguments presented (Potter & Wetherell, 1996). Reflexivity, including the researcher's perspective and how the analytic process was affected by this, was addressed throughout the study as indicated in Chapter Three, *Reflexivity*, and in reflexivity boxes.

Potter & Wetherell (1987) also talk about the importance of fruitfulness. The power of the discursive research refers not to numbers, but the power to produce new developments, or revelations on existing research. These were noted in *Applications and implications*, Chapter Ten.

Reliability in this discourse analysis is to some extent established by the fact that there was in most cases a general consistency between the counsellors' accounts, and common discourses, even with the exceptions noted. A further instance of consistency arose when it was found that the discourses of the participants in the study paralleled RA those of therapists and counsellors in similar overseas Western sociological settings, described in the literature, as the "heuristics" group. The participants' concern for the client, and their discourses regarding truth, recovered memories in therapy, and DSM-IV categorisation in particular, are strong examples.

Criticism

What are the strengths and weakness of this study? The main strength lies in quality data, in the form of interviews willingly given by nine professionals, embedded in context, rich with personal accounts, lightened with humour and enlivened with shafts of perception.

The weaknesses are probably many, stemming from my amateur status as a discourse analyst. I endeavoured to avoid *a priori* thinking when reading for discourses, as it more belonged to nomothetic methods, but still wonder how much my own beliefs, and the acknowledgement by participants of the reality of RA, affected what I drew, or chose to draw, from the texts. In an assessment of what Edwards & Potter (1992, p. 166) call "interactional consequences", I also ponder reflexively, did my acknowledged belief in the controversial and unproven RA enlarge

the participants' belief, permitting them to say more? Were their constructions therefore intersubjective, and did that limit the study? There were also times in the interview when I would try to pause and regroup by saying "it seems to me you are saying such and such" to which the participant would usually respond yes, and continue speaking. However this meant that I could not quote what I had said as their own words, even if they had agreed by building on it, and this broke up their thread of their text at times.

Although the validation criteria used in a positivist epistemology does not apply to discourse analysis, it could be argued that if I had had a much larger *n*, I would have included participants who had not considered or met RA in their work. However as the aim of this study was to analyse what counsellors had to say about RA in New Zealand, it seemed appropriate to recruit those who were willing to talk on this topic and/or had treated RA clients. In an empirical study, the small sample size would lead to it being described as underpowered; however, this study achieved its cited aims, to study the talk of New Zealand counsellors around RA, and nine participants produced many powerful and consequential discourses.

Critiquing epistemology

Empiricist say finite facts are found through observation and testing, that words are neutral and texts have a single fixed meaning, but discourse analysts deny this representational view; language is action oriented in is constructions, discourses are affected by many contextual factors. This however means that discourse analysis can become an endless process (Riger, 1992) because there are no static absolutes, and because it is understood that neither could words provide these accurately even if they did exist (Gavey 1989). Given that discursive work is subject to debate, if a critic did not agree with this researcher's findings, they would then have to work through the processes outlined in order to understand the interpretations and how they were arrived at. Having taken up these interpretations, the critic would then be positioned to offer improved analysis on the data. This would be a reproduction of the process of intersubjectivity (Bondarouk & Ruel, 2004), with new constructions being provided by the challenger. The validity of their discourse could then be dialectically examined, in a new creation of social reality, which could then, in its turn, be reconstructed. The justification for this event lies in a tenet of social constructionism, that all knowledge is situated, and part of its validation lies in its continued reconstruction.

A further criticism of discursive analysis is the supposed lack of clear criteria for identifying discourses; how can the results be clearly delineated if there is no clear criteria for the process? Although research is a dichotomous world, qualitative and quantitative research are not yet equally privileged, and it is already difficult, without using inferential statistics, to place clear results in the market place (Wilkinson, 2001). However it was endeavoured to make clear the final results of this study, and it is hoped that the discourses and constructions described are sufficiently clear to be understood and informative.

The last word

The aim of this study was to provide a discourse analysis of the talk of New Zealand counsellors about RA, and this has been covered in the preceding chapters. In one sense, there is no last word; after interviewing, interactional consequences between researcher and participant, and the intersubjectivities engendered, inevitably lead to continuing changes in the thinking of both parties. The interviewer's existing respect for the counselling profession has been added to, and her knowledge about RA in New Zealand increased. Further thought and discussion among some therapists may occur. Keri's use of the word *now* reflects this, when after recounting that RA hadn't been talked about much at her place of work, she adds

Keri *It would be an interesting conversation to have now. Maybe at my peer supervision we could talk about it.*

(Keri, 54)

Because the participants in this study constructed RA as real, in doing so they took agency, positioning themselves and by implication, others in the profession, in an ontology in which there also existed an ethical responsibility to provide therapy, and if necessary, change.

In all discussions, the participants' moral stake of concern for the client was evident. Despite the difficulties of lack of specialized training and New Zealand literature, and in some cases lack of experience, they constructed preparedness and willingness to treat RA clients, and the "last word" must be given to them. Timothy sums up his work and its results.

Timothy *I couldn't take away the experience (.)b:::ut I could contribute towards the healing process that he would get into (.hh)and it would um(.) reflect right around and infiltrate the whole infrastructure of the whole family(.) to bring him to a place of (.)peace*

(Timothy, 64)

References

Accident Compensation Commission (ACC) (2006). Information for ACC recognised counselling providers: Sensitive claims unit (draft 1). Wellington, NZ: Author.

Accident Compensation Commission (ACC) (2009). *Registered counsellors*. Retrieved April 29, 2009, from http://www.acc.co.nz/index.htm

Adams, J. (2000). *Childhood ritual abuse: A resource manual for criminal justice and social service*. St George, UT: Mr Light & Associates.

Adams, J. (2003). *Drawn swords: My victory over childhood ritual abuse.* St George, UT: Mr Light & Associates.

Advocates for Survivors of Child Abuse (2006). *Ritual abuse and torture in Australia*. Melbourne: Mono Limited.

Aldridge, M. R. (1995). A sceptical reflection on the diagnosis of multiple personality disorder. *Irish Journal of Psychological Medicine, 11*(3), 126-129.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Andrews, B., Morton, J., Bekerian, D. A., Brewin, C. R., Davis, G. M., & Mollon, P. (1995). The recovery of memories in clinical practice: Experiences and beliefs of British Psychological Society practitioners. *The Psychologist: Bulletin of the British Psychological Society, 8*(5), 209-214.

Baetz, M., Bowen, R., Jones, G., & Koru-Sengul, T. (2006). How spiritual values and worship attendance relate to psychiatric disorders in the Canadian population. *The Canadian Journal of Psychiatry, 51*(10), 654-661.

Barstow, D. (1993). A critical examination of the false memory syndrome. *Family Violence & Sexual Assault Bulletin, 9*, 21-22.

Berger, P. L., & Luckmann, T. (1966). *The social construction of reality: A treatise in the sociology of knowledge*. Garden City N Y: Doubleday.

Blood, L. (1994). *The new Satanists.* NY, NY: Warner.

Bloom, S. L. (1994). Hearing the survivor's voice: Sundering the wall of denial. *Psychohistory, 21*(4), 461-477.

Bondarouk, T., & Ruel, H. (2004). *Discourse analysis: Making complex methodology simple.* Paper presented at the Proceedings of the 12th European Conference on Information Systems (ECIS), Turku, Finland.

Bottoms, B. L., & Davis, S. L. (1997). The creation of Satanic ritual abuse. *Journal of Social and Clinical Psychology, 16*(2), 112-132.

Bottoms, B. L., Shaver, P.R., & Goodman, G. (1991). *Profile of ritualistic and religion-related abuse allegations reported to clinical psychologists in the United States.* Paper presented at the 99th Annual Convention of the American Psychological Association, August 16-20, San Fransisco, CA.

Briggs, F., & O'Neill, M. (2006). Foreword. In: Advocates for Survivors of Child Abuse, *Ritual abuse and torture in Australia* (p. 3). Melbourne: Mono Limited.

Brown, D. (1996). *Satanic ritual abuse: A handbook for therapists: How to deal effectively with the multiple personalities of ritual abuse survivors.* Denver, CO: Blue Moon Press.

Buchanan, L. (1994). *Satan's child: A survivor tells her story to help others heal.* Minneapolis, MN: CompCare.

Bucky, S. F. (1992). The relationship between training of mental health professionals and the reporting of ritual abuse and multiple personality disorder symptomology. Special Issue: "Satanic ritual abuse: The current state of knowledge." *Journal of Psychology and Theology, 20*(3), 233-238.

Burr, V. (2003). *Social Constructionism* (2nd ed.). London: Routledge.

Burr, V. (2005). *An Introduction to Social Constructionism*. London: Routledge.

Carlson, S. (1989). *Satanism in America: How the devil got much more than his due*. El Cerrito, CA: Gaia Press.

Cherry, F. (1995). Kitty Genovese and culturally embedded theorizing. In *The stubborn particulars of Social Psychology* (pp. 16-29). London: Routledge.

Chu, J. A. (2002). Suggestive techniques and fad therapies: Comment. *The Scientific Review of Mental Health Practice, 1*(2), 101-102.

Coleman, J. (1994). Presenting features in adult victims of Satanist ritual abuse. *Child Abuse Review, 3*(2), 83-92.

Coons, P. (1994). Reports of Satanic ritual abuse: Further reports of pseudo-memories. *Perceptual and Motor Skills, 78,* 1376-1378.

Coons, P., & Grier, F. (1990). Factitious disorder (Munchausen type) involving allegations of Satanic ritual abuse. A case report. *Dissociation, 3,* 177-178.

Cotton, P. (1994). Biology enters repressed memory fray. *JAMA, The Journal of the American Medical Association, 272*(22), 1725-1726.

Cozolino, L. J. (1989). The ritual abuse of children: Implications for clinical practice and research. *The Journal of Sex Research, 26*(1), 131-138.

Cozolino, L. J. (1990). Ritualistic child abuse, psychopathology and evil. *Psychology and Theology, 18*(3), 218-227.

Davidson, J. (2001). 'Joking apart...' a 'processual' approach to researching self-help groups. *Social and Cultural Geography, 2*(2), 163-183.

Daymore, R. (2001). *Blessed: Reclaiming my life from the hidden horror of ritual abuse.* Indianapolis, IN.: Life Path Publication House.

De Mause, L. (1994). Why cults terrorize and kill children. *The Journal of Psychohistory, 21*(4), 505-518.

De Young, M. (1994). One face of the devil: The Satanic ritual abuse moral crusade and the law. *Behavioral Sciences and the Law, 12*(4), 389.

De Young, M. (1996). A painted devil: Constructing the Satanic ritual abuse of children problem. *Aggression and Violent Behaviour, A Review Journal, 1*(3), 235-249.

De Young, M. (1997). Satanic ritual abuse in day care: An analysis of 12 American cases. *Child Abuse Review, 6*(2), 84-93.

De Young, M. (2004). *The day care ritual abuse moral panic.* Jefferson, NC.: McFarland.

Driscoll, L. N., & Wright, C. (1991). Survivors of childhood ritual abuse: Multi-generational Satanic cult involvement. *Treating Abuse Today, 1*(4), 5-13.

Edwards, D., & Potter, J. (1992). *Discursive psychology*. London: Sage.

Edwards, L. M. (1991). Differentiating between ritual assault and sexual abuse. *Journal of Child and Youth Care, 6*(4), 169-188.

Faller, K. C. (1990). *Understanding child sexual maltreatment*. Newbury Park, CA: Sage.

False Memory Syndrome Foundation (2008). *About the False Memory Syndrome Foundation.* Retrieved September 24, 2008, from http://www.fmsfonline.org.

Foucault, M. (1972). *The archeology of knowledge*. London: Tavistock.

Frankfurter, D. (2006). *Evil incarnate: Rumors of demonic conspiracy and Satanic abuse in history*. Princeton, NJ, US: Princeton University Press.

Fraser, G. A. (1990). Satanic ritual abuse: A cause of multiple personality disorder. Special Issue: "In the shadow of Satan: The ritual abuse of children". *Journal of Child and Youth Care,* 55-65.

Fraser, G. A. (1997). Ritual abuse: Lessons learned as a therapist. In G. A. Fraser (Ed.), *The dilemma of ritual abuse: Cautions and guides for therapists.* Washington D.C.: American Psychiatric Press.

Freyd, J. (1993). Personal perspectives on the delayed memory debate. *Family Violence and Sexual Assault Bulletin, 9*(3).

Freyd, P., & Goldstein, E. (1998). *Smiling through tears*. Boca Raton FL: Upton Books.

Friesen, J. G. (1992). Ego-dystonic or ego-alien: Alternate personality or evil spirit? Special Issue: Satanic ritual abuse: The current state of knowledge. *Psychology and Theology, 20*(3), 197-200.

Gannaway, G. (1989). Historical truth versus narrative truth: Clarifying the role of exogenous trauma in the etiology of MPD and its variants. *Dissociation, 2*, 205-220.

Gavey, N. (1989). Feminist post-structuralism and discourse analysis. *Psychology of Women Quarterly, 13*, 459-475.

Gelb, J. L. (1993). Multiple personality disorder and Satanic ritual abuse. *Australian and New Zealand Journal of Psychiatry, 27*(4), 701-708.

Geraci, J. (1993). Paidika Interview: Hollida Wakefield and Ralph Underwager. *The Journal of Pedophilia. Winter 1993*.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275.

Gergen, K. J. (1998). The ordinary, the original and the believable in psycholgy's construction of the person. In B. Bayer & J. Shotter (Eds.), *Reconstructing the psychological subject*. London: Sage.

Gergen, K. J. (2001). *Social construction in context*. London: Sage.

Gergen, M. M. (1988). Building a feminist methodology. *Contemporary Social Psychology, 13*(47-53).

Gibson, S. (2006). Respect as esteem: The case of counselling. *Res Publica, 12*(1), 77-95.

Gilbert, G. N., & Mulkay, M. (1984). *Opening Pandora's box: A sociological analysis of scientists' discourse*. Cambridge: Cambridge University Press.

Goldman, J. D. G., & Padayachi, U. K. (2000). Some methodological problems in estimating incidence and prevalence in child sexual abuse research. *The Journal of Sex Research, 37*(4), 305.

Goldstein, E. (1997). False memory syndrome: Why should they believe such terrible things if they weren't true? *American Journal of Family Therapy, 25*(4), 307-318.

Gonzalez, L. S., Waterman, J., Kelly, R. J., McCord, J., & Oliveri, M. K. (1993). Children's patterns of disclosures and representations of sexual and ritual abuse allegations in therapy. *Child Abuse and Neglect, 17*(2), 281-289.

Goodman, G. S., & Schaaf, J. M. (1997). Over a decade of research on children's eyewitness testimony: What have we learned? Where do we go from here? *Applied Cognitive Psychology, 11*(5).

Goodyear-Smith, F. (1998). Parents and other relatives accused of sexual abuse on the basis of recovered memories: a New Zealand family survey. *New Zealand Medical Journal, 111*(1068), 225-228.

Gould, C. (1992). Ritual abuse, multiplicity, and mind-control. Special Issue: "Satanic ritual abuse: The current state of knowledge." *Journal of Psychology and Theology, 20*(3), 194-199.

Gould, C. (1995). Denying ritual abuse of children. *Psychohistory, 22*(3), 329-339.

Gould, C., & Graham-Costain, V. (1994a). Play therapy with ritually abused children, Part I. *Treating Abuse Today, 4*(2), 4-10.

Gould, C., & Graham-Costain, V. (1994b). Play therapy with ritually abused children, Part II. *Treating Abuse Today, 4*(3), 14-19.

Gould, C., & Neswald, D. (1992). Basic treatment and program neutralization strategies for adult MPD survivors of Satanic ritual abuse. *Treating Abuse Today, 2*(3), 5-10.

Greaves, G. (1992). Alternative hypotheses regarding claims of Satanic cult activity: A critical analysis. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 45-71). New York: Lexington Books/Macmillan.

Green, J., Franquiz, M., & Dixon, C. (1997). The myth of the objective transcript: Transcribing as a situated act. *TESOL Quarterly, 31*, 172-176.

Hare-Mustin, R. T., & Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism, and psychology. *American Psychologist, 43*, 455-464.

Herman, J. L. (1993). *Adult memories of childhood trauma: current controversies.* Paper presented at the annual meeting of the American Psychiatric Association. San Francisco, CA, May 26, 1993.

Hill, M. (1998). Satan's excellent adventure in the antipodes. *IPT Journal, 10*.

Hudson, J. (1991). *Ritual child abuse: Discovery, diagnosis and treatment.* Saratoga, CA: R & E Publishers.

Ivey, G. (1993). The psychology of Satanic worship. *South African Journal of Psychology, 23*(4), 180-185.

Katchen, M. H. (1992). The history of Satanic religions. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 1-19). New York: Lexington Books/MacMillan.

Katchen, M. H., & Sakheim, D. K. (1992). Satanic beliefs and practices. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 21-43). New York: Lexington Books/Macmillan.

Kelley, S. J. (1988). *Responses of children to sexual abuse and Satanic ritualistic abuse in day care centres.* Paper presented at the National Symposium on Child Victimisation, April 29, 1988, Anaheim, California.

Kelly, L. (1998). Confronting an atrocity: The Dutroux case. *Trouble and Strife, 36*(16-22).

King, G. F., & Yorker, B. (1996). Case studies of children presenting with a history of ritualistic abuse. *Journal of Child and Adolescent Psychiatric Nursing, 9*(2), 18-26.

Kinscherff, R., & Barnum, R. (1992). Child forensic evaluation and claims of ritual abuse or Satanic cult activity: A critical analysis. In D. K. Sakheim & S. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 73-107). New York: Lexington Books/Macmillan.

Kohls, N., & Walach, H. (2007). Psycholgical distress, experiences of ego loss and spirituality: Exploring the effects of spiritual practice. *Social Behavior and Personality, 35*(10), 1301-1316.

La Fontaine, J. S. (1994). *The extent and nature of organized and ritual abuse: Research findings*. London, England: Stationery Office Books.

Langone, M. D. (1993). *Recovery from cults: Help for victims of psychological and spiritual abuse*. NY, NY: W.W. Norton.

Lanning, K. V. (1985). *Satanic, occult, ritualistic crime: A law enforcement perspective*. Quantico, VA: Federal Bureau of Investigation, Behavioral Science Instruction and Research Unit.

Lanning, K. V. (1992). A law-enforcement perspective on allegations of ritual abuse. In D. K. Sakheim & S. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 109-146). New York: Lexington Books/Macmillan.

Lather, P. (1992). Postmodernists and the human sciences. In S. K. Vale (Ed.), *Psychology and postmodernism* (pp. 88-109). London: Sage.

Leavitt, F. (1994). Clinical correlates of alleged Satanic abuse and less controversial sexual molestation. *Child Abuse and Neglect, 18*(4), 387-392.

Leavitt, F. (1997). False attribution of suggestibility to explain recovered memory of childhood sexual abuse following extended amnesia. *Child Abuse and Neglect, 21*(3), 265-272.

Leavitt, F., & Labott, S. M. (1998). Revision of the Word Association Test for assessing associations of patients reporting Satanic ritual abuse in childhood. *Journal of Clinical Psychology, 54*(7), 933-943.

Lloyd, D. W. (1992). Ritual child abuse: Definitions and assumptions. *Journal of Child Sexual Abuse, 1*(3), 1-14.

Loftus, E. (1993). The reality of repressed memories. *American Psychologist, 49*(5), 443-445.

Loftus, E., & Ketcham, K. (1994). *The myth of repressed memory: False memories and allegations of sexual abuse*. New York: St Martin's Press.

Lorena, J. M., & Levy, P. (Eds.). (1998). *Breaking ritual silence: An anthology of ritual abuse survivors' stories*. Gardnerville, NV: Trout and Sons.

Los Angeles County Commission for Women. (1989). *Report of the Ritual Abuse Task Force.* LA, CA: Author.

Lotto, D. J. (1994). On witches and witch hunts: Ritual and Satanic cult abuse. Special Issue: Cult abuse of children: Witch hunt or reality? *The Journal of Psychohistory, 21*(4), 373-396.

Lowney, K. S. (1995). Teenage Satanism as oppositional youth subculture. *Contemporary Ethnography, 23*(4), 453.

Maddox, M. P. (1991). Task force study of ritual crime. *Cultic Studies Journal, 8*(2), 191-250.

Marron, K. (1988). *Ritual abuse: Canada's most infamous trial on child abuse*. Toronto, ON., Canada: McClelland-Bantam (Seal).

Martinez-Taboas, A. (1996). Repressed memories: some clinical data contributing towards its elucidation. *American Journal of Psychotherapy, 50*(2), 214-230.

Massey University (1999). *Code of ethical conduct for research and teaching involving human subjects*. Palmerston North, New Zealand: Massey University.

Mayer, R. S. (1991). *Satan's children: Case studies in multiple personality.* NY, NY: G.P. Putnam.

Mayr, U. (2005). False memories. Messages from the transitional space. [German]. Forum der Psychoanalyse: Zeitschrift fur klinische. *Theorie & Praxis, 21*(1), 58-67.

McFarland, R. B., & Lockerbie, G. (1994). Difficulties in treating ritually abused children. *Journal of Psychohistory, 21*(4), 429-434.

Moore, L. (2005). It happened to me. *Community Care*, May 5, 36-38.

Nathan, D., & Snedeker, M. (1995). *Satan's silence: Ritual abuse and the making of a modern American witch hunt*. New York: Basic Books.

Neswald, D. W., Gould, C., & Graham-Costain, V. (1991). Common programs observed in survivors of Satanic ritualistic abuse. *California Therapist, 3*(5), 47-50.

New Zealand Psychological Society (2002). *Code of ethics for psychologists working in Aotearoa/New Zealand*. Wellington, New Zealand: New Zealand Psychological Society.

Noblitt, J. (1995). Psychometric measures of trauma among psychiatric patients reporting ritual abuse. *Psychological Reports, 77*, 743-747.

Noblitt, R. (2007). An empirical look at the ritual abuse controversy. Retrieved October 21, 2007 from http://members.aol.com/ritualabuselinks/RA_evidence/htm.

Nurcombe, B., & Unutzer, J. (1991). The ritual abuse of children: Clinical features and diagnostic reasoning. *American Academy Child Adolescent Psychiatry, 30*(2), 272-276.

Oberhardt, M., & Keim, T. (2004). Ritualistic abuser gets eight years. August 14, 2004. *The Courier-Mail*.

Ofshe, R., & Watters, E. (1994). *Making monsters: False memories, psychotherapy, and sexual hysteria.* NY, NY: Charles Scribner/MacMillan.

Ondrovik, J. (1992a). Is therapy science or religion, logic or faith? A response to Shaffer and Cozolino, Gould and Cozolino, and Friesen. Special issue: Satanic ritual abuse: The current state of knowledge. *Psychology and Theology, 20*(3), 210-212.

Ondrovik, J. (1992b). A reaction to Rosik's 'Conversations with an internal self helper'. Special issue: Satanic ritual abuse: The current state of knowledge. *Psychology and Theology, 20*(3), 224-225.

Paludi, M. (1992). Psychology of women: Perspectives on research methods. In *The psychology of women.* (pp. 28-52). USA: Brown & Benchmark.

Pepinsky, H. (2002). A struggle to inquire without becoming an un-critical non-criminologist. *Critical Criminology, 11*(1), 61-73.

Perlmutter, D. (2004). *Investigating religious terrorism and ritualistic crimes.* Boca Raton, FL 33431: CRC Press.

Potter, J. (1996). *Representing reality: Discourse, rhetoric and social construction*. London: Sage.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. London: Sage.

Potter, J., & Wetherell, M. (1996). Discourse analysis and constructionist approaches: Theoretical background. In J. T. E. Richardson (Ed.), *Handbook of qualitative methods for psychology and the social sciences.* (pp. 125-140). Leicester: BPS Books.

Potter, K., Martin, J., & Romans, S. (1999). Early developmental experiences of female sex workers: a comparative study. *Australian and New Zealand Journal of Psychiatry, 33*(6), 935-940.

Prendergast, M. (1995). *Victims of memory: Incest accusations and shattered lives.* Hinesburg, VT: Upper Access.

Putnam, F. W. (1991). The Satanic ritual abuse controversy. *Child Abuse and Neglect, 15*, 175-179.

Reinharz, S. (1992). *Feminist methods in social research.* New York: Oxford University Press.

Richardson, A. (1997). *Double vision: A travelogue of recovery from ritual abuse*. Pasadena, CA: Trilogy Books.

Riger, S. (1992). Epistemological debates, feminist voices: Science, social values, and the study of women. *American Psychologist, 47*, 730-740.

Rockwell, R. B. (1994). One psychiatrist's view of Satanic ritual abuse. *Psychohistory: Special Issue: Cult abuse of children: Witch hunt or reality? 21*(4), 443-460.

Ross, A. S. (1986). Sensational cases across the country. September 29, 1986. *San Francisco Examiner*.

Ross, C. A. (1995). *Satanic ritual abuse: Principles of treatment*. Toronto, Canada: University of Toronto Press.

Sakheim, D. K., & Devine, S. E. (1992). Introduction. In S. D.K. & S. E. Devine (Eds.), *Out of the darkness: Exploring Satanism and ritual abuse* (pp. 279-293). New York: Lexington/MacMillan.

Schmuttermaier, J., & Veno, A. (1999). Counsellors' beliefs about ritual abuse: An Australian study. *Journal of Child Sexual Abuse, 8*(3), 45-63.

Schnabel, J. (1994). Chronic claims of alien abduction and some other traumas as self-victimization syndromes. *Dissociation, 7*(1), 51-62.

Schreiber, F. R. (1973). *Sybil*. Chicago: Regnery.

Schumacher, R. B., & Carlson, R. (1999). Variables and risk factors associated with child abuse in daycare settings. *Child Abuse and Neglect, 23*(9), 891-897.

Scott, S. (2001). *The politics and experience of ritual abuse*. Buckingham: Open University Press.

Sharfstein, S. S. (2005). Big pharma and American psychiatry: The good, the bad and the ugly. *Psychiatric News, 40*(16).

Shattuck-Hufnagel, S., & Turk, A. E. (1996). A prosody tutorial for the investigators of auditory sentence processing. *Journal of Psycholinguistic Research, 25*(2), 193-247.

Showalter, E. (1998). *Hystories : Hysterical epidemics and modern media*. NY, NY: Columbia University Press.

Sinason, V. (1994). *Treating survivors of satanist abuse*. London: Routledge.

Smith, M., & Pazder, L. (1980). *Michelle Remembers*. New York: Congdon and Lattes.

Snow, B., & Sorenson, T. (1990). Ritualistic child abuse in a nieghbourhood setting. *Journal of Interpersonal Violence, 5*(4), 474-486.

Stafford, L. L. (1993). Dissociation and multiple personality disorder: A challenge for psychosocial nurses. *Journal of Psychosocial Nursing and Mental Health Services, 31*(1), 15-20.

Summit, R. C. (1994). The dark tunnels of McMartin. *Journal of Psychohistory, 21*(4), 397-416.

Tamarkin, C. (1994). Investigative issues in ritual abuse cases, Part II. *Treating Abuse Today, 4*(5), 5-9.

Tanesini, A. (1999). *An Introduction to Feminist Epistemologies*. Oxford: Blackwell.

Tate, T. (1994). Press, politics and paedophilia: A practitioner's guide to the media. In V. Sinason (Ed.), *Treating Survivors of Satanist Abuse* (pp. 183-194). London and New York: Routledge.

Taub, D. E., & Nelson, L. D. (1993). Satanism in contemporary America: Establishment or underground? *Sociological Quarterly, 34*(3), 523-541.

Taylor, S. (2001). Evaluating and applying discourse analytic research. In M. Wetherell, S. Taylor & S. J. Yates (Eds.), *Discourse as data: A guide for analysis*. London: Sage.

Tuffin, K. (2005). *Understanding critical social psychology*. London: Sage.

Valente, S. M. (1992). The challenge of ritualistic child abuse. *Journal of Child and Adolescent Psychiatric Mental Health Nursing, 5*(2), 37-46.

Valliere, P., Bybee, D., & Mowbray, C. T. (1988). *Using the Child Behavior Checklist in child sexual abuse research: Longitudinal and comparative analysis.* Paper presented at the National Symposium on Child Victimisation, Anaheim, CA.

Van Benschoten, S. C. (1990). Multiple personality disorder and Satanic ritual abuse: The issue of credibility. *Dissociation, 3*(1), 22-30.

Victor, J. S. (1993). *Satanic panic: The creation of a contemporary legend*. Chicago: Open Court.

Wakefield, H., & Underwager, R. (1994). *Return of the furies: An investigation into recovered memory therapy*. La Salle, IL: Open Court.

Warnke, M. (1972). *The Satan seller*. Plainfield, NJ: Logos International.

Waterman, J., Kelly, R. J., Oliveri, M. K., & McCord, J. (1993). *Behind the playground walls: Sexual abuse in preschools*. New York: Guilford Press.

Weir, I. K., & Wheatcroft, M. S. (1995). Allegations of children's involvement in ritual sexual abuse: Clinical experience of 20 cases. *Child Abuse and Neglect, 19*(4), 491-505.

West, L. J. (1993). A psychiatric overview of cult-related phenomena. *American Academy of Psychoanalysis, 21*(1), 1-19.

Wetherell, M., & Potter, J. (1988). Discourse analysis and the idenitifcation of interpretive repertoires. In C. Antaki (Ed.), *Analysing everyday explanation: A casebook of methods*. London: Sage.

Wilkinson, S. (2001). Theoretical perspectives on women and gender. In R. Unger (Ed.), *Handbook of the psychology of women and gender* (pp. 23-27). New York: John Wiley & Sons.

Wooffitt, R. (1993). Analysing accounts. In N. Gilbert (Ed.), *Researching social life* (pp. 287-305). London: Sage.

Worsnop, R. L. (1996). Recovered-memory debate: Can painful memories be repressed and later recalled? *CQ Researcher, 6*(25), 579-595.

Yeager, C., & Lewis, D. (1997). False memories of cult abuse [letter to the editor]. *American Journal of Psychiatry, 154*, 435.

Yoder, J. (1999). *Women and gender: Transforming psychology*. New Jersey: Prentice Hall.

Young, W. C. (1990). *President's report.* Paper presented at the International Society for the Study of Multiple Personality and Dissociation, Executive Council Meeting, Ottawa, Ontario, May.

Young, W. C. (1992). Recognition and treatment of survivors reporting ritual abuse. In D. K. Sakheim & S. E. Devine (Eds.), *Out of darkness: Exploring Satanism and ritual abuse* (pp. 249-278). New York: Lexington Books/MacMillan.

Young, W. C., Sachs, R. G., Braun, B. G., & Watkins, R. T. (1991). Patients reporting ritual abuse in childhood: A clinical syndrome. *Child Abuse and Neglect, 15*(3), 181-189.

Young, W. C., & Young, L. J. (1997). Recognition and special treatment issues in patients reporting childhood sadistic ritual abuse. In G. A. Fraser (Ed.), *The dilemma of ritual abuse: Cautions and guides for therapists.* (1st ed., pp. 65-103). Washington: American Psychiatric Press.

Youngson, S. C. (1990). Ritual abuse: The personal and professional cost for workers. In V. Sinason (Ed.), *Treating survivors of ritual abuse*. London: Routledge.

Appendix A

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Te Kura Hinengaro Tangata
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2040
F 64 6 350 5673
www.massey.ac.nz
http://psychology.massey.ac.nz

New Zealand counsellors talk about ritual abuse: a discourse analysis.

Information Sheet

Who is the researcher?

My name is Sylvia Pack. I currently co-run a support group for women recovering childhood sexual abuse (three years) and work on prison ministry teams (twelve years). I am also a postgraduate student doing my Masters thesis in the School of Psychology at Massey University under the supervision of Associate Professor Dr Keith Tuffin.

What is this study about?

The controversy surrounding Ritual Abuse (RA) has given rise to ongoing debate. Some regard RA as fictitious, citing a lack of physical evidence, or False Memory Syndrome. Others regard it as real, and describe common symptoms and treatment. Others again may describe a "client's reality" that is, the client's account. This project uses discourse analysis to explore understandings around the topic of ritual abuse, as found in texts of contemporary literature, and

interviews with New Zealand counsellors. Ten Wellington counsellors will be invited to participate.

What would I have to do if I participated?

You would be interviewed before August 2008, at a time and place of your choosing, and this is estimated to take around an hour.
In the interview you would be invited to talk about your ideas about ritual abuse, and your thoughts on counselling such clients.
The interview would be recorded on audio tape.

Confidentiality and the participant's rights

- You may turn off the tape recorder at any time during the interview.
- You may decline to answer any particular question.
- You will be given the opportunity to amend your transcripts if desired.
- You may withdraw from the research at any time.
- The researcher is aware of the need for total confidentiality and anonymity for participants, and will make every effort to maintain this.
- Anonymity will be ensured by the use of pseudonyms which will be adopted at time of transcription. There will be no keeping of identifying records.
- The data will be viewed only by the researcher and the data supervisor.
- The data will be stored securely with the researcher. At the conclusion of the research, you may choose whether the audiotapes are stored in a research archive for five years, or returned to you, or destroyed.
- You will be offered a summary of the research.
- The data is intended for use in the researcher's MA thesis, and may be offered for publication in academic journals.

Please feel free to contact me at any time if you have any questions about the research:

Phone (H) 939 7810 (Mob) 029 939 7810
Email: sylviapack@netscape.net

Appendix B

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Te Kura Hinengaro Tangata
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2040
F 64 6 350 5673
www.massey.ac.nz
http://psychology.massey.ac.nz

New Zealand counsellors talk about ritual abuse: a discourse analysis.

Participant Consent Form

I have read the Information Sheet for this Study.
I have had my questions answered satisfactorily and understand my right to ask further questions throughout the study.
I agree to the interview being audio taped.
I understand my right to ask for the tape recorder to be turned off at any time during the interview.
I understand my right to decline any question.
I understand my right to withdraw from the study at any time before September 2008.
I agree to take part on the condition that the interview is confidential and my real name will not be used in the data.
I agree to parts of the interview being used in the researcher's thesis or articles based on the thesis, provided I cannot be identified by these.
I agree to participate in the study under the conditions set out in the information sheet.

Name (printed)_____

Signature_____

Date_____

Appendix C

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Te Kura Hinengaro Tangata
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2040
F 64 6 350 5673
www.massey.ac.nz
http://psychology.massey.ac.nz

New Zealand counsellors talk about ritual abuse: a discourse analysis.

Interview Schedule

There are no right or wrong answers.

1. Definitions

How would you define ritual abuse?

2a. False Memory Syndrome and Ritual Abuse (RA)

Would you say RA is fact or fiction? Why?

False Memory Syndrome:

> In research such as the "Lost in the mall" experiment, trusted family members were induced to tell a younger relative anecdotes of their childhood, and include a fictitious time they were 'lost in the mall' and delivered back by an elderly relative. 25% of participants said they remembered the false memory.

Do you feel such research proves or disproves memories of RA? Why?

NB to researcher:

If participant believes RA to be fictitious, ask the questions in 2b.

If participant believes RA to be a physical fact, omit question 2b.

2b: RA as False Memory.

a) Why do you think adult clients recite childhood experience of RA?
b) Where do children get their RA stories from? For example: television, rock bands, movies, church, internet or other.
c) Do you think overprotective parents are responsible for these accusations?
d) The interview can then become an opportunity for the participant to enlarge on why clients present thus, and to suggest treatment for such clients.

3. New Zealand

a) How prevalent would you say RA, or claims of RA, are in New Zealand today?
b) What sort of things have you read in popular or academic literature regarding RA?
c) Do you feel those texts relate to our lived reality as New Zealanders?

4. RA Symptoms

a) Do you think there might be recognisable symptoms in common for all adult RA clients, for example, emotional or lifestyle patterns?
    i. Can you talk about that?
b) Do you think Sexual Abuse clients show similar symptoms to those citing RA?
    i. Can you describe these symptoms?

5. Diagnosis: RA and mental disorder

a) What are your thoughts about RA clients being diagnosed with Dissociative Identity Disorder (DID) once called Multiple Personality Disorder (MPD)?

b) Do you think symptoms of RA could be, or have been, confused with symptoms of schizophrenia?
c) How helpful are DSM-IV diagnoses for clients claiming RA?
d) What are your comments on this statement: Christian counsellors and therapists are more likely than non-Christian counsellors and therapists, to diagnose RA in clients?

6. Counselling

a) How important is hard evidence of RA, for you as a counsellor?
b) What are your thoughts about the integrity of clients who claim to have experienced RA?
c) Have you ever counselled anyone who claimed to be an RA survivor?
d) How would/did you, go about counselling such a client, or to whom would/did you refer them, and why?
e) Do you think there is are risks attached to counselling RA clients?
    i. What are these risks?
    ii. Do you feel there are risks of repercussion?
    iii. From whom?

7. In conclusion

a) What other views regarding RA, have you heard or read?
b) What is your opinion of those views?
c) Do you have anything else you might like to add? Anything at all?

8. Are there any questions regarding this research?

Appendix D

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Te Kura Hinengaro Tangata
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2040
F 64 6 350 5673
www.massey.ac.nz
http://psychology.massey.ac.nz

New Zealand counsellors talk about ritual abuse: a discourse analysis.

Consent for the Release of Tape Transcripts

I confirm that I have been given the opportunity to read and amend the transcript of my audio tape interview.

I understand that in the interests of confidentiality I may change my pseudonym.
I am satisfied that all identifiers, e.g., names or names of clinics, have been edited out.

I agree that the edited transcripts may be used by the researcher, Sylvia Pack, in her current project and in reports or publications arising from the research.

At the conclusion of the research I would like my tape returned / destroyed / stored

Name (printed)_____

Signature_____

Date_____

Appendix E

Massey University
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

SCHOOL OF PSYCHOLOGY
Te Kura Hinengaro Tangata
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099 extn 2040
F 64 6 350 5673
www.massey.ac.nz
http://psychology.massey.ac.nz

New Zealand counsellors talk about ritual abuse: a discourse analysis.

Name of researcher: Sylvia Pack

A summary of results for participants

This is a summary of the results of the study in which you so kindly participated in 2008. I would like to take this opportunity to thank for your participation, and for the many thoughtful and intelligent observations drawn from your experience and knowledge.

Nine counsellors gave interviews, eight women and one man, all Pakeha, of whom six were ACC accredited. The longest interview was 83 minutes, the shortest 28, and the rounded mean, 48 minutes. The findings of the discourse analysis were as follows:

All of the nine participants constructed RA as a physical reality, although one was not sure it could take place in New Zealand. RA was described as an extreme form of abuse, taking place on many levels, physical, emotional, mental, sexual, and spiritual. The ritual was conducted for a purpose, with multiple abusers who exercised power and maintained secrecy. Some participants

felt that New Zealanders would find RA hard to believe, in the same way that childhood sexual abuse had not been believed in the 1950s.

Part of the analysis involved looking for stake, or what interests consistently and unavoidably guided the participants in their evaluations and arguments. A moral stake of *concern for the client* emerged, which underpinned the discourses and discussions. Examples of this were found in the participants' talk of feeling responsible for their client, or their questioning the helpfulness of various therapeutic methods.

Positioning within a social constructionist or a scientific ontology was also looked at. The participants emerged as being informed by language, but worked for the most part for a government framework which remained informed by a traditional scientific epistemology. Participants positioned themselves in a traditional ontology and used a discourse of *government backing*, to warrant voice. The *government backing* discourse involved the citing of employment experience or qualifications which gave credibility, or the use of scientific nomenclature, when commenting on controversial subjects.

Participants who had had experience of treating RA clients used a discourse of *the credible client.* Participants also constructed three contextual relative truths; the first was a *legal truth,* which involved physical evidence or scientific proof. Secondly, in a *counsellor's truth*, the participants talked about how their doubts regarding RA were explored with their supervisors, and how their own thoughts regarding the facticity of RA had evolved. The *client's truth* was defined as the client's own story, told from the client's standpoint and respected by the counsellor. While not denying the existence of a reality beyond discourse, they were pragmatic in their therapeutic approach, and worked with what the RA client presented.

Discussion on the recovered memory debate, led to the emergence of the discourse *memory is a twilight zone*. In this discourse, repression, fragmentation, and change, were constructed as a part of the memory process, and the dual possibility of correct and incorrect recall in no way discounted the purpose or validity of recovered memories. Experiments such as *Lost in the mall* were critically examined, and not accepted as revealing finite or universal truths. Participants agreed that memories could be implanted, but equally, that some recovered memories could be correct.

In discussion of DSM-IV categorisation, a powerful discourse emerged: *labelling,* which had both negative and positive connotations. The participants maintained respect for essential mental disorders, and saw advantages and disadvantages to labelling, in a discourse of *ambivalence*. Participants also constructed RA as capable of producing some of the symptomologies mentioned in the DSM-IV. Post Traumatic Stress Disorder and Dissociative Identity Disorder were cited as possible conditions resulting from RA.

In a discourse of *preparedness*, the participants talked about the therapeutic and counselling skills needed to provide therapy to RA clients. There was a strong resistance to providing only psychological assessment and medication. Adequate supervision and awareness of risk factors, were regarded as precursors to successful therapy and counselling. Therapy included attending to identity, positioning, and blame, as the client worked through issues of agency and accountability. Some participants talked about accompanying the client on their journey, as they repositioned themselves in stories of resilience and resistance. A spiritual component not normally included in counselling requirements, was also discussed. Several participants described the positive rewards of successfully counselling RA clients.

Application and implications for future research

The need for training and literature on treating RA clients was mentioned by participants and noted to be considered in future research. Because police and hospital records tended to record only physical or sexual abuse, it was suggested that invisibilisation of RA through a lack of category provision, be addressed.

The importance of this study lies in its sympathetic investigation of what could be seen as a neglected area. Participants mentioned the fact that RA was seldom talked about; it is hoped that these findings have in some ways addressed this, and will have relevance for those wishing to research further.

Should you require further information, a copy of the thesis will be available through the Massey University Library after July.

Appendix F

Transcription notation

Overlapping speech

Extended square brackets mark overlap between utterances, e.g.:

A: You were saying you saw that programme on television

[ ]

B: Yes I did

Continuous speech

An equals sign at the end of one utterance and at the start of the next indicates continued speech without pause, e.g.:

A: Anyway you know what I mean=

B: =Oh indeed I do

Pauses

Pause lengths are shown by numbers in brackets.

(.) indicates a pause <1 second,

(1) indicates a pause >1 second and <2 seconds

(2) indicates a pause >2 seconds and <3 seconds

(3) indicates a pause >3 seconds and <4 seconds

E.g.:

A: Just let me think a moment (3) yes I (.) think I remember now

Extended words

One or more colons indicate an extension of the preceeding vowel or consonant sound, e.g.:

A: Ye::::s:: I think it might be

Emphasis

Underlining indicates that words are uttered with emphasis, e.g.:

A: I do think it's a good idea.

Volume

Capitals indicate the volume is louder than surrounding text.

Smaller font size indicates the volume is quieter than surrounding text, e.g.:

A: I yelled at him HEY and he turned

B: mmm

Rising intonation

A question mark indicates rising pitch or intonation, e.g.:

A: I've been doing this job for eleven years you know?

Audible breaths:

(hhh) indicates an audible exhalation

(.hh) indicates audible inhalation

E.g.:

A: (.hh) Is it ten oclock already?

B: (hhh) Yes and I still have a report to write

Laughing talk

Laughing the talk, indicating that the speaker finds the text humorous, is shown by enclosing the text in single curly brackets, e.g.:

A: He expected me to believe him {although he was a convicted conman}

Laughing the talk can also establish sympathetic nervousness between participant and interviewer. This is shown by enclosing the text in double curly brackets:

A: I've heard of rituals you know {{with altars and sacrifices}}

Indistinct utterances

Speech that is too quiet to hear is indicated thus: (inaudible)

Speech where the words are indistinct is indicated thus: (indistinct)

A question mark in the bracket indicates that because of low volume, or the indistinct nature of the utterance, there is uncertainty about its accuracy.

E.g.:

A: I've thought about it a lot but (inaudible) I don't know (indistinct)

B: Mm it's intriguing (as a concept?) but I'm not sure either

Paralinguistic features

Double parenthesis indicate nonverbal activity which inevitably expresses the speaker's state or emotion, paralinguistic features such as laughter, sighing, groaning. e.g.:

A: ((tch)) We've certainly missed the bus

B: ((groan)) Oh no

A: The conversation was too interesting ((laughs))

Identifiers

In the interests of confidentiality, square brackets indicate that identifying data has been removed from the transcript. The word "identifier" is used rather than more definitive terms such as 'relative' or 'head counsellor'. e.g.:

A: I was working at [clinic] back in [year] when [name] was still there(.) she was [identifier] at that time.