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Cinematic sessions : the ethics of therapy in Hollywood film

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ABSTRACT

This qualitative study was undertaken to examine how the therapeutic process is depicted in modern films produced for American audiences over the past two decades, with special reference to how the conventions of ethics in therapy are treated, and to discuss the implications of these findings for clinical practice. A sample of 50 films that featured at least one scene of individual therapy was identified and surveyed using a coding scheme developed for this project. The domains of interest included: clinician, client, and session demographics, and adherence to ethical standards as portrayed in therapy scenes. This study was undertaken to contribute a more recent voice to the growing clinical discussion about the representation of mental health practitioners in film and to call attention to the specific strengths and shortcomings therein. The findings are discussed from a social learning theory framework and the implications for social work practice are discussed.

The findings suggest that many cinematic representations of therapy and therapists are inaccurate and negative. The demographics of the sessions appear to be a representation of Hollywood and not the actual demographics of real clients or clinicians. These cinematic sessions depict ethical transgressions or gloss over ethics entirely, sending an erroneous message about what the actual therapeutic process is like.

This researcher hopes to increase awareness about the existing cinematic portrayals of the therapeutic process and further the discussion of what action social workers can take in response.

CINEMATIC SESSIONS:

THE ETHICS OF THERAPY IN HOLLYWOOD FILM

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

Introduction

The purpose of this study is to examine how the therapeutic process is depicted in modern films produced for American audiences over the past two decades, with special reference to how the conventions of ethics in therapy are treated, and to discuss the implications of these findings for clinical practice. Since the first fictitious depiction of a therapist graced the Silver Screen in 1906 (Schneider, 1987, p. 996), mental health practitioners have been of great interest to movie-going audiences in the United States. The prolific nature of American cinema, coupled with home-viewing technology, has made these portrayals even more procurable over the past twenty years. Inevitably, individuals are bound to make inferences about the therapeutic process, therapists themselves, and to whom they offer their services based, at least in part, on these ubiquitous representations by the film industry.

The past three decades have yielded a number of studies about the portrayal of various kinds of mental health practitioners in American cinema; some have studied the portrayal of psychologists (Schultz, 2005), others, the portrayal of psychiatrists (Schneider, 1987; Gabbard & Gabbard, 1992), and still others the portrayal of social workers (Freeman & Valentine, 2004). However, very few studies have analyzed, as it were, the films of the 1990s and early 2000s; most stop at 1990 and only a few go into the early Aught years. Most often the studies examine narrow criteria about a solitary profession, rarely tying the data together across professional lines. They often look at the data with only vague regard to ethical practice; only a few have

focused on specific ethical violations from the professions' official codes of ethics, while most reference only "ethics" or "boundaries" in a general sense. This leaves a marked hole in the research regarding this topic.

It would seem that the movie industry has created a whole new set of demographic data and ethical values for mental health practitioners in film. The breakdown of clientele and practitioners alike along race, gender, class, and most other demographic lines are culled from the demographics of Hollywood's working actors and not based on national statistics. To varying degrees of ethical misconduct, therapists in the movies interact with their clients in a way that would raise serious ethical red flags for the majority of mental health professions. As social workers in training and by profession, we firstly claim to work exceedingly hard to break through race-, gender-, and class-based barriers and secondly claim we need to be acutely aware of the ethical guidelines and obligations of our practice. It is imperative that we critically examine what the mass media is feeding the general public about the demographics of people served by and those serving in the mental health profession, in addition to clinicians' conduct with regard to ethical matters. It will help us further understand the possible perception or exposure of a population that includes our potential clients.

This topic is also relevant to social work practice and preparation in that, according to the National Association of Social Workers' (NASW) website, "professional social workers are the nation's largest providers of mental health services. Social workers provide more mental health services than psychologists, psychiatrists and psychiatric nurses combined" (National Association of Social Workers, 2007). This indicates that we are already serving the majority of clients in the mental health field. Additionally, the website for the Bureau of Labor Statistics states that "between 2008 and 2018, jobs for social workers are expected to grow faster than the

average for all occupations" (Bureau of Labor Statistics, 2010), indicating that our clientele and practice will only continue to increase. It will be imperative for us, as practitioners, to have a sense of the possible viewing experiences of our clients, as we will be serving the greatest number of clients in the field and doing more intake interviews. While a question regarding past experience with therapeutic services is often part of an intake interview, questions about perceptions of the process are rarely included. Past viewing experiences and the resulting perception could play as big a role in a person's opinion or attitude toward services as actual personal experience. In that light, as we see a greater array of clientele and need to assess their attitude towards the therapeutic process, it is important for clinicians to be prepared to ask about this sort of thing and have an understanding of what is out there on film in the first place.

The purpose of this study is, therefore, to look at how the therapeutic process is depicted in modern films produced for American audiences over the past two decades, with special reference to how the conventions of ethics in therapy are treated, and to discuss the implications of these findings for clinical practice. The next section of this paper explores the literature on this topic.

CHAPTER II

Literature Review

Anecdotally, film is salient to us. “Going to the movies” appears on many a self-care list generated in the summer at the Smith College School for Social Work, and nearly everyone in the profession has a movie they can reference where they either loved or hated the representation of the mental health practitioner therein. This anecdotal ubiquity inspired me to look at the existing analytic literature and attempt to understand, in more concrete terms, who is being portrayed in these films and how.

Fundamental to this project is the premise that film has a significant impact on the perception of viewers. The literature review begins by documenting research in this area. The second section reviews literature with regard to how the therapeutic profession is presented in film, and what effect that is seen to have on viewers, leading to the finding that the ethical portrayal of the mental health profession is vastly different in film than in actual sessions, to the possible detriment of people’s perception of the profession. The third section explores ethical standards across professional lines in order to develop a typology of ethics that are central to all mental health practitioner disciplines and to identify criteria for identifying ethical breaches as they may be portrayed in films.

The Influence of Film on Perception

Many studies have concluded that film has an effect on perception. For the most part, these studies explain that media portrayals can at worst be the origin of, and at best, reinforce, stereotypes. Greenberg (2009) refers to this as “Hollywood’s fascinating colonization of the

collective mind" (p. 244), beautifully conveying his conception of our societal social awareness as an entity that can be commandeered by notions implanted by the film industry.

Supporting theories

Some use theories to frame these conclusions (Bandura, 1978; Carr, 2008), such as social learning theory – later renamed social cognitive theory in 1986 (Bandura, 2007, p. 65), mass society theory, social responsibility theory, and limited effects theory.

Bandura conducted extensive studies on the effect of aggression on children and the role of television and media as a form of observational learning on people of all ages. He looked at the ways in which our brains are affected by what we see and how we learn certain types of behavior. In discussing how children are affected by viewing aggression in the media, Bandura (1978) uses social learning theory to explain how

> during the course of their daily lives, people have direct contact with only a small sector of the physical and social environment… Consequently, people form impressions of the social realities with which they have little or no contact partly from televised representations of society…[This] can distort knowledge about the real world (p. 16).

In other words, for those viewers who have not encountered a certain kind of profession or experience in person, the representation by the media, and more specifically for the purposes of this study, film, can absolutely influence their perception of reality.

Hedley (1994) flushes out this theory by noting, "to the degree that a given individual has been exposed to behavioral experience that contradicts these stereotypes, the stereotype weakens for that individual" (p. 737). This reinforces the idea that people whose only 'encounter' with a

given profession is from the media will believe that impression because they have no other experience with which to compare it.

Social learning theory is a complex idea, yet a relevant one when considering the potential influence of film on perception. The theory includes the concept that "observational learning conveys information to the individual about what types of actions are likely to be rewarded (or punished) and the stimulus conditions under which it would be appropriate to engage in them" (Tedeschi & Felson, 1994, p. 105). Therefore, watching things on film sends a number of messages to viewers about what is acceptable, unacceptable, and expectable in the world depicted; "by extracting a general principle from observing the model's experience, observers can develop the expectation that under the same conditions, if they imitate the model, they will receive the same outcome obtained by the model" (Tedeschi & Felson, 1994, p. 106). This concept does not sound revelatory, as the basic concepts of social learning theory, i.e. observational learning and learning through direct consequences, "have become an accepted part of our knowledge base" (Grusec, 1992, p. 776). Also of note in this theory is the idea that "positive expectations may activate… behavior, but negative consequences and unfulfilled expectations will decrease the tendency to repeat it" (Tedeschi & Felson, 1994, 107). Therefore, if someone is exposed to something on film that they think might be negative or unfulfilling, they may be less likely to engage in that activity themselves.

In a lecture about quality of life, Carr (2008) provides an overview of that topic from the perspectives of nursing, psychology, and behavioral medicine, and discusses the way that terminal cancer patients' view of quality of life is affected, using three theories of media influence: mass society theory, social responsibility theory, and limited effects theory. She describes how mass society theory posits that "media is the source of corruption – brainwashing

defenseless, average people with propaganda and creating paranoia" (p. 47). Noting that other theories of the effects of the media exist, she nevertheless takes as a given that media affects viewers' perceptions. In social responsibility theory, she states that "media reflects the diversity of the society it serves and is accountable to," yet notes that this is an "idealistic" theory with "obvious weaknesses" (p. 47), not assigning any accountability to the media for the negative images and messages it represents. Regardless, she says, it is a "powerful source of information" (p. 47), upholding, yet again, the idea that we are affected by what we see. Finally, she goes on to explicate limited effects theory, which "proposes that the mass media reinforces existing social trends and strengthens the status quo" but is "powerless to overcome an individual's strong inherent beliefs" (p. 47). Unaccounted for here is the question of the effect of the media on a person without "strong inherent beliefs" – what if, for example, they were seeing a depiction of something they had never seen before, as Bandura discussed above? We can infer that the first statement of the theory would then reign supreme and "strengthen the status quo," thereby perpetuating un-contradicted stereotypes presented in film.

Both theoretically-based studies concluded that the groups they examined were adversely affected by the portrayal of aggression and sickness in the media; Bandura (1978) put it poignantly, stating "many of the misconceptions that people develop about certain occupations, nationalities, ethnic groups, sex roles, social roles, and other aspects of life are cultivated through modeling of stereotypes by the media" (p. 16). No studies were identified that discuss a positive effect.

Empirical studies

Numerous other studies used empirical data to support the idea that film has an effect on perception. These other studies have primarily used things like body image, self-esteem, gender

roles, and aggression to test the effect of film on perception, usually concluding that it does, in fact, have an influence. A study of 5th, 8th, and 12th graders administered a survey to 209 students asking for qualitative responses about each student's perception of self and the correlating influence of the media on said view (Polce-Lynch, Myers, Kliewer, & Kilmartin, 2001). They found the participants' self esteem, gender presentation, and evaluation of physical appearance were all correlated and negatively influenced by media representation (p. 237-9). Aubrey's (2007) study of 384 undergraduate students relied on self report about sexual activity and perceptions and individual ratings of 77 television shows and 61 magazines for sexual content; a survey was administered to these students asking them to rank various things about their bodies and self esteem. In this study they found that, even in older young adults, "sexual media exposure is related to sexual attitudes, expectations, beliefs, and behavior" (p. 2). These studies are important in that they account for the effect of film on perception at a wide range of ages, although a weakness is that they did not ask about specific films, but rather about film, media and movie stars in general.

Even more compelling in support of the idea that film has an effect on perception are studies that showed participants clips of movies in addition to administering surveys; this strengthened the link to film, specifically, as opposed to just "media" or "popular culture," in general. Hedley (1994) coded film clips from the 50 top grossing films of 1986-1990, using content and statistical analysis and qualitative structural analysis to establish that the "systematic stereotyping of gender and affect… influences the generation of similar sentiments at the individual level" (p. 737); Hedley also found corroboration for the idea held by Polce-Lynch et al. (2001) and Aubrey (2007) that body image and gender presentation are affected by images on film (p. 734). Kulick & Rosenberg (2001) showed film clips to undergraduates to establish a link

between film and drinking, and concluded that “even relatively short (under 1 hour) exposure to motion-picture portrayals of distilled spirits can have an immediate effect on older adolescents’ expectancies about the consequences of drinking alcohol” (p. 1498). A weakness of these studies is that they were unable to determine whether there were long-term effects on perception.

As each of these studies have concluded, film does indeed have an effect on perception in many arenas; quality of life (Carr, 2008), the view of psychiatric nursing (deCarlo, 2007), aggression (Bandura, 1978), body image and gender presentation (Polce-Lynch et al., 2001; Aubrey, 2007; Hedley, 1994), drinking (Kulick & Rosenberg, 2001), childbirth (Pincus, 2010), and more. As Pincus (2010) puts it, “these films… taken one by one, may seem innocuous, but seen in the aggregate, have a great deal of negative power” (p. 82). Not only do film representations of things have an effect on people, they have the potential to, and often do, have a negative effect, at least part of which is because of their prolific availability.

A few studies found that society had an effect on film in addition to film having an effect on society (deCarlo, 2007; Freeman & Valentine, 2004; Gabbard, 2001; Young, Boester, Whitt, & Stevens, 2008). Applying ethnographic content analysis to nineteen American made films between 1942 and 2005, deCarlo examined the way film treated psychiatric nursing. Apparently noticing dual effects, deCarlo (2007) first stated that “film merely reflects a society’s values, attitudes, and beliefs; it does not create them” (p. 346) and then went on to say later, “research confirms that such stigmatizing portrayals in the media have a direct effect on the viewer’s attitudes towards the people depicted” (p. 347). Others have noted that the film depiction of therapists is influenced by society’s views in addition to the other way around; “the way that psychotherapists have been portrayed in the cinema is a direct reflection of how society regards psychotherapy” (Gabbard, 2001, p. 366). While initially frustrating to read directly contradictory

statements such as these, it merely indicates that it is, perhaps, an ongoing discussion in the field at large about whether art imitates life or life imitates art. If we can hold a both/and stance for the purposes of this study, this ongoing quandary does not need to negate the idea that film has an effect on society merely because society might also have an effect on film.

The Presentation of the Therapeutic Profession in Film

This study's initial premise, that film has an effect on perception in general, was supported in the literature. The next task was to examine how the therapeutic profession, specifically, is presented in film and what influence that is seen to have on viewers. Across the board, research literature on this topic found the portrayal of therapists and therapy in film to be highly stereotyped, sexist, unboundaried, unethical, diagnostically limited, and ultimately unrealistic (Akram, O'Brien, O'Neill, & Latham, 2009; Freeman & Valentine, 2004; Gabbard, 2001; Gabbard & Gabbard, 1992; Gordon, 1994; Greenberg, 2009; Schill, Harsch, & Ritter, 1990; Schultz, 2005; Young et al., 2008).

Common stereotypes

In their respective studies, in which the researchers used content analysis of films depicting mental health professionals, Schultz (2005), Gabbard & Gabbard (1992), Greenberg (2009) and Freeman & Valentine (2004) all based their analyses, in some way, on Schneider's 1977 theory that the movies present three salient stereotypes of therapists. Some expanded upon them, adding more of their own. A professor of psychiatry who often uses film within his classes, Greenberg analyzed the usefulness of such a technique by looking at a few portrayals of psychosis and reflecting on the strengths and weaknesses of what could be gleaned from them in a classroom. Within this piece, Greenberg (2009) summarized and described Schneider's original stereotypical clinicians best, detailing the characteristics of "Dr. Dippy (crazier than then

clientele), Dr. Evil (psychiatric avatar of the mad, bad scientist), Dr. Wonderful (the analyst you wish you had: ever available to the hero or heroine, no other patient in sight; a Hamishe hugger (comforting), fee never mentioned)." Greenberg also added "Dr. Horny, sometimes an eminent seducer; sometimes eminently seducible by a sensuous, psychopathic client" (p. 243). Schultz (2005) posited, somewhat more vaguely, that "the most common movie stereotype… may be Dr. Line Crosser. He or she crosses boundaries of different types, typically becoming romantically involved with patients. This is a recurring theme, portrayed with the strong implication that such love affairs are curative for both patient and therapist" (p. 102).

Schultz had compared psychologists in film with psychiatrists in film, looking specifically at the breakdown of boundary violations along gender and professional lines. In one of their many articles on the stigmatization of psychiatrists in film, Gabbard & Gabbard (1992) expanded this list into ten categories by analyzing the content of an extensive list of films from the first two thirds of the twentieth century. In a similar study that looked at social workers, Freeman & Valentine (2004) explored the stereotypes of that profession, noting that "social workers [in films and plays produced before World War II] were portrayed either as 'young fallen angels' or 'older spinsters or misguided mother-types'" (p. 151). Each of these studies looked at films produced before the late-1990s, analyzed only one profession, and did not specify that there be actual therapy depicted.

Gender

Many studies highlighted a difference in gender representation in the depiction of mental health professionals (Aubrey, 2007; Freeman & Valentine, 2004; Gabbard, 2001; Gabbard & Gabbard, 1992; Greenberg, 2009; Hedley, 1994; and Schultz, 2005). While male practitioners were as susceptible to general boundary violations, female practitioners were much more likely

to cross a sexual boundary. According to one source, the female mental health professional is often shown to be an "unfulfilled single woman who works compulsively to make up for a lack of fulfillment in her personal life… the love of the male patient brings these women to life so that they no longer need their careers" (Gabbard & Gabbard, 1992, p. 118). Most of these studies looked at films from all time periods and eras, and general gender stereotypes of both the time periods in which they were made and those that they claimed to depict were not necessarily taken into account. They found that this theme extended into films made in and depicting the later half of the 20th century as well. While another study also noted that "female therapists are repeatedly de-professionalized and reduced to sex objects" (Gabbard, 2001, p. 367), only one (Freeman & Valentine, 2004), which, as a reminder, examined the portrayal of social workers, pointed out that they were all heterosexual representations and thereby doubly limited by this presentation.

Title and diagnosis

Another trend that these studies pinpointed was the lax attitude taken towards official title; this was twofold, with film therapists shown to be inexact both in diagnosing patients with formal, real disorders, and also in appropriately credentialing themselves as professionals (Gabbard, 2001; Gabbard & Gabbard, 1992; Greenberg, 2009; Schultz, 2005). A couple of studies focused primarily on how psychiatrists were portrayed on film, and they noted that films tended to "use the term 'psychiatry' in a general sense with no distinction among different kinds of mental health practitioners" (Schultz, 2005, p. 102), or observed that "psychiatrists are almost always portrayed as psychotherapists… I have yet to see one [film] that depicts the effective prescribing of psychotropic medication" (Gabbard, 2001, p. 365). Either the mental health practitioners were inaccurately titled, or they were all grouped into the category of "therapists," with little-to-no explanation for the schooling or differentiation between disciplines.

In a similar instance of inexactitude, many patients within film are labeled with some phony jumble of psychological-sounding words that are not actual diagnoses, or they fall into only a few popular categories, as laid out in one study which noted that "the diagnostic compass of the typical psychiatric movie is meager indeed… Hysterias, amnesias, and sundry dissociative reactions are privileged over subtler illnesses, as are various post-traumatic syndromes and flagrant impulse control disorders" (Greenberg, 2009, p. 242). This representation sends the message that mental health professionals use convoluted language to label their clients, and/or only treat a certain niche of clientele holding a one of a very few, limited possible diagnoses. It sends the message that certain things are more deserving of therapy, or, through another lens, are more serious or concerning and therefore more in-need of help. Each of these studies noted that it is an inaccurate depiction of both diagnoses and professional titles, sending a skewed message about who is actually practicing in the field and who is utilizing services.

Unrealistic features

The existent literature also noticed that there are a handful of other unrealistic features of cinematic depictions of therapy (Greenberg, 2009, Gabbard & Gabbard, 1992, Gabbard, 2001). Perhaps most prominent of these unrealistic things is the idea of "catharsis without insight" (Greenberg, 2009, p. 243). Characters who reach some sort of breakthrough in the course of the 90-140 minutes of a movie are a dime a dozen, regardless of the real trajectory of most treatments. As one researcher concluded, this trend is a result of the fact that "movies are a medium of action… The cathartic cure may be psychiatric myth, but it is good drama… The 'showbiz' value of any treatment is of much more importance to filmmakers than its clinical accuracy" (Gabbard, 2001, p. 366-7). While this might make cinematic sense, it constitutes a large portion of the unrealistic portrayals of therapy in film.

Influence on Viewers

Studies differed in the analysis of the effect on viewers, with some believing the unrealistic portrayal to be of negative consequence (Freeman & Valentine, 2004; Gabbard & Gabbard, 1992; Schill et al., 1990; Schultz, 2005; Young et al., 2008), others concluding that viewers are mature enough to understand the erroneous depiction as being fictitious and far from what an actual mental health experience might be like (Greenberg, 2009), and others conceding that it might be more complicated than just one or the other (Gordon, 1994; Gabbard, 2001).

Negative influence on viewers

Those who concluded that the inaccurate cinematic portrayals of mental health practitioners would have a negative effect on viewers did so emphatically, noting that such a rendering might plant the seed of a negative perception or serve to reinforce an existent misconception (Schultz, 2005; Gabbard & Gabbard, 1992). Towards the former, Gabbard & Gabbard noted that film depictions lay the groundwork for our societal perceptions in the first place, saying, “cinematic portrayals of various professional groups serve to construct a cultural mythology that becomes a part of the collective unconscious of the American public” (Gabbard & Gabbard, 1992, p. 114). Towards the latter, Schultz laid out, with concern, that “it seems reasonable to assume that for those who are ambivalent about seeking help or who already hold negative opinions about psychotherapy, these stereotypes could reinforce and resonate with their fears, especially if movies are their only source of information about the profession” (Schultz, 2005, p. 104). Gordon referred to this as “widespread misunderstanding” (Gordon, 1994, p. 144), implying that it might be remedied with suitable explanation, yet all of the research seemed cognizant of the fact that such a repair would entail a large uphill battle because of the prolific and deep-seeded nature of these misconceptions.

Some authors maintained that even positive portrayals might set the stage for unreasonable expectations about the miraculous nature of therapy or an individual therapist. Gabbard & Gabbard (1992) noted that "certain positive portrayals of mental health professionals can be just as stigmatizing as negative portrayals in that they misrepresent psychiatry to the public and mislead patients into expecting the impossible" (p. 119-120). Indeed, the short-term, big-effect nature of cinematic sessions alone could easily make therapy seem like a one-shot deal to someone unfamiliar with the process.

One empirical study about the effect of a film portrayal on a viewer's perception was found. Schill et al. (1990) showed college students the 1983 film *Lovesick*, in which a therapist pursues a romantic relationship with a client, and they administered a survey before and after about beliefs about the therapeutic frame and process. They concluded that the film depiction had a negative impact; "subjects held more erroneous beliefs about psychiatry after seeing the film" (p. 401). It is of particular note that this is the only study identified in an extensive literature review that empirically measured perception; and the authors concluded that perceptions of the therapeutic frame and process were negatively effected.

Harmless influence on viewers

Arguing that the cinematic portrayal of mental health professionals, while erroneous, is not ultimately harmful to the perception of the actual process, Greenberg states, "the bulk of movies are not deliberately shot to educate viewers about *anything*" (Greenberg, 1994, p. 241). He believes that even well-informed filmmakers "sacrifice truth for narrative punch" (p. 242) and the average viewer must therefore have come to assume that cinematic portrayals are not necessarily accurate. Going a step further, Young et al. argue that depictions of mental health practitioners, however accurate or inaccurate, "may come to seem less threatening and more

revealing, shedding light on real professional motivations – the noble, the ignoble, and everything in between" (Young et al., 2008, p. 96). They posit that whatever exaggerations made for the sake of narrative in fact "parallel actual human motivations" (p. 96), and therefore even an embellished portrayal cannot be ultimately harmful because it has strains of truth at least somewhere behind it.

A potentially positive influence on viewers

Two researchers put forward the idea of these invalid representations not actually being the sole fate of the reputation of mental health practitioners. They acknowledged that, while such portrayals do have an effect, they also serve a purpose not ultimately condemning. Gordon made the case that these representations are a kind of defense, wondering if

> underlying all this is… a fear of the world of emotions, the irrational and the unruly, the uncontrollable, and the pain of coming to terms with these. The response, the defence [sic] one might say in the jargon, is to misrepresent and to make fun of: what is eccentric, crazy even, need not be taken seriously (Gordon, 1994, p. 144).

Gabbard also chose to frame these representations in terms of a therapeutic event, conceiving of it as transference and stating that "if therapists can accept that their roles as transference objects transcend the confines of the consulting room and spread onto the great silver screen, they can view the distortions with detached curiosity, with empathy, and with understanding, just as they approach transference attitudes in patients" (Gabbard, 2001, p. 369). Gordon and Gabbard both appear to have sublimated the possible reactions to the usually-erroneous depictions of mental health practitioners in film, but the overall sense was that these portrayals are complicated at best and harmful at worst.

Ethical Standards across Professions

Having reached an understanding of what the existent literature said about the effect of a cinematic portrayal of a mental health practitioner on an average viewer, the next step was to explore which ethical standards are most salient, holding true across professional lines, so as to understand which ethics apply to every type of mental health practitioner. Each profession has an official Code of Ethics to which each practicing professional must adhere (American Psychiatric Association, 2009; American Psychological Association, 2002; National Association of Social Workers, 2007). These are updated periodically to stay up-to-date with the times and incorporate language that suits our more technologically advanced era, and it is the duty of each professional to learn these ethics by heart so as to be able to uphold them in individual practice. The National Association of Social Workers publishes a twenty-seven page handbook (NASW, 2008), the American Psychiatric Association issues a forty-one page handbook of medical ethics with special annotations for psychiatry (2009), and the American Psychological Association publishes a thirty-six page code of ethics (2002). Ten salient rules that applied across the board for each profession were identified (Appendix A) and later incorporated into the viewing guide as categories that were present or absent in the film. The review identified which ethical standards are important in every kind of consulting room, regardless of specific professional affiliation; confidentiality, conflicts of interest, sexual relationships, sexual harassment, informed consent, billing standards, termination, multiple relationships, interruption of services, and documentation were all clearly stated and mandated by each profession's ethical standard.

Jain & Roberts (2009) provided an explanation of why ethical standards are important, first providing a succinct definition of the components of therapy subject to ethical frame:

> role, time, place and space, money, gifts, clothing, language, and physical contact. A healthy therapeutic process has clarity and relative consistency regarding these specific domains for professional interaction… [They] help establish a pattern that allows for the development of greater trust in interactions between therapist and patient… [and] creates fewer opportunities for missteps by the therapist in serving the needs of the patient. (p. 304)

Ergo, having consistent boundary violations depicted on film would establish an opposite pattern in the minds of viewers and possibly impede the 'development of greater trust.' This is not a small matter of concern, as "even the subtlest ethics issue may greatly influence the therapist's ability to establish a safe, effective, and beneficent framework for treatment" (Jain & Roberts, 2009, p. 299-300). Boundary violations are presented in the literature as something about which practitioners must constantly be aware, not to be taken lightly, and certainly not to be transgressed in the flagrant way as so many films depict.

Much of the existing literature drew a distinction between boundary violations and boundary crossings (Gabbard, 2006; Jain & Roberts, 2009). Gabbard (2006) described the two very clearly, saying "boundary violations are generally regarded as egregious enactments, such as sexual relations with a patient, that are repetitive, pervasive, and harmful to the patient as well as destroying the viability of the analytic treatment" (p. 40). He seems to agree with Gordon (1994), who stated that, in the case of a boundary violation, "the fundamental idea of the analytic space as one which must be free of external impingements and the distractions of ordinary social intercourse goes out the window" (p. 143). As ethical standards are so clearly defined, so therefore are boundary violations, seen to significantly affect the content and frame of a session.

Boundary crossings, however, as defined by Gabbard (2006) “are benign and even helpful countertransference enactments that are attenuated… They are more likely to occur in isolation, are subject to analytic scrutiny, and extend the analytic work in a positive direction” (p. 41). According to this view, not every ethical transgression is necessarily harmful to the treatment, but can rather serve to provide room for a further investigation of a dyadic exchange or dynamic that ultimately helps the therapy.

The literature clearly states, however, that such a situation, in order to be advantageous, needs further attention in the actual session, back within the frame, and the support of supervision or consultation (Gabbard, 2006; Jain & Roberts, 2009). That context would “allow for the emergence of a transference object or series of objects that can be analyzed and interpreted” (Gabbard, 2006, p. 40). It seems to be accepted that there is a “universal vulnerability of all therapists to such misconduct” (Jain & Roberts, 2009, p. 305) and self-awareness and case-consultation help to insure a healthy, optimal way of dealing with it. That the films depicting ethical transgressions rarely also show such self-awareness or case-consultation is, perhaps, the real issue.

Summary

In summary, the literature review found that film, in general, has an effect on society, which Greenberg (2009) refers to as “Hollywood’s fascinating colonization of the collective mind” (p. 244). Bandura (1978) put it clearly, stating “many of the misconceptions people develop… are cultivated through modeling of stereotypes by the media” (p. 16). Therapy in film has an influence on viewers and is often portrayed in an erroneous way, shown as highly stereotyped, sexist, unboundaried, unethical, diagnostically limited, and ultimately unrealistic (Akram, O’Brien, O’Neill, & Latham, 2009; Freeman & Valentine, 2004; Gabbard, 2001;

Gabbard & Gabbard, 1992; Gordon, 1994; Greenberg, 2009; Schill, Harsch, & Ritter, 1990; Schultz, 2005; Young et al., 2008). Lastly, specific, similar ethical guidelines exist in all three branches of the mental health field and, without self-awareness or supervision, could be egregious if transgressed, as "even the subtlest ethics issue may greatly influence the therapist's ability to establish a safe, effective, and beneficent framework for treatment" (Jain & Roberts, 2009, p. 299-300).

The literature review supported the need for additional research in this area; the theories of film as an influence on culture and ethics as a frame for good therapy provide a backbone for the study; they show that we are affected by what we see, and the ethical deportment of a therapist exists for an important reason. It is additionally clear that the portrayal of therapists in film has already been shown to have an effect on the general public; if we are influenced by what we see, and what we see is inaccurate, we therefore must have an erroneous view of what has been presented. The tension in the existing literature shows a need for continued research on this topic, to understand which specific ethical guidelines are violated or upheld in more recent films and what messages those cinematic portrayals of the therapeutic process send to our potential clientele.

It will be important to build upon the existing research and attempt to view a wide and diverse array of more recent films, assessing for the ethical portrayal therein. And, it will be important to track the demographic depictions of each therapeutic interaction. Having reached an understanding that yes, mental health practitioners are portrayed in a way that is inconsistent with their professional ethical standards, this study does not undertake to analyze the impact of that portrayal on individuals. The goal of the study is to identify the specific ways in which the target films deviate from accepted ethical standards across therapist types, and, to discuss the

implications of the findings for clinical practice. The next part of this paper will detail the methodology regarding this topic.

CHAPTER III

Methodology

The purpose of this project was to explore how the therapeutic process is depicted in modern films produced for American audiences over the past two decades, with special reference to how the conventions of ethics in therapy are treated, and to discuss the implications of these findings for clinical practice.

This study was designed as a qualitative study using a purposive, non-probability sampling approach. Data were entered into two spreadsheets of the researcher's design. Demographic data for both client and clinician and therapeutic frame in each film were collected in one measure (Appendix B). The second measured ten overlapping ethical guidelines taken from the professional codes of ethics for social workers, psychologists, and psychiatrists, coding for adherence, inadherence, or inapplicability (Appendix A). These served as scoring guides for each film.

For the purpose of this study, the canopy terms of "therapy" or "mental health services" were used, as they often are in cinematic culture, to interchangeably describe interactions between patients and variously classified mental health professionals, such as social workers, psychologists, or psychiatrists. On occasion, the actual professional title of the clinicians was not specified. Only films that show, on screen, an actual portrayal of the therapeutic interaction itself in the form of an individual session, and not merely reference an off-screen occurrence or feature a so-titled character whom we never see performing his or her actual job, were selected for inclusion.

Sample

Inclusion criteria

All films had to be created by studios in the United States and released to American audiences between the years of 1990 and 2010. They had to feature at least one scene of individual therapy between a client and a mental health practitioner of any professional qualification. Lastly, they had to be available through Netflix, a video rental service that sends DVDs to the home and also makes movies available for streaming online through a personal computer.

Sampling strategy

For the purposes of this study, I used a purposive, non-probability sample. Candidate films meeting inclusion criteria were selected using the following methods:

1. A standard search engine available online, Internet Movie Database (IMDb), was interrogated to identify films with “therapy” in the search string. The list was refined by selecting “Movies,” and excluding “Television,” “Video Games,” and “Short Films.” This strategy generated a list of 151 movie titles. These 151 movies were sorted by “Release Date,” and films made before 1990 were eliminated. This reduced the list to 116 films. The Head of Cataloging and Access in the Motion Picture Department at the George Eastman House in Rochester, New York was consulted. He indicated that the search string keywords are generated by IMDb users and not by professionals or by any standardized method. A film would appear on this list if a user had happened to use “therapy” in the description of the film (J. Case, personal communication, November 9, 2010). This meant that the list as generated using the strategies described above included films that did not actually meet all of the

inclusion criteria. For example, some of the films were not American, did not feature individual therapy, or rather featured a different kind of therapy entirely, like physical therapy. The initial sort also included films that had been erroneously labeled by a user, and excluded films that did meet my criteria but had happened not to be coded accordingly. This therefore proved not to be as exhaustive a list of films as originally thought.

2. Therefore, as a second strategy, a user account was created on the online discussion board at IMDb, and participants, self-identified "movie buffs," were asked to help the author create a list of movies meeting criteria for study entry. (Appendix C). 24 responses were received actually listing titles, and several taking issue with the author for posting where she had and why she had. Using those responses, the author's own personal knowledge of films, and various titles that were identified in the course of the literature review, an additional list of 171 film titles meeting inclusion criteria were created.
3. This list of 171 titles was combined with those generated by the IMDb key word search, resulting in a list of 287 films.
4. Duplicate titles were eliminated; 18 films appeared on both lists, leaving 269 candidate films.
5. Next, detailed synopses of the remaining films were obtained through IMDb and/or Wikipedia in order to eliminate films that were produced before 1990, not produced by American companies or whose descriptions did not include individual therapy. After these procedures, 94 films were considered to have met inclusion criteria. The list of 94 candidate films was entered into a random number generator (Haahr, 2010,

p. 1) and the first 50 films were selected for the sample. When four of those titles later became unavailable at Netflix, the next four titles off the randomly generated list were selected to replace them.

6. Upon starting to watch the films, the author realized that some actually featured multiple clients, and some featured multiple clinicians. For the purposes of efficiently coding this study, only the dyad that was featured most prominently in the narrative of the film was included for scoring. Thus, each film could be scored using the same criteria without having to eliminate films featuring multiple dyads.
7. Finally, as viewing progressed, it was realized that six of the films did not actually meet inclusion criteria in that they did not depict a scene of individual therapy after all, and so the final sample submitted for analysis consisted of 44 films (Appendix D).

Because this sampling method relied heavily on subjective experience with the movie industry, it is possible that it is not representative or exhaustive of all movies made during the period under study that fit inclusion criteria. There are significantly more depictions of psychologists and psychiatrists than of social workers in the sample, demonstrating the need for more representations of social work in film.

Data collection

A chart listing all the demographic data that were to be tracked in each film was created (Appendix B). The selected films were viewed between December, 2010 and March, 2011. The chart was used to record information about each film. The data collected included race, gender, age, class, marital status, sexual orientation, family constellation, appearance, modality, fee structure, setting, ethical deportment, presenting problem, diagnosis, and theoretical orientation

of each therapeutic dyad depicted. Each film was viewed in its entirety so as to collect demographic or qualitative responses relevant to the study that were not uttered within the scene depicting therapy. The researcher manually entered the respective data into each column as it was revealed over the course of the film.

Qualitative responses were also captured in the form of quotations transcribed from the films if they provided information about the theoretical orientation, opinion about the process, bias, or view of mental health practices.

Finally, a second tracking chart was created to classify the adherence of each film to ten overlapping ethical guidelines culled from the codes of ethics of the social work, psychological, and psychiatric professions (Appendix A). This was created by examining each code of ethics and identifying ten principles that appeared across all codes of ethics. The chart in Appendix A includes the sequencing codes from each code of ethics so that any future researchers could easily replicate the chart if necessary. Specific quotations from the Codes of Ethics, including the section in which that ethical guideline was mentioned, were listed as subcategories and used to operationalize each ethical domain.. Each ethical domain was classified as either “adherent,” “inadherent,” or “not indicated.” This was then used as a guide when deciding in which category to code the observed interaction.

Limitations of the study method

As previously described, it is possible that the sample was not representative of all films in the time period under study. The film industry does not maintain a comprehensive index of films and various, potentially limiting, strategies had to be employed to develop a list of films for inclusion. The way in which the film list was compiled was, in part, subjective and reliant on human recall and experience, thereby opening it up to a greater risk of error and omission. It also

required that the films in question made it to DVD distribution within the timeframe specified, which may therefore have unintentionally excluded any financially unsuccessful or particularly small independent films. The films also had to be readily available for viewing, and the reliance on Netflix as the only source added another level of subjectivity and potential bias. Lastly, if someone watching the films featuring multiple dyads thought, for any reason, that a different dyad was the "main" one in the film's narrative, then that would change the data set as well.

As only American films were sampled, there is an inherently Western bias regarding the representation of society as a whole and of the therapeutic process, which would need to be taken into consideration if attempting to replicate. Similarly, because the sample is entirely in English, this inherently excludes the point of view of non-English films.

Data analysis

Data were entered manually by the researcher using two spreadsheets. Missing data were coded, when present. Analysis of the mixed-method data collection consisted of descriptive statistics for all demographic and ethical data and qualitative analysis of open-ended quotations. Details of this analysis are provided below.

Descriptive statistics were used to catalog the clients and clinicians in the sample demographically and to provide summary information about the session setting and details. Using Microsoft Excel's statistical tools, frequencies were run for the following *film and session* demographics: year of release, genre, rating, geographic location(s) of the therapy, setting(s) of the therapy, length of one session, length of treatment, and frequency of sessions. Frequencies were run for the following demographic variables on both clients and clinicians: total number in the film, age group, gender, race, religion, sexual orientation, marital status, number of children, and socioeconomic status. Frequencies were run for client demographics for profession,

medication, and diagnosis. Frequencies were run for clinician demographics for professional title. Frequencies were also run for the following ethical categories: informed consent, conflicts of interest, privacy and confidentiality, sexual relationships, termination of services, sexual harassment, multiple relationships, interruption of services, documentation/records, and billing/fees.

Thematic analysis was performed on open-ended quotations and transcriptions of dialogue from the movie. Quotations from films were transcribed by the researcher into separate text tables within the demographic tracking spreadsheet (Appendix B). Data were coded according to themes that applied to the research question, emergent themes raised film by film, and also by current literature regarding this topic. Marjorie Postal, the statistical consultant at the Smith College School for Social Work, provided the analysis support for these statistics.

CHAPTER IV

Findings

This chapter presents the major findings beginning with the demographics of the films themselves, and continuing with those of the therapy framework and setting within the film. The demographics of the clients and the clinicians in the films are described next, followed by a discussion of the findings of the adherence, inadherence, or omission of ten ethical guidelines within the sessions presented on screen. The chapter will be interspersed with the qualitative comments transcribed from the dialogue of the films, and will conclude with a summary of the major themes of those qualitative findings.

Demographics

Data from 44 films were analyzed. Although a total of 50 films were viewed while collecting data, six of these films were excluded from the study because they did not feature a scene of individual therapy. Demographics were coded for each of the remaining 44 films, the sessions, the clients, and the clinicians.

Film demographics

As one might expect of 44 films made over the course of twenty years, the films themselves had a number of varying demographics entirely separate from anything relating to the content of the narrative. Out of the 44 analyzed films, 4.5% were produced in each of the years from 1991 through 1997 and also the year 2000. 2.3% of the films were produced in the years 1998, 2008 and 2009, while 6.8% were produced in 1999, 2002, and 2007. The year 2001 hosted

9.1% of the sample and 2005 produced 11.4%. The most prolific timeframe was 2006, with 15.9% of the films in the sample coming from that year.

The demographic characteristics of the films are illustrated in Tables 1.1, 1.2, and 1.3.

Table 1.1

Films: Year of Release (N=44)

Year	Frequency	%
1991	2	4.5
1992	2	4.5
1993	2	4.5
1994	2	4.5
1995	2	4.5
1996	2	4.5
1997	2	4.5
1998	1	2.3
1999	3	6.8
2000	2	4.5
1001	4	9.1
2002	3	6.8
2005	5	11.4
2006	7	15.9
2007	3	6.8
2008	1	2.3
2009	1	2.3
	44	100.0

As described in Table 1.2, the films spanned a number of different genres and ratings. Of note is that 22.7% of the films were classified, by Netflix, as a “romantic comedy,” although this of course refers to the overarching storyline of the film and not necessarily to the story arc of the therapy; the unethical overlap between those two will be addressed in the discussion chapter.

Table 1.2

Films: Genre (N=44)

Genre	Frequency	Percent
Romantic Comedy	10	22.7
Dark Humor and Black Comedy	4	9.1
Indie Comedy	4	9.1
Romantic Drama	4	9.1
Indie Drama	3	6.8
Biography	2	4.5
Comedy	2	4.5
SciFi Drama	2	4.5
Comic Books and Superheroes	1	2.3
Courtroom Drama	1	2.3
Crime Drama	1	2.3
Crime Thriller	1	2.3
Drama	1	2.3
Erotic Thriller	1	2.3
Gay and Lesbian	1	2.3
Gay and Lesbian Comedy	1	2.3
Indie Romance	1	2.3
Mobster	1	2.3
Psychological Thriller	1	2.3
SciFi Fantasy	1	2.3
Sports Comedy	1	2.3
	44	100.0

Additionally of note, 70.5% of the sampled films received an “R” rating by the Motion Picture Association of America (MPAA).

Table 1.3

Films: Rating (N=44)

Film Rating	Frequency	Percent
PG	3	6.8
PG-13	8	18.2
R	31	70.5
NR	2	4.5
	44	100.0

Session demographics

The sessions within each film were conducted in a number of different geographic locations, with a few very apparent, more commonly occurring locations. It is unclear if these locations were selected for purposes of the greater narrative of the film, tax purposes for general film production, or because of stereotypical ideas about therapy and where Hollywood supposes it takes place. For example, 31.8% of the film sessions take place in New York City, a metropolis made famous for analysis by Woody Allen movies in particular but also known for its forgiving tax breaks for filming within city limits (City of New York, 2011, p. 1). The next most popular location in the sample was Los Angeles, home to 13.6% of the cinematic sessions and also to Hollywood itself, providing, therefore, another reason for it to be a common filming location. Again, the reasons for selecting these cities cannot be known at this time. 6.8% of the locations were not indicated, while 4.5% each took place in Boston, Chicago, and San Francisco. The rest of the specified cities accounted for 2.3% of the therapy each, in Baltimore, Brooklyn, Gotham City, Middlesex, Mumford, Paris, Princeton, and Punxatawney. Some films did not specify a city, but merely a state; Arizona, California, Connecticut, Massachusetts, New York, Rhode Island, and Texas also accounted for 2.3% each of the session locations.

Table 2.1 illustrates the distribution of the geographic locations of the sessions.

Table 2.1

Therapy Sessions: Geographic Location (N=44)

Location	Frequency	Percent
New York City	14	31.8
Los Angeles	6	13.6
Not Indicated	3	6.8
Boston	2	4.5
Chicago	2	4.5
San Francisco	2	4.5
Arizona	1	2.3
Baltimore	1	2.3
California	1	2.3
Connecticut	1	2.3
Gotham City	1	2.3
Massachusetts	1	2.3
Middlesex	1	2.3
Mumford	1	2.3
New York State	1	2.3
Paris	1	2.3
Princeton	1	2.3
Punxatawney	1	2.3
Rhode Island	1	2.3
Texas	1	2.3
	44	100.0

The therapy itself was set within offices of varying definition throughout the 44 films. It is safe to assume these placements were made according to filmmakers' choices or assumptions in creating the character of the therapist in the films' narratives. The most common office settings were an office building and an externally unidentified private office, the outside of which the viewer never sees; both of these settings made up 27.3% of this demographic each. The second most common setting was a home office, with 18.2%. Clinics and inpatient hospitals both had 9.1% of the settings depicted, while a school hosted 4.5% and a jail and a doctor's office both housed 2.3% each. Table 2.2 illustrates the demographics of session settings.

Table 2.2

Therapy Sessions: Setting (N=44)

Setting	Frequency	Percent
Doctor's office	1	2.3
Jail	1	2.3
School	2	4.5
Clinic	4	9.1
Inpatient hospital	4	9.1
Home office	8	18.2
Office building	12	27.3
Private office	12	27.3
	44	100.0

It was difficult to assess the length of sessions based on what the films showed, as they obviously rarely, if ever, showed a full session in real time. For the majority of the films (70.5%, n=31), the session length is not indicated. However, some characters would mention the session length to another character over the course of the movie, or often within the therapy itself. Based on this, 27.3% were stated to be 50-60 minutes in length, while 2.3% were stated to be 30 minutes long. Table 2.3 illustrates the demographics of individual session length.

Table 2.3

Therapy Sessions: Length (N=44)

Length	Frequency	Percent
30 Minutes	1	2.3
50-60 Minutes	12	27.3
Not Indicated	31	70.5
	44	100.0

It was similarly difficult to ascertain the length of treatment as a whole, as timeframes are not always addressed explicitly in film. In 34.1% of the films, treatment length was not indicated. In 34.1% of the films it went on for months. In 9.1% of the films the therapy spanned multiple years, with the same percentage for multiple days and for one singular session. In 4.5%

of the films it went on for one year alone. Table 2.4 illustrates the demographics of duration of treatment.

Table 2.4

Therapy Sessions: Length of Treatment (N=44)

Length of Treatment	Frequency	Percent
1 Session	4	9.1
Days	4	9.1
Months	15	34.1
1 Year	2	4.5
Years	4	9.1
Not Indicated	15	34.1
	44	100.0

As in other categories, 38.6% of the films did not indicate how often clients were being seen. In 25% of films, clients were seen once a week, while in 20.5% they went to therapy daily. In 11.4% clients were seen only once, and in 4.5% they attended sessions twice a week. Table 2.5 illustrates the demographics of session frequency.

Table 2.5

Therapy Sessions: Frequency (N=44)

Frequency	Frequency	Percent
Once	5	11.4
Once a week	11	25.0
Twice a week	2	4.5
Daily	9	20.5
Not Indicated	17	38.6
	44	100.0

Fee was not often discussed within the films at all, let alone within the therapy. It was not indicated in 72.7% of the films, and was free in 9.1%. In 9.1% it was between $100 and $200, while in 2.3% it was between $201 and $300. In 2.3% the fee was not mentioned because the

therapist was on retainer. In 2.3% each the fee was either trade for service or trade for drugs. Table 2.6 illustrates the fee structure of the sessions on film.

Table 2.6

Therapy Sessions: Fee (N=44)

Fee	Frequency	Percent
On Retainer	1	2.3
Free	4	9.1
$100-$200	4	9.1
$201-$300	1	2.3
Trade for service	1	2.3
Trade for drugs	1	2.3
Not Indicated	32	72.7
	44	100.0

Client demographics

In the 44 films in the sample, there were a total of 69 clients. 77.3% of the films featured one client, 9.1% featured two, 4.5% featured three and four each, and 2.3% featured six and seven each. As previously mentioned, in coding the data for the films that featured more than one client, data of the most prominently featured client were selected for analysis. Table 3.1 illustrates the distribution of numbers of clients in the films.

Table 3.1

Clients: Number Portrayed in Film (N=44)

Number of Clients	Frequency	Percent
One	34	77.3
Two	4	9.1
Three	2	4.5
Four	2	4.5
Six	1	2.3
Seven	1	2.3
	44	100.0

Many film characters' ages are never explicitly stated. Clients were sorted into ten-year age groups based on stated age ranges, when applicable, physical appearance, and estimates based on character life experience. Based on those criteria, 13.6% of the clients were aged 10-19, and 22.7% were aged 20-29. The largest group of clients were aged 30-39, with 43.2% of the sample in that age bracket. 15.9% were aged 40-49, and only 4.5% were aged 50-59. That was the highest of the client age ranges.

In the cinematic sessions, 75% of the clients were male, while 22.7% were female. Only 2.3% were transgender. 6.8% were African American and 93.2% were Caucasian, and those were the only two racial groups represented by clientele. There was slightly more variation in client religious beliefs, when stated; 11.4% were Catholic, 13.6% were Christian, 2.3% were half Christian and half Jewish, 2.3% were Jewish, and 2.3% were Southern Baptist. A religious affiliation was not indicated for 68.2%. In coding for socioeconomic status, classification was based on profession and appearance of the character. Using this subjective assessment, 9.1% appeared to be lower class, 11.4% lower middle class, 54.4% middle class, and 25% upper middle class. Table 3.2 illustrates the demographic distribution of the clients for age group, gender, race, religion, and socioeconomic status.

Table 3.2

Clients: Age, Gender, Race, Religion, and Class (N=44)

Demographic Characteristic	Frequency	Percent
Age		
10-19 years	6	13.6
20-29 years	10	22.7
30-39 years	19	43.2
40-49 years	7	15.9
50-59 years	2	4.5
	44	99.9
Gender		
Male	33	75.0
Female	10	22.7
Transgender	1	2.3
	44	100.0
Race		
African American	3	6.8
Caucasian	41	93.2
	44	100.0
Religion		
Half Christian/Half Jewish	1	2.3
Jewish	1	2.3
Southern Baptist	1	2.3
Catholic	5	11.4
Christian	6	13.6
Not Indicated	30	68.2
	44	100.1
Class		
Lower Class	4	9.1
Lower Middle Class	5	11.4
Middle Class	24	54.5
Upper Middle Class	11	25.0
	44	100.0

The sexual preferences of the clients depicted were heteronormative; 93.2% were classified as heterosexual. 34.1% of clients were shown to be dating, while 38.6% were shown to be single, without any prospects. 9.1% were divorced, 6.8% were either cheating on a spouse or committed partner, and 6.8% were married. 4.5% were widowed. Most of the clients were shown

to be without children, with 81.8% not having any. 15.9% had one child, and 2.3% had four. Table 3.3 illustrates the demographics of the clients' sexual preference, marital status, and family composition.

Table 3.3

Clients: Sexual Orientation, Marital Status, and Number of Children (N=44)

Client Demographic	Frequency	Percent
Sexual Orientation		
Bisexual	1	2.3
Heterosexual	41	93.2
Homosexual	1	2.3
Not Indicated	1	2.3
	44	100.1
Marital Status		
Cheating	3	6.8
Dating	15	34.1
Divorced	4	9.1
Married	3	6.8
Single	17	38.6
Widowed	2	4.5
	44	99.9
Number of Children		
0 Children	36	81.8
1 Child	7	15.9
4 Children	1	2.3
	44	100.0

The professions of the clients in each film were varied (Table 3.4). 13.6% were high school students, 11.4% were not indicated, and 4.5% each were actors, assassins, poets, psychologists, or tax accountants. The remaining twenty-two professions were each mentioned once (2.3%).

Table 3.4

Clients: Profession (N=44)

Profession	Frequency	Percent
Not Indicated	5	11.4
High school student	6	13.6
Actor	2	4.5
Assassin	2	4.5
Poet	2	4.5
Psychologist	2	4.5
Tax accountant	2	4.5
Advertising	1	2.3
Baseball player	1	2.3
Carpenter	1	2.3
Chef	1	2.3
Cop	1	2.3
Drag Queen	1	2.3
English teacher	1	2.3
FBI agent	1	2.3
Golf professional	1	2.3
Homicide detective	1	2.3
Janitor	1	2.3
Knocker on cattle ranch	1	2.3
Logician	1	2.3
Mafia boss	1	2.3
Mathematician	1	2.3
Navy seaman	1	2.3
Stand up comedian	1	2.3
Stylist	1	2.3
Superhero	1	2.3
Telemarketer	1	2.3
Unspecified desk job	1	2.3
Volunteer	1	2.3
Weatherman	1	2.3
	44	100.0

For many clients, a diagnosis was not ever formally stated within the film (Table 3.5). This was true for 52.3% of the clients depicted. For those who did receive a diagnosis, ‘schizophrenia’ was the most common, with 11.4% of the clients holding this diagnosis. The diagnoses of ‘delusional,’ ‘rage,’ ‘bipolar,’ and ‘repressed memories’ each accounted for 4.5% of

the clients. ‘Multi-phobic personality,’ ‘romanticism,’ ‘depressive,’ ‘gender dysphoria,’ ‘narcissism,’ ‘attachment disorder,’ ‘homosexuality,’ and ‘attention deficit disorder’ accounted for 2.3% each of the given diagnoses. You will notice that not all of these stated diagnoses are recognized as real outside of Hollywood. As Table 3.6 indicates, 68.2% of these clients were not on medication, 29.5% were on medication, and only 2.3% did not indicate either way.

Table 3.5

Clients: Diagnosis (N=44)

Diagnosis	Frequency	Percent
Attention Deficit Disorder	1	2.3
Attachment Disorder	1	2.3
Bipolar	2	4.5
Delusional	2	4.5
Depressive	1	2.3
Gender Dysphoria	1	2.3
Homosexuality	1	2.3
Multi-phobic Personality	1	2.3
Narcissism	1	2.3
Rage	2	4.5
Repressed Memories	2	4.5
Romanticism	1	2.3
Schizophrenia	5	11.4
Not Indicated	23	52.3
	44	100.0

Table 3.6

Clients: Medication (N=44)

Medication	Frequency	Percent
Not on medication(s)	30	68.2
On medication(s)	13	29.5
Not Indicated	1	2.3
	44	100.0

Clinician demographics

In the 44 films in the sample there were a total of 51 clinicians. Most featured just one clinician (n= 39); three of the films (6.8%) featured two clinicians, and two (4.5%) featured three clinicians. As previously mentioned, in coding the data for the films that featured more than one clinician, only the data of the most prominently featured clinician were selected for analysis.

Table 4.1

Clinicians: Number Portrayed in Film (N=44)

Number	Frequency	Percent
One	39	88.6
Two	3	6.8
Three	2	4.5
	44	99.9

The clinicians spanned a different age range than the clients but were coded in similar ten-year age groups. Based on stated age ranges, when applicable, looks, and estimates based on character life experience, 6.8% of clinicians were 20-29 years old, 27.3% were 30-39, 25% were 40-49, 31.8% were 50-59, 6.8% were 60-69, and 2.3% were 70-79. Similar to the clients, the majority of clinicians were male, with 56.8% of those depicted being so and only 43.2% being female. There was more racial and ethnic variance within the clinician group; while 88.6% were Caucasian, 2.3% each were African American, Argentinean, Asian, Indian/Southeast Asian, and Latino. In the religious category, the beliefs of 75% of clinicians were not indicated, while 11.4% were Jewish, 9.1% were Christian, and 4.5% were Catholic. Based on the appearance of offices, personal spaces, fees, and various other factors, 54.5% of the clinicians were assessed to be of the middle class, 43.2% to be of the upper middle class, and only 2.3% to be not indicated due to insufficient screen time to make such an assessment. Table 4.2 illustrates the demographic distribution of the clinicians' age group, gender, race, religion, and socioeconomic status.

Table 4.2

Clinicians: Age, Gender, Race, Religion, and Class (N=44)

Demographic Characteristics of Clinicians	Frequency	Percent
Age		
20-29 years	3	6.8
30-39 years	12	27.3
40-49 years	11	25.0
50-59 years	14	31.8
60-69 years	3	6.8
70-79 years	1	2.3
	44	100.0
Gender		
Male	25	56.8
Female	19	43.2
	44	100.0
Race		
Caucasian	39	88.6
African American	1	2.3
Argentinean	1	2.3
Asian	1	2.3
Indian/Southeast Asian	1	2.3
Latino	1	2.3
	44	99.9
Religion		
Not Indicated	33	75.0
Christian	4	9.1
Jewish	5	11.4
Catholic	2	4.5
	44	100.0
Class		
Middle Class	24	54.4
Upper Middle Class	19	43.2
Not Indicated	1	2.3
	44	99.9

In the category of sexual orientation, 2.3% of clinicians were bisexual, 54.5% were heterosexual, and 43.2% were not indicated. None were shown to be homosexual. While a large percentage of cinematic clinicians – 45.5% – did not have an indicated relationship status, 18.2% were married, 11.4% were dating, 9.1% were widowed, 6.8% were cheating, and 4.5% each were

divorced or single. It was not indicated whether 52.3% of depicted clinicians had children, but of those for whom it was specified, 27.3% had none, 9.1% each had one or two, and 2.3% had three. Table 4.3 illustrates the demographics of the clinicians' sexual preference, marital status, and family composition.

Table 4.3

Clinicians: Sexual Orientation, Marital Status, and Number of Children (N=44)

Clinician Demographics	Frequency	Percent
Sexual Orientation		
Bisexual	1	2.3
Heterosexual	24	54.5
Not Indicated	19	43.2
	44	100.0
Marital Status		
Cheating	3	6.8
Dating	5	11.4
Divorced	2	4.5
Married	8	18.2
Single	2	4.5
Widowed	4	9.1
Not Indicated	20	45.5
	44	100.0
Number of Children		
0 Children	12	27.3
1 Child	4	9.1
2 Children	4	9.1
3 Children	1	2.3
Not Indicated	23	52.3
	44	100.0

Of particular interest was the coding of the stated professional title of each clinician. Psychiatrists made up 47.7% of the clinicians, psychologists 25%, social workers 2.3%, therapists 4.5%, while 20.5% remained not indicated. Table 4.4 illustrates the breakdown of clinician professional title.

Some films questioned the accreditation of the clinicians within the dialogue; for example, in the 1999 film *Mumford*, a patient's mother asks, "What kind of doctor are you?"

Table 4.4

Clinicians: Professional Title (N=44)

Professional Title	Frequency	Percent
Psychiatrist	21	47.7
Psychologist	11	25.0
Social Worker	1	2.3
Therapist	2	4.5
Not Indicated	9	20.5
	44	100.0

When the clinician responds "PhD. Psychologist," she says, "Oh, not a real doctor" (Kasdan, Okun, & Kasdan,1999). In the 2005 film *The Squid and the Whale*, the client's father surmises that his son's school will "unfortunately" likely have hired a counselor "…with a BA in psychology. Not a real shrink" (Anselmo, Bailey, Johnson, Lauren, & Baumbach, 2005).

Ethical Comportment

There were ten ethical categories selected that were prominent in the codes of ethics of social workers, psychologists, and psychiatrists alike. Each film was coded as adherent, inadherent, or not indicated for each of these ethical guidelines. When it came time to go over informed consent within a session, 6.8% were adherent, 9.1% were inadherent, and 84.1% did not even address it. Only 2.3% were adherent in dealing with conflicts of interest, while 50% were inadherent and 47.7% did not indicate this as an issue.

It was not indicated that 52.3% had cause to address the issue of privacy and confidentiality, but of those for which this issue did arise, only 4.5% were adherent while 43.2% were inadherent. A good example of a clinician who was adherent to the ethical guideline of

confidentiality was in the 2006 film *Stephanie Daley*, when the therapist explained the concept of mandated reporting, saying, “I also need to tell you that anything you talk to me about, in that it may be relevant to the case, could be considered evidence and used against you in court. Do you understand?” (Dey, Swinton, & Brougher, 2006). An example of when privacy was not respected arose in *Charlie Bartlett* (Hofmann, Horberg, Perini, Toll, & Poll, 2007), *Donnie Darko* (Ball, Barrymore, La Scala, Lowry, Ryder, Tyrer, & Kelly, 2001), *Grosse Point Blank* (Glickman, Ryan, & Armitage, 1997), *Ira and Abby* (Levine, Perez, Smith, Westfeldt, & Cary, 2006), and *The Treatment* (Rudavsky & Shoemaker, 2006) alike when therapists would allow message machines to play aloud regardless of potentially confidential information being disclosed within the voicemails.

The issue of sexual relationships between client and clinician did not come up for 72.7% of dyads shown, but 27.3% were inadherent; of those 27.3%, 18.2% were female clinicians. For example, in *The Departed*, when the male protagonist, who until recently had been a patient of the clinician, shows up at her apartment and asks “Look, if this is inappropriate, I can [leave],” the clinician shakes her head and says, “No. No, it’s not inappropriate. You’re not a patient” (Brown, Davison, Hahn, Lee, Nunnari, & Scorsese, 2006). This, despite the fact that it is clearly indicated in all three codes of ethics that sexual relationships with past patients are not ethical (American Psychiatric Association, 2009; American Psychological Association, 2002; National Association of Social Workers, 2007). No clinical dyads were shown to adhere to the ethical codes in this category.

When it came time to terminate, 72.7% did not show this process at all, 20.5% were inadherent, and only 6.8% were adherent. In *Antwone Fisher* (Paloian & Washington, 2002), *Final Analysis* (Gere, Wilde, & Joanou, 1992), *Prime* (Gordon, Yari, & Younger, 2005), *Shrink*

(Brunetti, Pope, Spacey, & Pate, 2009), and *Walking and Talking* (Berwin, Meek, & Holofcener, 1996), clients are shown to be surprised by the clinician's announcement that the therapy would be terminating. 2.3% of therapists were shown to adherently interrupt services, while 97.7% of films did not indicate this issue.

Sexual harassment, which shares some characteristics with sexual relationships but is defined differently enough in the codes of ethics to stand alone, was not indicated in 86.4% of the dyads, but was inadhered to in 13.6%. In *The Lovemaster* the clinician was shown asking the patient how big his penis was (Breen, David, Turtle, & Goldberg, 1997). Again, no relationship was shown to be adherent in this category.

Many were shown to have multiple relationships beyond the clinical dyad, with 25% being inadherent to this ethical guideline; 75% were not indicated, while no one was shown being actively adherent. Examples of this inadherent behavior range from that in *Basic Instinct*, when the clinician is not only sleeping with her client but also consulting on his murder case as a coworker within the police precinct (Kassar & Verhoeven, 1992), to that depicted in *Running With Scissors*, where the clinician assumes guardianship over his client's son (Samuels & Murphy, 2006).

The documentation and record-keeping specified as necessary within each ethical code was not indicated in 93.2% of the films, was not adhered to within 4.5%, and was adhered to in 2.3%. One of the only clinicians who even mentions keeping records is in *The Watcher*, and while she keeps hers in a locked cabinet within her locked office, they are still vandalized and accessed by a determined criminal (Choi, Pompian, & Charbanic, 2000).

In the last of the ten categories, billing and fees, 4.5% films were adherent, 11.4% were inadherent, and 84.1% did not indicate this issue. Incidentally, even in the films that mentioned

payment in dialogue, the actual act of paying the therapist was never actually shown or the method thereof discussed. In *The Prince of Tides,* Dr. Lowenstein attempts to hire her patient's brother, also a pseudo-patient, to coach her son in football. She runs into a bit of a catch-22 over fee.

> Tom Wingo: Is this a job offer?
> Dr. Lowenstein: Yes, and I would insist on paying you. What would you consider a reasonable rate?
> Tom Wingo: What are your rates?
> Dr. Lowenstein: I charge $150 an hour.
> Tom Wingo: Fine, I'll take it. (Corman, Roe, & Streisand, 1991).

Table 5.1 illustrates the ethical comportment of the cinematic sessions.

Table 5.1

Ethical Comportment (N=44)

	Adherent		Inadherent		Not Indicated	
Ethical Component	n	%	n	%	n	%
Informed Consent	3	(6.8)	4	(9.1)	37	(84.1)
Conflicts of Interest	1	(2.3)	22	(50.0)	21	(47.7)
Privacy and Confidentiality	2	(4.5)	19	(43.2)	23	(52.3)
Sexual Relationships	0	(0.0)	12	(27.3)	32	(72.7)
Termination of Services	3	(6.8)	9	(20.5)	32	(72.7)
Sexual Harassment	0	(0.0)	6	(13.6)	38	(86.4)
Multiple Relationships	0	(0.0)	11	(25.0)	33	(75.0)
Interruption of Services	1	(2.3)	0	(0.0)	43	(97.7)
Documentation/Records	1	(2.3)	2	(4.5)	41	(93.2)
Billing / Fees	2	(4.5)	5	(11.4)	37	(84.1)
	13		90		337	

Recurrent Themes

Many recurrent themes, observable through storyline and dialogue, were expressed within the films.

The devoted clinician

Many clinicians were depicted as having only the one client, or, despite a full caseload, being able to devote seemingly unlimited amounts of time to that one client. In *Antwone Fisher*, for example, Dr. Davenport states, "I can delay my next appointment if you want to talk some more" (Paloian & Washington, 2002). Of note to practicing clinicians is that this was not in response to a crisis, but presented as his normal level of professional functioning – going above and beyond to serve his client, regardless of time and schedule. Similarly, in *Mumford*, the clinician appears willing to do anything to meet the client's needs, no matter what they may be.

> Sofie: What would you do?
> Mumford: *We*. We would try several things, but I need to see you a lot.
> Sofie: I dunno. I barely made it today.
> Mumford: I'll come to you.
> Sofie: I don't think I can afford it. I don't want my dad paying.
> Mumford: We'll work it out.
> Sofie: You have the best answer for everything! (Kasdan et al., 1999)

Others accept abuse, reduced or nonexistent fees, and deal with unenlightened colleagues, all for the love of the job and the joy they get from their clients, who inevitably make their lives better. A great example of this is the following exchange from *The Departed*:

> Billy: Why do you work for the state? With the degrees and everything you got, you're hot shit.
> Madolyn: Yeah.
> Billy: So why do you make as much as a guidance counselor?
> Madolyn: Because I believe in public service.

As if all the remuneration she needs is to know that she is doing some good (Brown et al., 2006). Sometimes, of course, this dogged devotion to the job comes at the expense of the clinician's

personal life, exemplified in *K-PAX* when Dr. Powell's wife challenges, "Maybe *we* should start paying you for your time. You got a family rate?!" (Pollock & Softley, 2001). But these sacrifices are presented as worth it; in the words of Dr. Davenport again, "Because of you, Antwone, I'm a better doctor. And I'm learning to be a better husband. You don't owe me anything. I owe *you*" (Paloian & Washington, 2002).

The detached clinician

At the other end of the spectrum lie the detached clinicians, the ones who can't be bothered to remember details about their patients, who do not take their clients seriously, who do not anticipate the effect the medications they prescribe might have on a person, and who forget entirely that their clients are, in fact, people. When the young clinician in *Groundhog Day* sees Phil Connors, a patient complaining of reliving the same day over and over and asking frantically "What do I do?!" he offers this inane, out of touch response: "I think we should meet again. How's tomorrow for you?" (Erickson & Ramis, 1993). Phil then proceeds to commit suicide every day. In *Walking and Talking*, the young clinician Laura cannot even remember the basic family constellation of a patient she sees frequently:

> Patient: I been thinkin' about my son a lot lately.
> Laura: I didn't know you had a son.
> Patient: Yeah, you did. Remember, you suggested I send him a card a couple months ago.
> Laura: Oh, right. (Berwin et al., 1996).

But beyond even the inattentiveness of inexperience that one might benevolently use to explain away both those examples is the infamous Dr. Leo Marvin from *What About Bob?* Upon receiving a call from his answering service after being stalked by his new patient Bob, Leo learns a distressing piece of news, which he shares with his wife.

> Leo: That patient? The one who called before?
> Fay: Mmm?

> Leo: Committed suicide.
> Fay: Oh, Leo, how horrible!
> Leo: [Turns over in bed.] Oh well, let's not let it spoil our vacation! [Claps light off.] (Ziskin & Oz, 1991).

What about Bob, indeed.

Boundary crossings

A number of clinicians crossed boundaries with their patients in ways that run the gamut from exhibiting violent behavior towards a client, violating trust, being overtly sexual, to speaking with severe judgment. In *Good Will Hunting*, a film well remembered for the therapeutic alliance within, the therapist, Sean, actually throttles his new client in their first session, saying "If you ever disrespect my wife I will end you – I will fuckin' end you! Got that, Chief?" (Armstrong, Gordon, Weinstein, Weinstein, & Van Sant, 1997). In *Basic Instinct* (Kassar & Verhoeven, 1992), *Martin and Orloff* (Bastian, Blume, Holland, Moran, & Blume, 2002), and *Shrink* (Brunetti et al., 2009), the supposedly confidential files of the protagonist patients are read or left visible for others to easily access; in each of these films the patient finds out about this transgression and is understandably upset. In *Sordid Lives*, the therapist attempts to force a sexual encounter on her openly gay patient in a misguided attempt to "change" him; the exchange ends with her half naked and screaming in her office, "Oh, shit! You are just one hopeless, pathetic, freak! Shit!" (Alonso, Civon, Harris, Leavitt, & Shores, 2000). In *The Wackness*, Ben Kingsley's Dr. Squires prescribes a hooker in lieu of medication for his high school aged patient Luke, whose only response is "God, I was this close to respecting you" (Calder, Marino, Neurauter, & Levine, 2008). Finally, in *Analyze This*, Dr. Sobel, overwhelmed with his gangster client's antics, explodes, "You don't have a shred of common decency! I actually thought I could help you, but nobody in the world could help you because you're a

common thug!" (Berman, Brigham, Crystal, & Ramis, 1999). In each instance the clinician visibly loses credibility, to say the least, with their client. The further ramifications of these boundary crossings will be addressed in the discussion chapter.

Help! I'm going to cross a boundary!

It would be unfair to condemn the boundary-crossing clinicians without at least acknowledging that there was a theme of them asking for help with their predicament. However, of the clinicians who did reach out for help in this way, not one of them actually turned back or changed their behavior.

In *Tin Cup*, Dr. Griswold calls a colleague, saying, "You always said to call if something came up that confused me, that, you know, shrinks need shrinks, and, well, it's happened, and you said it would. A patient has come in and said that he thinks he is falling in love with me" (Milchan & Shelton, 1996). While we admittedly only witness one side of the following phone conversation, it is obvious that it does not contain the levelheaded, boundary-based consultation she was seeking. After about twenty seconds, she concludes the call, saying, "Well, he's a good-looking man. Green eyes. I mean – that's not the point, is it? He's kind of cute. He's *cute*. Okay. Okay. Uh huh." She hangs up, head in hands. Beyond her initial question about her client's erotic transference, she has revealed, by the end of the call, that she is clearly experiencing erotic countertransference as well, and yet this goes unchecked by her advisor. Her attempt to receive guidance is basically useless.

In *Prime*, when Lisa Metzger's son starts seeing one of her clients – at first, unbeknownst to all involved – she takes the issue to her own therapist.

> Rita: If you end treatment with her, and they break up after two weeks, that is not serving her best interests.
> Lisa: You mean I should keep seeing her? That sounds crazy! Is that even ethical?

Rita: Your job is to help her. That's your ethical boundary. (Gordon et al., 2005).

Rita might want to take another look at her Code of Ethics. When the truth comes out after months have gone by, Lisa's client confronts her about this absolute betrayal of trust, demanding, "Is this what you call preserving our relationship?!" Again, the clinician's attempt to seek outside counsel proved useless and damaging to her own clinical relationship.

At times, this cry for help appears to be mainly for show, as it is already relatively clear that they are going to go ahead anyway, or in some cases, already have. In *Final Analysis*, Richard Gere's Dr. Isaac Barr only goes to a colleague after he has already acted on his desire. As in *Prime*, he references the existence of an ethical code, but, in the absence of explicit wording prohibiting his specific course of action, finds a way to justify himself anyway.

> Dr. Barr: I've been treating this attractive, seductive young woman who has an older sister who just happens to be married. We've met a few times to discuss family history, and, ah, then we, um…
> Dr. Lowenthal: You didn't sleep with her? Oh, Isaac.
> Dr. Barr: I went through the AMA's principles of ethics. Even the Special Annotations for Psychiatry didn't say anything about sleeping with a patient's sister!
> Dr. Lowenthal: It's a tawdry cliché, Isaac, a shrink with a weakness for an unhappy woman (Gere et al., 1992).

He is, of course, wrong. While there is not a direct line of text about a sexual relationship with a patient's sister, it is clear that a dual relationship or conflict of interest like this one, if avoidable, should be.

Lastly, in *Mr. Jones*, incidentally also starring Richard Gere, just now as the patient, Lena Olin's Dr. Libbie Bowen sleeps with her patient and goes to a colleague to attempt to transfer the case after the fact (Baerwitz, Gere, & Figgis, 1993). The colleague angrily understands the issue at hand, calling into question her twelve years of training, reminding her of the likelihood of being fired, going to jail if he presses charges, and the ultimate tragedy, her other patients

suffering the loss of their therapist even if she bows out early and resigns. “You cannot see him again,” he warns her. “If you do I will turn you in. This is not about protecting myself, the hospital, this is about him, the patient.” But in the movies, love conquers all and surpasses even the clearest ethical boundary, and Dr. Bowen continues her romantic relationship with Mr. Jones. The movie ends before we see any ramifications.

It seems that asking for help with a therapeutic ethical dilemma in the movies is not actually asking for help, but merely a way to build suspense about how deep the sexual connection must run in order for these seemingly professional practitioners to abandon all semblances of principled behavior and pursue their patients anyway.

Slippery slope

Some cinematic clinicians find out firsthand how one ethical transgression opens the floodgates for all the others. They may be trying to cover their tracks or simply recover from their earlier error, but a boundary crossing is a boundary crossing no matter which way you spin it, and they often get caught in a corrupt and unforgiving cycle. In *Basic Instinct*, Dr. Garner has been sleeping with her coworker and patient, Detective Curran (Kassar & Verhoeven, 1992), when a superior of his suddenly reveals that he has read his supposedly confidential file. When confronted by her patient and lover, Dr. Garner admits that she gave him the file, saying, “I had to! He was going to recommend your discharge from the force! He didn’t buy my evaluation. He said I wasn’t objective, so I made a deal with him to review the session notes for himself. I didn’t think he’d show them to anybody.” Having already stepped over the clear ethical line in multiple ways, Dr. Garner violates her client’s privacy yet again in an effort to backtrack from her previous transgressions. She does so in service of herself and not her client, and both, unfortunately, suffer as a result. In *What About Bob?* Dr. Marvin attempts to convince a

colleague of Bob's inappropriate behavior and finds himself, again, on a slippery slope (Ziskin, & Oz, 1991).

> Dr. Tomsky: If you want to be rid of him, just tell him you won't treat him anymore.
> Dr. Marvin: Catherine, that's easy for you to say. The man is human crazy glue!
> Dr. Tomsky: Well, you should never have let him sleep in your pajamas, Leo.

"Fuck Freud"

Sigmund Freud is everywhere in the movies. In *What About Bob?* Dr. Leo Marvin's children are named Sigmund and Anna, busts of his head adorn many an analyst's office, and any psychological sounding language gets ascribed to or associated with Freud and then broken down in layman's terms as part of the process of establishing the therapist as smart, yet relatable, time and time again. A noticeable theme, however, is that Freud, and psychology in general, gets somewhat of a bad rep. When Dr. Sobel attempts to explain the Oedipal Complex to his mobster client in *Analyze This*, it does not go over well at all.

> Paul: Are you saying I want to fuck my mother?
> Dr. Sobel: No, it's a primal fantasy.
> Paul: Have you ever seen my mother?
> Dr. Sobel: Paul.
> Paul: Are you out of your fucking mind?
> Dr. Sobel: It's Freud.
> Paul: Well then Freud's a sick fuck and you are too for bringing it up.
> Dr. Sobel: Freud believed that you are everyone in your dreams.
> Paul: Fuck Freud (Berman et al., 1999).

This attitude is popular in the movies. In *Good Will Hunting*, the therapist is warned "…don't give me that Freudian crap!" (Armstrong et al., 1997). In *The Prince of Tides* the client fumes, "Ugh, God, I hate this Freudian crap" (Corman et al., 1991), the process is dismissed in *The Departed* as "psychiatry bullshit" (Brown et al., 2006), and in *Basic Instinct* a team of psychiatric evaluators are told to "go fuck yourselves" when they ask exploratory questions about the character's childhood (Kassar & Verhoeven, 1992).

People seem to be infinitely frustrated with the language of psychology. In *Final Analysis,* the patient repeatedly describes a recurrent dream she claims to have, and gets upset when she 'slips.'

> Diana: The paper feels like velvet. I have three kinds of flowers. Lilies, carnations…
> Dr. Barr: And the third kind?
> Diana: Violence.
> Dr. Barr: Violence?
> Diana: I didn't say violence. I said violets. Violets! Violets, I said violets. They're just flowers! I once took floral arranging. Why does everything have to be about sex?! (Gere et al., 1992)

In *Batman Forever,* the female clinician – who later engages in a sexual relationship with her one-time client, Bruce Wayne – attempts to formulate about Bruce's stalker. She starts by using entirely casual words and then gets clinical, which proves to be too much.

> Dr. Meridian: In my opinion, this letter writer is a total wacko.
> Bruce Wayne: Wacko? Is that a technical term?
> Dr. Meridian: Patient may suffer from obsessional syndrome with potential homicidal tendencies. Does that work better for you?
> Bruce Wayne: So what you're saying is this guy's a total wacko (Melniker, Uslan, & Schumacher, 1995).

This is a perfect example of how the movies ask for technical language and then immediately for it to be broken down. Clinicians in the movies walk a fine line between being too Freudian, and not Freudian enough.

Film referencing film

The final significant theme of this sample of films was the fact that we have reached a point in cinematic and psychoanalytic history where it is mainstream enough to be self-referential. Especially since the films in this sample were produced in the last twenty years, it is unsurprising that they are able to allude to the many films made in the many decades before them. In *Shrink,* for example, the clinician comforts a young adolescent patient he imagines is

feeling reluctant about therapy. “You know just because they sent you here doesn’t mean they think you’re crazy or anything, just means they think it might be good for you to have someone to talk to” (Brunetti et al., 2009). She, an avid film fan, responds, “Yeah, I know. I’ve seen *Ordinary People*.” In *Martin and Orloff,* the film’s titular clinician imitates a memorable scene from *Good Will Hunting* in the client’s intake interview, rocking back and forth, repeating, “It’s not your fault” (Bastian et al., 2002). Later, he tells his patient, “Now you’re going to get an old fashioned psychotherapy session, just like in the movies.”

The final chapter will discuss the implications of these findings.

CHAPTER V

Discussion

This study was undertaken to examine how the therapeutic process is depicted in modern films produced for American audiences over the past two decades, with special reference to how the conventions of ethics in therapy are treated, and to discuss the implications of these findings for clinical practice. Client and clinician demographics were examined and the therapeutic frame was described for each film. In addition, the level of adherence of the cinematic sessions to ten ethical guidelines for professionals in the mental health field was analyzed.

The results of this research study indicate that therapy is inadequately represented in Hollywood film on many levels; (1) session length, frequency of sessions, and length of treatment as a whole are grossly inexact or vague; (2) client diagnosis and professional title of the clinicians are imprecise, overly stereotyped, or inaccurately interchanged; (3) the demographic characteristics of the clinical dyad are limited; (4) the process is portrayed in stereotypical ways with regard to gender and professional style; and (5) the ethical guidelines of the mental health professions are mostly ignored or violated. This chapter will summarize and synthesize these core findings by comparing identified patterns and themes to findings in the literature reviewed in Chapter Two. This chapter will also discuss the limitations, strengths, and further clinical and research implications inferred from this study.

Major Findings

Many of the findings have to do with the discrepancy between cinematic sessions and more conventional therapy. This was not a surprise, as, according to Gabbard (2001), “the ‘showbiz’ value of any treatment is of much more importance to filmmakers than its clinical accuracy” (p. 366-7). It was interesting to see where those concessions or adjustments were made in the contemporary films studied here.

Session demographics

It was in keeping with expectations to find that session demographics were difficult to portray within a feature-length Hollywood film, given the time constraints of the artistic medium. In a two and a half hour movie, for example, it would be impractical to devote fifty minutes to a single therapy session, so it is inevitable that any featured therapy sessions would be abbreviated in order to portray the course of treatment. Similarly, the frequency and length of total treatment must be adapted in favor of the narrative. However, when, in 70.5% of the films, session length is not indicated, in 34.1% of films the length of treatment is either not indicated or goes on for months, and in 20.5% of films the clinical dyad meets daily for treatment, it sends a nebulous message about what a client might expect from a normal course of therapy. As mentioned in the review of the literature presented in Chapter Two, for a client who had been exposed to therapy before, this might not be an issue, as, according to social learning theory, “to the degree that a given individual has been exposed to behavioral experience that contradicts these stereotypes, the stereotype weakens for that individual” (Hedley, 1994, p. 737); for someone who had not taken part in therapy before, this could prove to be misleading. Without a full view of the treatment, it sets a precedent for availability of the clinician and the consistency

of the sessions, which, in today's shorter-term, insurance-compliant world, is unfortunately less common.

Title and diagnosis

The findings of this study were mostly consistent with the literature reviewed in Chapter Two with regard to title and diagnosis. Gabbard (2001) noted, "psychiatrists are almost always portrayed as psychotherapists" (p. 365), and accordingly, almost half (47.7%) of the clinicians practicing therapy in the films were identified as psychiatrists. However, when paired with the statistic that 68.2% of the clients in this study were shown not to be on medications, it seems that there is still a lack of understanding about what psychiatrists actually do; this is in keeping with the observation that "I have yet to see one [film] that depicts the effective prescribing of psychotropic medication" (Gabbard, 2001, p. 365).

20.5% of clinicians were not identified as a specific profession within the mental health field, which fits with Schultz's (2005) assertion that there is often little to "no distinction among different kinds of mental health practitioners" (p. 102). A new discovery through content analysis of the quotations of the films in this study was the hierarchy of professions established within each film; there were multiple films (*Mumford,* 1999; *The Squid and the Whale,* 2005) that placed a premium on receiving treatment from a psychiatrist and no other kind of mental health practitioner. There seemed to be little appreciation for the training involved in every course of study.

Similarly, most of the clients were depicted without an indicated diagnosis, but the highest percentage of those with a stated diagnosis, 11.4%, had schizophrenia. This was in keeping with the observation in the literature that "the diagnostic compass of the typical psychiatric movie is meager indeed… Hysterias, amnesias, and sundry dissociative reactions are

privileged over subtler illnesses, as are various post-traumatic syndromes and flagrant impulse control disorders" (Greenberg, 2009, p. 242). It appears from the content of the films that diagnoses like these provide more fodder for the narrative of the film, be it shock value or a source of humor.

Limited demographics

The demographics of the clinicians portrayed in the films were extremely limited. If one were to take the highest percentage of each demographic category to create an amalgam of the stereotypical cinematic clinician, that practitioner would be between 50-59 years old, white, male, middle class, and of no clear religious affiliation. He would be clearly heterosexual, although it would not be as clear whether he was married or had children. This picture of a mental health professional is a very narrow one.

Similarly, the typical client, made up of the highest demographic percentages from this sample, would be 30-39 years old, male, white, middle class, of no clear religious affiliation, heterosexual, single or dating, with no children. Again, this is a very limited view of the possible kinds of people who might seek and receive services.

It is of particular note that over half of the clinicians were given some kind of specified romantic life, be it singledom, marriage, divorce, or widowhood. One can infer that this information is revealed for the sake of the narrative of the film, because it is often more interesting to feature a character to whom can be ascribed a history and individuality of some sort. This is, of course, a direct contradiction of general standards in therapy, which state that

> "the cultural and reciprocity effects of self-disclosure do not seem to have been effectively assimilated within the therapeutic field. Consequently, therapist self-

> disclosure remains controversial and… many theorists and researchers continue to highlight its detrimental effect in therapy" (Carew, 2009, p. 267).

Based on this, while many practicing therapists might explore any client questions about their personal lives, it is unlikely that such information would be as freely disclosed as it is in the movies.

Common stereotypes

The literature predicted many of the stereotypical roles in which clinicians would be portrayed in film. Within this sample, the most common were Dr. Wonderful and Dr. Line Crosser, explained by Greenberg (2009) and Schultz (2005), respectively. Many films featured the former, "the analyst you wish you had: ever available to the hero or heroine, no other patient in sight; … fee never mentioned" (Greenberg, 2009, p. 243). These clinicians set their clients up on dates (*Martin and Orloff*, 2002), conducted sessions within the client's home (*Mumford*, 1999), and even invited them to their homes for Thanksgiving dinner, as in *Antwone Fisher* (2002).

Many, however, engaged in sexual relationships with their clients (*Basic Instinct*, 1992; *Batman Forever*, 1995; *Charlie Bartlett*, 2006; *The Departed*, 2006; *Final Analysis*, 1992; *Martin and Orloff*, 2002; *Mr. Jones*, 1993; *Mumford*, 1999; *The Prince of Tides*, 1991; *Shrink*, 2009; *Tin Cup*, 1996; and *Twelve Monkeys*, 1995), in keeping with Greenberg's stereotypical "Dr. Horny" (p. 243). This stereotype overlaps with Schultz's "Dr. Line Crosser," in that both have a tendency of "becoming romantically involved with patients. This is a recurring theme, portrayed with the strong implication that such love affairs are curative for both patient and therapist" (Schultz, 2005, p. 102).

Ethical violations

From the literature reviewed in Chapter Two, it was expected that there would be many ethical violations in the cinematic sessions. In fact, most ethical categories were not even indicated at all in the films included in this study, which was a surprise. The categories that were least addressed were Interruption of Services, with 97.7% of the films not indicating this even being mentioned, Documentation and Records, with 93.2% not indicating their existence, Sexual Harassment, with 86.4% not indicating its occurrence, and Informed Consent and Billing/Fees both having 84.1% of films not indicating their existence at all. Sexual Harassment was a complicated topic, however, because for many clinicians, they crossed the line into sexual relationships without harassment occurring, but there was still a sexual component involved. Through the eyes of social learning theory, the absence of these ethical guidelines might teach that they do not exist, which of course is erroneous.

Sexual Relationships were violated in 27.3% of the films, Conflict of Interest in 50.0%, and Confidentiality in 43.2%. Very few of the ethical guidelines were followed, but the ones that were most frequently adhered to were Informed Consent, with 6.8% of the films following ethical protocol, and Termination procedures, also with 6.8% adherence.

There are many possible reasons for these ethical errors. We can posit that a likely, practical one is film length; to take the time to explain or show the steps of proper ethical protocol would take too much time. By the same token, it is easy to imagine that such an inclusion could wreck the fantasy, escapist quality of film. In a romantic comedy, where audiences are ostensibly going to the movie for the romantic part of the storyline and the comedic part of the storyline, a thorough explanation of therapeutic ethics would not fit in either category. Greenberg (2009) and Gabbard (2001) say the facts are sacrificed for narrative punch,

as relationships are more valued cinematically. It is not likely this can be changed. What could be changed, however, is the decision of filmmakers to have clinicians get involved with patients. It would be possible to feature therapy on film, and clinicians as characters with a full private life, without having them cross that specific ethical line.

Strengths and Limitations

There were a number of strengths and limitations to this study. As previously described, it is possible that the sample was not representative of all films in the time period under study. The film industry does not maintain a comprehensive index of films and various, potentially limiting, strategies had to be employed to develop a list of films for inclusion. The way in which the film list was compiled was, in part, subjective and reliant on human recall and experience, thereby opening it up to a greater risk of error and omission. It also required that the films in question made it to DVD distribution within the timeframe specified, which may therefore have unintentionally excluded any financially unsuccessful or particularly small independent films. The films also had to be readily available for viewing, and the reliance on Netflix as the only source added another level of subjectivity and potential bias. Lastly, if someone watching the films featuring multiple dyads thought, for any reason, that a different dyad was the “main” one in the film’s narrative, then that would change the data set as well.

It is hard to say that it is generalizable, because of the comparably small sample size to the number of films that have been made to-date that feature therapy. While the coding tools were created specifically for this study and proved effective in guiding data collection, there were a number of subjective elements that might make it difficult for this study to be replicated in future studies. Chapter Three does outline the specific ways in which decisions were made and steps taken to advance through the selection and data analysis process, however, and it details the

moments of subjectivity in a transparent fashion. A final limitation is that the research does not account for the possible influence of other media portrayals, which are so readily accessible to viewers and could be equally significant.

Implications for Future Practice and Research

This study has clear implications for practice and has illuminated opportunities for future study. These implications will be framed from a social learning perspective and also from an individual and institutional practice level.

From a social learning perspective, there are a number of implications of this study. First, there is the threat of the unethical behavior displayed in film being taken even further by an undiscerning audience. As stated by Bandura (1978), "from observing the behavior of others, people can extract general tactics and strategies of behavior that enable them to go beyond what they have seen or heard" (p. 14). This implies that people without exposure to the therapeutic process could take what they see on screen and adapt it as their own truth. This could have an effect on the perceptions of potential clientele, and possibly even the expectations of future clinicians without adequate training.

Secondly, Bandura clearly states the ways in which social learning is enacted by exposure to media.

> …exposure to televised violence can have at least four different effects on viewers: (1) it teaches aggressive styles of conduct, (2) it alters restraints over aggressive behavior, (3) it desensitizes and habituates people to violence, and (4) it shapes people's images of reality upon which they base many of their actions (Bandura, 1978, p. 15).

While he frames it in the context of learning aggression, if one were to substitute “unethical behavior” for “violence” or “aggression,” it is easy to see the parallels. Through repeated viewing of such a plethora of unethical and demographically limited clinical moments, viewers might learn that this is the way of real sessions and make them less sensitive to understanding true ethical behavior. Again, this could affect both potential clientele and potential clinicians in a detrimental way if not adequately addressed. If it goes unaddressed, society runs the risk of “refining” and ingraining these unethical styles through “reinforced practice” (Bandura, 1978, p. 16).

Finally, a last important point from a social learning perspective is that “behavior is extensively regulated by its consequences” (Bandura, 1978, p. 21). This applies to film with regard to the tidy endings many are given in order to wrap up the narrative; however, if there is no visible aftermath to the ethical transgressions, there is no impetus not to behave unethically, as in *Mr. Jones* (1993).

The implications on an individual practice level are multi-layered. First, the literature states that portrayals of therapy in film, both accurate and inaccurate, can affect perception and expectation of viewers. This holds true for negative and positive representations of the process; for example, a therapist who engages in a sexual relationship with a client could have a negative effect on viewers, while a clinician who makes themselves constantly available to clients, an ostensibly positive action, could also have a negative effect in that it sets up an expectation of behavior that is unrealistic. On an individual practice level, it would be important for practicing clinicians to bear in mind that incoming clients could have perceptions of the process formed, at least in part, by what they may have seen in films, and it would behoove the clinician to assess what those might be before proceeding with the work. Questions about previous exposure and

perceptions of the therapy process could be included in intake evaluations as a way of assessing this information straight away.

At the institutional level, it is also possible that adjustments could be made by the film industry to address the misrepresentations within films. In the same way animal rights and similarities to real life are addressed at the beginning of movies or the end of credits, perhaps a statement could be placed there about mental health representations. Bandura (1978) is clear in social learning theory that the media "can foster humanitarian qualities, as well as injurious conduct" (p. 15). The film industry could attempt to make more use of that potential with regard to the portrayal of the therapeutic process.

Also at the institutional level, perhaps organizations and websites such as IMDb and NASW could compile list of films that chronicles ways in which films are ethically accurate or inaccurate. Making this readily available through both industries could mean that viewers would be more likely to find the information and learn something about the therapeutic process beyond what was portrayed in the film.

Perhaps most relevantly, organizations such as NASW could continue their efforts to address the ways in which social work is portrayed in film. One affiliated website was created in 2008, and states its mission as the following

> SocialWorkersSpeak.org gives you a chance to influence how the entertainment industry and news media depicts the social work profession and issues social workers care about. The National Association of Social Workers (NASW) developed this site to allow social workers and the general public to critique and improve the way social workers and social issues are covered in the news media, and portrayed in the entertainment industries (Social Workers Speak, 2008, p. 1)

While this is an excellent resource and forum for precisely the kind of dialogue this study indicates is needed, it could be better publicized within the social work community and the film industry. Perhaps a reference to the site could be included in films as well as a way of drawing attention to the conversations happening there.

Future research should examine the effects of these films on audience attitudes. As mentioned in Chapter Two, only one empirical study was available that measured audience effects, and a widening of this part of the research would add a valuable, quantifiable voice to the conversation about the representation of therapy in film.

In conclusion, it seems that there are many ways in which therapy is presented in film, sometimes to its detriment and sometimes innocuously. On the one hand, it is exciting to have a cinematic voice. On the other, there are ways in which it could be addressed by the film industry that would show the therapeutic process in a more accurate light. The social work profession, on an individual, institutional, and organizational level, can work towards addressing these portrayals, however. We can discuss it with clients, teach about it in social work schools, and make resources available to the public that chronicle the ethical obligations of therapists more clearly and address specific cinematic misrepresentations.

Finally, and most importantly, we can continue to practice ethically, as that is what will counteract these distorted representations most effectively. Indeed, social learning theory clearly states that “to the degree that a given individual has been exposed to behavioral experience that contradicts these stereotypes, the stereotype weakens for that individual” (Hedley, 1994, p. 737). The more we practice ethically, the more we weaken cinematic stereotypes.

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APPENDIX A

Ethical Categories Viewing Guide

Ethical Code	Adherent?	Examples
Informed Consent (SW 1.03a-f) (Psy 3.10a-d, 10.01a-c)		
Use understandable language/language of comprehension		
If client lacks capacity, get from other 3rd party		
Explain even if mandated		
Appropriately document		
NASW: also if via electronic (Psy 8.03)		
NASW: also before taping (Psy 4.03, 8.03)		
Conflicts of Interest (SW 1.06a-d) (Psy 3.06)		
Inform if arise, terminate if have to. Anything that might impair objectivity, competence, effectiveness		
Expose the person to harm or exploitation		
Business, financial, legal, personal, religious, etc. If working with 2 or more clients, clarify role first (Psy 10.02a-b)		
Privacy & Confidentiality (SW 1.07a-r), (Psy 4.01, 4.02a-c) (CHI4.1)		
Do not solicit info unless essential (Psy 4.04a) Disclose when appropriate, with valid consent (Psy 4.05a) (CHI4.2) All is confidential unless to prevent imminent harm (CHI4.2) (CHI4.8)		
Inform clients about those limits, at beginning		
If electronic, inform re: risks		

Ethical Code	Adherent?	Examples
In couples work, have agreement first		
Do not discuss unless privacy can be ENSURED. Respect Confidentiality in court; with media (Psy 4.05b) (CHI4.9, 11)		
Store records in safe location (Psy 6.01, 6.02a-c)		
Protect electronic records		
Dispose of records confidentially		
Protect if terminate		
Protect if teaching (Psy 4.07) (CHI4.3, 10)		
Protect with Consultations (Psy 4.06) (CHI4.4)		
Protect after death of client		
Only disclose what is necessary (CHI4.5) Talk about lack of confidentiality for professional competency evaluations (CHI4.6)		
Sexual Relationships (SW 1.09a-d) (Psy 10.05-08) (CHI 2.1)		
No sex with current clients (Psy 10.05) (CHI 2.1) No sex with relatives or close acquaintances of client (Psy 10.06) No sex with former clients (Psy 10.08a-b -- after 2 years, technically) No clinical services for previous sex partners (Psy 10.07)		
Termination of Services (SW 1.16a-f) (Psy 10.10a-c)		
Terminate when not needed, no longer needed		
Do not abandon clients still in need of services Okay to terminate if not paying and not at risk, and discuss with patient Do not terminate to pursue other kind of relationship with patient		

Ethical Code	Adherent?	Examples
If know need to terminate, notify immediately & start process Inform patients of options for continuing with other clinician if terminate		
Sexual Harrassment (SW 1.11) (Psy 3.02) No advances, solicitation, requests for sexual favors, verbal, physical		
Multiple Relationships (Psy 3.05a-c) Patient or person *close* to patient if reasonably expect will impair objectivity, cause exploitation or harm		
Interruption of Services (SW 1.15) (Psy 3.12, 10.09) Plan for facilitation of other services in case of interruption		
Documentation/Records (SW 1.08a-b) (Psy 6.01, 6.02a-c, 6.03) Provide clients access to records Provide assistance with understanding Protect confidentiality of others within record		
Billing/Fees (SW 1.13a-c) (Psy 6.04a-e) Set reasonable fee as early as possible in treatment. Consider ability to pay. Do not accept goods or services as payment (Psy 6.05) Do not get private fee if client can get from agency/employer of Social worker CHI 2.6: Okay to charge for missed appointment if talked about first		

APPENDIX B

Demographic Viewing Guide

	Professional Title (Clinician)
Client Clinician	Gender
Client Clinician	Race
Client Clinician	Age
Client Clinician	Religion
Client Clinician	Sexual Orientation
Client Clinician	Marital Status
Client Clinician	Kids
Client Clinician	Socioeconomic Status
	Client Profession
	Ethically Adherent? (See Appendix A)
	Fee
	Length of 1 Meeting
	Length of Treatment
	Frequency of Meetings

Setting

Geographic Location

Diagnosis?

Presenting Problem

Medications

Client

Physical Appearance

Clinician

APPENDIX C

IMDb Message Board Post

Subject **Posted by** mflouton **Date** Thu Aug 12 2010

Therapy in Film?

by mflouton

I'm writing a masters thesis on movies with therapy in them – not just referred to, and not a character who is a therapist. I'm talking actual scenes of therapy (ex: Good Will Hunting, The Departed, What About Bob?, etc.) They can be new, old, "good" or "bad," I don't care – the wider the variety the better. Thanks for your help!! (Flouton, 2010, p. 1).

APPENDIX D

Films Sampled

Film Title	Year	Director
Analyze This	1999	Ramis, H.
Antwone Fisher	2002	Washington, D.
Basic Instinct	1992	Verhoeven, P.
Batman Forever	1995	Schumacher, J.
Beautiful Mind, A	2001	Howard, R.
Charlie Bartlett	2007	Poll, J.
Departed, The	2006	Scorsese, M.
Don Juan de Marco	1994	Leven, J.
Donnie Darko	2001	Kelly, R.
Ellie Parker	2005	Coffey, S.
Final Analysis	1992	Joanou, P.
Good Will Hunting	1997	Van Sant, G.
Great New Wonderful, The	2006	Leiner, D.
Grosse Point Blank	1997	Armitage, G.
Groundhog Day	1993	Ramis, H.
Ira and Abby	2006	Cary, R.
K-PAX	2001	Softley, I.
Lars and the Real Girl	2007	Gillespie, C.
Lovemaster, The	1999	Goldberg, M.
Martin and Orloff	2002	Blume, L.
Merci Docteur Rey	2002	Litvack, A.
Mr. Jones	1993	Figgis, M.
Mumford	1999	Kasdan, L.
No Reservations	2007	Hicks, S.
Panic	2000	Bromell, H.
Prime	2005	Younger, B.
Prince of Tides, The	1991	Streisand, B.
Running With Scissors	2006	Murphy, R.
Scout, The	1994	Ritchie, M.
Shopgirl	2005	Tucker, A.
Shrink	2009	Pate, J.
Sordid Lives	2001	Shores, D.
Squid and the Whale, The	2005	Baumbach, N.
Stephanie Daley	2006	Brougher, H.
Stranger Than Fiction	2006	Forster, M.
There's Something About Mary	1998	Farrelly, B. & Farrelly, P.
Tin Cup	1996	Shelton, R.
Transamerica	2005	Tucker, D.
Treatment, The	2006	Rudavsky, O.
Twelve Monkeys	1995	Gilliam, T.
Wackness, The	2008	Levine, J.
Walking and Talking	1996	Holofcener, N.
Watcher, The	2000	Charbanic, J.
What About Bob?	1991	Oz, F.