

The Psychotherapist and the Quest for Power: How Boundaries have Become an Obsession

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Psychology may have seeped into virtually every facet of existence, but that does not mean that it has always been there... Understanding the recent history of psychological experts is critical to understanding psychology's place in contemporary society. That history is based on an extraordinary quest for power.

Ellen Herman,
The Romance of American Psychology

Long before it dawned on me that I might become a psychologist, I was intrigued by some of the men and women considered to be pioneers of the discipline. It was the seemingly insignificant details about their lives, the provocative thinking, and the unexpected comments that caught my interest. Sigmund Freud seemed less arrogant to me than he is generally portrayed for I remember that he once responded to an inquiry about one of his theoretical notions: "Oh, that was just something I dreamed up on a rainy Sunday afternoon" (Kardiner, 1977, p.75). And the following tale, said to have been Carl Jung's favorite story, has stuck with me throughout my career as a psychotherapist:

The water of life, wishing to make itself known on the face of the earth, bubbled up in an artesian well and flowed without effort or limit. People came to drink of the magic water and were nourished by it, since it was so clean and pure and invigorating. But humankind was not content to leave things in this Edenic state. Gradually they began to fence the well, charge admission, claim ownership of the property around it, make elaborate laws as to who could come to the well, put locks on the gates. Soon the well was property of the powerful and the elite. The water was angry and offended; it stopped flowing and began to bubble up in another place. The people who owned the property around the first well were so engrossed in their power systems and ownership that they did not notice that the water had vanished. They continued selling the nonexistent water, and few people noticed that the true power was gone. But some dissatisfied people searched with great courage and found

the new artesian well. Soon that well was under the control of the property owners, and the same fate overtook it. The spring took itself to yet another place - and this has been going on throughout recorded history. (Johnson, 1991, pp. vii-viii)

What first attracted me to Psychology was a fascination with the complexity of human life and a respect for scientific inquiry. Being both curious and skeptical, I was naturally inclined to challenge ill-founded authority. So I entered, with hopeful enthusiasm, what I thought to be an unpretentious profession.

My first teacher, Donald Hebb, despite his academic status, was easily approachable. During my first year as an undergraduate, he talked often with me about the science of psychology, its possibilities - and its limitations. Hebb was fond of stating that psychology must be “more than common sense,” explaining that he did not mean to imply that psychologists had access to some hidden fund of superior knowledge but rather that we must always be skeptical of anything deemed obvious. Over and over again, he emphasized that psychologists had an obligation to avoid being swept along by socially sanctified beliefs. The essence of the profession, as I came to view it, was a combination of critical thinking and humility.

After graduation, in 1969, I worked in the psychiatry department of a large general hospital developing a system to monitor and evaluate how clinicians were diagnosing and treating their patients. Very soon, I was reminded of Hebb’s warning when I had my first glimpse of just how dangerous people can be when they act as if they have access to some superior knowledge which separates them from, and places them above, others. The psychiatrists were “the doctors,” the patients were “the patients;” the roles were clearly and hierarchically defined. As I watched, I began to suspect that behind the haughty, professional, “I’m the doctor” image was a dubious ability to either understand or help patients. Because everyone seemed to be taking the experts’ opinions so seriously, I became concerned about the actual impact these psychiatrists were having on people’s lives.

Over the next five years, my research delved into the manner in which psychiatrists went about deciding what was wrong with their patients and what therapy to provide. As I systematically examined their decision making, it became evident that personal beliefs and subjective theories, especially about the causes of problems, influenced diagnoses and treatments more so than did any available information about specific patients, including observable symptoms and verifiable histories. (Dineen, 1975) It was clear that diagnoses were generally more consistent with psychiatrists’ beliefs than with patients’ problems and that prescribed therapies could be traced, not to any legitimate knowledge but rather to what they believed in – whether it was medication, Primal Scream, Gestalt, some version of psychoanalysis or a behavioral technique.

These findings became part of a growing body of literature challenging the authority of the psychiatric profession (e.g. Neisser, 1973 and Rosenhan, 1973). The contrast between Psychology and Psychiatry seemed clear at that time:

- Psychiatry was powerful; Psychology was weak.

- Psychiatry lacked genuine expertise; Psychology would develop it.
- Psychiatry slotted people into categories; Psychology respected individuality.

What it seemed to boil down to was that Psychiatry was unworthy of the power entrusted to it and that, if given a chance, Psychology could make things better. Believing that to be so, I began clinical work, first in a hospital setting, then for several years as treatment director in a large psychiatric facility before moving, in 1981, into private practice.

Thinking that, as psychologists, we were challenging Psychiatry's position of authority, it didn't occur to me that we were actually trying to grab the power for ourselves. I tried to ignore the continual flow of beliefs being disguised as findings, the psychological fads being promoted as the latest discoveries, and the spread of "pop psychology." However, I cringed as I listened to my colleagues translate human life into a myriad of abuses, addictions and traumas, creating labels for them, and then promoting competing brands and preferred flavors of psychotherapy as the cures.

As I watched psychologists take on the characteristics we had so strongly criticized in psychiatrists, my respect for the profession waned. Psychology seemed intent on building fences and claiming territory, all in an effort to bolster the illusion that we, and we alone, were the legitimate dispensers of psychological wisdom and healing. Whether one accepted it or not, it became a requirement that we take on a professional role in which we viewed patients/clients in debilitating ways, constructing barriers that would separate "us" from "them."

During more than twenty years of clinical work I encountered some people who might be considered so distraught, disoriented or disabled that some acknowledgement of vulnerability may have seemed appropriate. But virtually all of the patients I saw in my office were people whom I would refuse to identify in any way that would set them apart from the rest of us. I would consider it dishonest to declare them "sick," harmful to label them traumatized or damaged, and disrespectful to treat them as less competent, capable or mature than people I might meet in other contexts. All relationships, including those that patients have with psychologists and psychiatrists, involve a distribution of power but rarely is this fixed or absolute. In most cases this power is less clear and more fluid than is implied by the simplistic notion that places the power always with the therapist.

In April of 1993, no longer able to ignore how dramatically the profession had shifted from science to faith and from humility to arrogance, I closed my clinical practice. It was a moral decision strongly influenced by my uneasiness with the boundaries that have come to encircle Psychology and to make absolute and inescapable the supposed "power" of the psychotherapist.

THE NATURE OF BOUNDARIES

I intended to turn my back on the profession; instead, I forced myself to take a cold, hard look at what Psychology had become. Quickly I began to suspect that boundaries served to create an illusion of power.

The profession of Psychology and its derivative practice of psychotherapy are relatively new concepts, yet both are now taken for granted as part of our everyday lives. As Philip Cushman (1995) notes: "Psychology is one of the most significant cultural

artifacts of our times, reflecting and shaping the central themes of the last 150 years”(p.4). Over a brief, meteoric history, Psychology has established itself not only in the minds of millions of individuals but also in the psyche of Western society.

Along with knowledge and skills, the profession claims power. But the power it wields comes not from its expertise but rather from the State and the presumed positive influence its theories and therapies exert on peoples’ lives. For as Pope and Vasquez (1998) write: “In licensing therapists, the states invest them with the power of state-recognized authority to influence drastically the lives of their clients”(p.43).

Intangible and unproveable as this influence is, it has led to the professional and legal establishment of rules referred to as “boundaries,” including rules about dual and multiple relationships, which bar psychologists and psychotherapists from any involvement in the lives of their patients beyond the office and “couch.”

What I have come to understand about these boundaries is that:

- like all man-made fences, they are artificial and arbitrary. They “fence in” and “fence out,” serving to exclude certain groups, certain movements, and certain behaviors. They can be constructed, heightened or lowered, moved, or taken down at any time. (The confusion expressed in recent years by many psychologists regarding what is and is not allowed and what is or is not an ethical violation serves as a constant reminder, and a clear demonstration, of this artificial quality);

- while it is argued that boundaries exist for the purpose of protecting patients from exploitation due to the supposed power of the therapist, the real and much grander reason for building these fences is to establish practitioners, and the profession itself, as an elite and potent force;

- these fences are not built to control therapists’ power but rather to establish and embellish the impression that the people who are qualified to assume the role of psychotherapist are so powerful as to be able to exert a dangerous, Svengali-like, influence.

In this chapter, I will focus on how the quest for power captivated the profession in such a way as to make these arbitrary fences, as illustrated in the popularized notions of “dual” and “multiple” relationships, an obsession. I will look at the social and historical context in which psychotherapy has thrived, the nature of psychotherapy (if such an entity, in fact, exists), the primary characteristics of the therapeutic relationship, and the dilemma faced by those psychotherapists who question the legitimacy of current boundaries.

For convenience, I use the term “Psychology” to refer to the licensed profession, “psychologist” to refer to anyone who, like myself, is a licensed psychologist, and the term “psychotherapist” in referring to any member of the various other mental health professions which sell psychotherapeutic services.

While my comments will be limited to the topic of psychotherapy, it should be noted that the concerns expressed extend into virtually all areas of Psychology. Questions such as whether academics are in such clear positions of power over their students as to be “untouchable” or whether industrial psychologists should be free to have lunch with corporate clients, while relevant to the issues raised, are outside the current focus.

THE SOCIAL CONTEXT OF PSYCHOTHERAPY

We must admit that the rapid growth of psychology in America has been due to conditions of the soil as well as the vitality of the germ.

J. M. Cattell, Presidential
Address to the American
Psychological Association,
1895

When Cattell spoke these words, society was still deeply immersed in “modern” philosophy which held that truth was objective and universal. By the end of the 20th century, this view had given way to postmodern thinking that “affirms that whatever we accept as truth and even the way we envision truth are dependent on the community in which we participate” (Grenz, 1995, p.8). In other words, “there is no absolute truth: rather truth is relative to the community in which we participate” (p.8). One postmodernist, Richard Rorty (1991), contends that once the notion of objective truth is gone, we must choose between either self-defeating relativism or ethnocentrism. We should, he argues, “grasp the ethnocentric horn of the dilemma” and “privilege our own group” (p.24 & 29). Put in more cynical terms, truth is, and retrospectively, always has been, what works best for those establishing the truth. As Foucault concluded from his broad analyses of political and social power, whoever determines that truth holds the power. From prisons to advertising agencies, from schools and clinics to the media, truth became a matter of persuasion.

It was during these changing times that the practice of psychotherapy emerged as a profession and as Sarason (1981) points out, it was as much “shaped” by events and culture as it was a “shaper” of this new society. In many ways it secured its social influence role by adapting its theories and practices to this ‘zeitgeist;’ the intellectual, political and cultural climate of the era.

To understand the current obsession with boundaries, it is necessary to consider the social forces that influenced, restricted and directed the practice of psychotherapy. At times the predominant influences were war, immigration and racism; at other times, industrialism and capitalism. And more recently, Cushman (1995) notes that, “permeated by the philosophy of self-contained individualism,” psychotherapy “exists within the framework of consumerism, speaks the language of self-liberation, and thereby unknowingly reproduces some of the ills it is responsible for healing” (p.6). He contends that psychotherapy has metamorphized to “treat the unfortunate personal effects of the empty self (characterized by a pervasive sense of personal emptiness and committed to values of consumerism) without disrupting the economic arrangements of consumerism” (p. 6).

Earlier, in *Manufacturing Victims*, (Dineen, 1996/2001) I identified some aspects of the postmodern zeitgeist which merit brief consideration here:

- Psychologism
- Victimism
- Professionalism
- Feminism

Psychologism: The Psychologizing of Popular Thinking

In 1991, Christopher Lasch observed that “in the second half of the twentieth century therapeutic concepts and jargon have penetrated so deeply into American culture - most recently in the guise of a broad-gauged campaign to raise people’s ‘self-esteem’ that it has become almost impossible to remember how the world appeared to those not yet initiated into the mysteries of mental health”(p .219).

Despite Psychology’s beginning as an empirical science and its continued effort to craft that image, much of psychotherapy rests on unproven (and unprovable) theories. Cautions which have been raised within the profession have been conveniently ignored as the American public has adopted a psychologized way of thinking. The result of this love affair, as historian Ellen Herman (1995) points out in her aptly titled book, *The Romance of American Psychology*, is that: “psychological insight is the creed of our time” (p.1). From talk shows to televised news reports to the front page of our papers, psychological notions are continuously presented to explain everything from tragedy to success, pain to prosperity, fame to depravity. People have acquired an unquestioning faith in psychotherapists, believing that they have a deep understanding of these issues as well as the skills to change lives.

Psychologists respond by providing explanations and solutions. Early on, John Watson, the “father of behaviorism” claimed that he could manipulate children for either genius and success, or “doltishness” and failure.¹ So effective was his persuasion that, in 1915, *Good Housekeeping* declared that “the amateur mother of yesterday” would be replaced by the behaviorally-trained “professional mother of tomorrow.” J.M. Cattell, R. M. Yerkes and Frederick Winslow Taylor found their niche, applying psychometric skills to weed out mentally incompetent and disruptive characters in the military and in factories; an approach later applied to immigrants and blacks.² Commenting on this, Walter Lippman (1922) wrote of the power-hungry intelligence testers who yearn to “occupy a position of power that no intellectual has held since the collapse of theocracy” (p.10), but his warning went unheeded. Elton (George) Mayo and Carl Rogers began offering employers strategies for resolving worker unrest and ways to increasing productivity.³ Regardless of the harmful effects or questionable benefits of these, and countless other, psychological services, America became a “*Psychological Society*” (Gross, 1978), relying on psychotherapists not only to interpret what people say, feel and do, and to explain their words, moods, and actions, but to guide them onward and upward.

Psychology was heralded as the source not only of ‘cure’ but of ‘growth.’ As therapists, Erving and Miriam Polster put it: “Therapy is too good to be limited to the sick” (London, 1974, pp.63-68). Virtually everyone donned psychologically-tinted glasses and spoke in a psychological language which distorted life and portrayed psychotherapists as powerful healers. So, Psychology has, as Nichols Rose (1996) observes, “given birth to a range of psychotherapies that aspire to enable humans to live as free individuals through subordinating themselves to a form of therapeutic authority” (p.17). He continues: “freedom, that is to say, is enacted only at the price of relying upon experts of the soul;” the new psychologized *TruthMakers* of the 21st century.

Professionalism – Turf Ownership

As Psychology persistently inserted itself into our modern reality, the strategy of professionalization, of capturing and monopolizing market sectors, became progressively more urgent.

When G. Stanley Hall and six colleagues founded the American Psychological Association (APA) in 1892 it was their intention that it should advance the field of psychological research. Only four years later, Lightner Witmer at the University of Pennsylvania, was suggesting to APA that psychologists should be involved in the professional training of students in areas of vocational, educational, correctional, hygienic, industrial and social guidance. Initially, his proposal met with resistance from those who, as scientists, considered it both inappropriate and premature.

Despite these concerns, Witmer had cast the stone and Psychology was on its way to becoming a profession that applied its supposed 'expertise.' Within a few years, Hall would tell Freud, during his 1909 visit to America, that he had come at a good "psychological moment;" at a time when, "with mobility of place, profession and status, and a new instability of values, old ways of looking at the world no longer applied. The individual is thrown back on himself and is more receptive to theories such as psychoanalysis which search for meaning in his dreams, wishes, fears, and confusion" (Turkle, 1978, p.30-31).

What Psychology offered was a way of addressing these concerns that appealed to the public. Psychology, of course was not without competitors; medicine and religion had a long history of attending to such needs. The practical solution was to follow the example of medicine, which had already enacted laws restricting medical licensure to scientifically-trained practitioners with penalties for even fraternizing with the unlicensed practitioner - an early form of boundary violation.

It is generally assumed that professional licensing exists to protect the public but, in fact, its greater service is to the privileged group in society who possess the credentials. Rollo May, shortly before his death reflected on the early days of psychological licensing. He describes the mid 1950's as the "dangerous years" when the American Medical Association threatened to outlaw non-medical psychotherapists. May (1992) recalls that eventually he and his colleagues decided that "the best step for us as psychologists would be to clarify all the different branches of psychotherapy" and to organize a conference on the training, practice and safeguards of psychotherapy. "From that moment on, the fact that psychotherapy was conducted by psychologists... was then accepted in the various legislatures around the country." May goes on to describe a conversation he had at that time, with Carl Rogers; "expecting his (Rogers') enthusiastic help, I was taken aback by his stating the he was not sure whether it would be good or not to have psychologists licensed... During the following years, I kept thinking of Carl Rogers' doubts about our campaign for licensing. I think he foresaw that we psychologists could be as rigid as any other group, and this certainly has been demonstrated..." (pp. xx-xxvii).

As Psychology's prominence grew, wrapped in the garb of a healing profession, it assumed an arrogant sense of self-importance. The brief experiment during the early 1970's, when psychotherapy was seen as an interaction between equals, quickly evaporated, giving way to the present medicalized, hierarchical form. The fence that was created dividing therapists and patients not only serves to separate psychologists from those they want to help, it also creates a 'one-up' position in which power is usurped by

psychologists. As Robyn Dawes (1986) notes: “It is impossible to consider oneself ‘one-up’ without considering the other person involved in the relationship ‘one-down’. That means treating the other as if he or she were not a fully autonomous moral being” (p.2).

Victimism - Pathology for Everyone.

If these new *TruthMakers* were to appear powerful, what better way to do it than to make others appear weak by declaring ‘them’ troubled, injured, damaged, sick – powerless.

From the outset of traditional psychiatry (and psychology) in America with Benjamin Rush, the approach has been to label personal and social problems as illnesses. Although Rush, whose portrait adorns the seal of the American Psychiatric Association, is considered to be the Father of American Psychiatry, some consider him, instead, to be the “Father of the Medicalization of Deviance” (Conrad and Schneider, 1980, p.49). Exchanging a medical ideology for the earlier theological perspective, he perceived “the world in terms of sickness and health,” defining such behaviors as drinking, smoking, lying and murder as medical problems. (Szasz, 1970, p.140).

For instance, one of the problems that Rush confronted was slavery. He claimed to abhor slavery both as a Christian and as an avowed supporter of the Declaration of Independence that held “that all men are created equal.” But he had to deal with the realities of Negro slavery based on the view that blacks were racially inferior. To solve this moral dilemma, he reasoned that God did not create the Negro as black, nor were they black by nature but rather, their blackness was a sign of a disease that he labeled “Negritude.”

While this diagnosis and many others have come and gone in the intervening centuries, psychologists continue to invent pathologies according to the political and social climate of the day. In recent decades, most have been derived from a victim motif that explains away disappointments and difficulties as caused by trauma, abuse, and stress. People have been influenced to take on fabricated victim identities, prompting them to turn to psychotherapy for relief.

These individuals have been led to believe that they can be helped, as Gross (1978) puts it, “*only* if they learn the mysteries of psychology which can unlock the Unconscious. Like the primitive witch doctor, the modern psychologist promises to do this in exchange for power and money” (p.44). Charles Sykes (1992) notes that “the therapists (have) transformed age-old human dilemmas into psychological problems and claimed that they (and they alone) had the treatment... The result was an explosion of inadequacy” (p.34).

A further effect has been to accentuate the one-up/one-down relationship between psychologists and patients.

Feminism - Deconstruction of the Patriarchy

The 20th century served as the backdrop for women to set right the historical imbalances between the sexes and to overcome demeaning stereotypes and customs. Early feminism and the initial women’s liberation movement were committed to an egalitarian view of the sexes, emphasizing fewer boundaries and a more equal power sharing. Later forms of feminism, referred to now as “radical,” rejected “the principle of equal treatment either because legal standards are inherently ‘male’ or because one

cannot treat oppressor and oppressed as equals” (Young, 1999).

Psychology, rather than maintaining its objective and empirical perspective, quickly accommodated to the demands of this radical movement particularly with regards to issues of violence. Accepting biased and generally unreliable data (Dineen, 1998, pp. 145-148), the APA endorsed the notion that aggression was a male characteristic. The APA task force on male violence against women, the members of which were described as “experts in different aspects of female-directed violence,” declared that “one in every three women will experience at least one physical assault by an intimate partner during adulthood” and “34 to 59 per cent of women are sexually assaulted by their husbands” (APA, 1994). Violence was defined as a gender issue: men were inherently violent and there was “no safe haven” for women.

Over recent decades, Psychology has succumbed to the pressures exerted on it by radical feminism allowing this political force to reshape the practice of psychotherapy. Tossing aside such psychotherapeutic principles as introspection and self-examination, Rachel Perkins writes: “Understanding one’s experience as personal, private and psychological...is considered dangerous to the goals of feminism” (Satel, 1998, May, p.14). In the same vein, Laura Brown (1997, April), a prominent “feminist practitioner,” identifies feminist psychotherapy as an “opportunity to help patients see the relationship between their behaviors and the patriarchal society in which we are all embedded.” Brown describes her work as the “private practice of subversion,” and considers the job of a feminist therapist to be “the subversion of patriarchy in the client, the therapist, and the therapy process” (p.453).

Not surprisingly, given that psychotherapy itself is seen as an expression of the patriarchy, much concern has been raised regarding the power differential in the therapist-patient relationship. Feminists have tried to neutralize it, by encouraging, within the therapeutic relationship, such initiatives as woman-to-woman mutual self-disclosure. These initiatives have, of course, served to confuse and confound the very nature of psychotherapy and to construct a political image of the female therapist as safe, caring, and friendly and a contrasting one of the male therapist as a dangerous, self-focused, and predatory. Such imagery has served to support the assumption that virtually any type of dual relationship can reflect an underlying erotic intent, leading therapist and patient down some slippery slope into a sexual relationship that is inevitably harmful to the patient.

The overall effect has been to sexualize the issue of boundaries. Despite all the claims to the contrary, Psychology continues to widen the power-imbalance between men and women, portraying women as victims: weak and powerless, in need of both public and professional protection. The champions of this cause are not always women; often, in fact, they are men who, in earlier decades, would have been considered arrogantly paternalistic. Peter Rutter (1989), for example, writes: “A man in the position of trust and authority (as a therapist, doctor, clergy, teacher, and other) becomes unavoidably a parent figure and is charged with the ethical responsibility of the parent role” (p.101). When this image of women as child-like is melded with the belief in therapists’ power, it results in a preoccupation with gender, sexuality and sexual abuse. “Violations of these boundaries are,” as Rutter continues, “psychologically speaking, not only rapes but also acts of incest” (pp.23-24). Women, he contends, have no power for those who “behave seductively in forbidden-zone relationships are blindly playing out the part of the

masculine myth that wants them to behave seductively” (p.79).

The Obsession with Boundaries and Power

If, at the beginning of the 20th century, America was ripe for psychology, by the end of the century, the ground had been prepared for seeding the notion of professional power, planting the abstract concept of dual relationships, and erecting boundaries.

While postmodernism provided the stimulus, the analyses of Foucault and Lacan were abstruse. Psychotherapy, on the other hand, steeped in theories about transference and heavily influenced by radical feminism, was particularly susceptible to moral panic about the potential harm of a power imbalance. The perception of patients as weak and vulnerable victims, and often female, and therapists as knowledgeable and powerful, and frequently male, invited an ideology of power. Replacing the objective standards of empiricism were the “subjective narratives” which simply put is: “if you says its true, it is true!” This benchmark is applied not only to the reported histories of patients but also to the perception of boundaries, dual relationships and the balance of power.

PSYCHOTHERAPY

*Psychotherapy is a service, a business, an industry,
yet the mystique of psychotherapy endures beyond all reason.*

Robert Langs

Talking sensibly about boundaries in and around psychotherapy, requires that we first ask: “What is psychotherapy?”

“Psychotherapy,” as Cushman (1995) points out, “has had many faces and utilized many ideologies during its stay in North America” (p.2). While the term was rarely uttered in the first decade of the 20th century (Caplan, 1998, p.3), and practitioners were scarce, by the final decade, the word had come into common usage and hundreds of thousands were choosing psychotherapy as a career.

Despite the fact that virtually everyone uses the word and millions purchase the service yearly, “psychotherapy” defies any consistent definition, having shifted from mesmerism and moral treatment, to “mental hygiene” and psychoanalysis, and more recently to such varied and contrasting forms as Humanistic Therapy, Thought Field Therapy (TFT) and Cognitive Behavior Therapy (CBT). In 1978, Szasz highlighted this fundamental problem when he wrote of the “the promiscuous use of the term’ (p.208).

Bolstering this semantic confusion is the notion that “there is no consistent evidence,” as Orlinsky and Howard (1986) assert, “that any specific form of therapy produces better results than any other, whether it be individual or group therapy or family counselling, or short- compared to long-term treatment.” Seligman (1998, December) echoes this conclusion, noting that “when one treatment is compared to another treatment specificity tends to disappear or becomes quite a small effect... The fact is that almost no psychotherapy technique that I can think of shows specific effects when compared to another form of psychotherapy or drug, adequately administered.”

Cognitive-behavior and interpersonal therapists reject this view, claiming that their approaches include “empirically supported methods” for the treatment of specific conditions, such as panic disorders, obsessive compulsive disorders, depression and various persistent phobias. While they express concern that other clinicians are ignoring

research findings in order to justify calling whatever they do “effective psychotherapy,” their critics retort that their “promotions are more science fiction than science (Miller, Duncan and Hubble, 2001),” and offer studies that suggest the importance of relationship factors on cognitive behavioral therapy outcomes. (Keijsers, Schaap and Hoogduin, 2000)

So, the problem remains that if we can’t agree on its definition nor whether it really matters what it is, then why is psychotherapy seen as a potent treatment? In part, according to Leonard Bickman (1999), it is because “we (have been) seduced into believing this by the procedures we ourselves put into place for assuring effective services” (p.968). These criteria - training, qualifications, experience, licensure - have all been held to affect therapy outcome and yet all are professional “myths” unsupported by evidence (Bickman, 1999; Dawes, 1994). These same factors are, of course, seen as contributing to a power imbalance in the psychotherapeutic relationship; suggesting that we are being seduced into this belief in a similar mythological fashion.

If neither the specific therapy nor the professional qualifications explain it, then what is it that leads to the perceived positive effects? Apart from those relatively few conditions for which established treatments of choice seem to exist, research suggests that most of the change clinicians and their patients report is related to “non-specific effects:” of time, patient expectation, implicit suggestion and the therapeutic relationship. For instance, in reviewing the factors that accounted for significant patient progress, Lambert (1986) found that “spontaneous remission” (improvement without treatment) accounted for 40 per cent, 15 per cent of the change resulted from placebo effects (patient expectation), while a further 30 per cent improved as the result of common relational factors such as trust, empathy, insight and warmth. Only 15 per cent of the overall improvement was attributable to any specific psychological intervention or technique. Based on this, as I concluded elsewhere (Dineen, 2001), one might expect “that 85 per cent of clients would improve with the help of a good friend and 40 per cent without even that” (p.117).

The research literature that generally supports this idea has led to the popular assumption that the “power” to help (or to harm) is somehow embedded in what is called the therapeutic relationship. The impression has been created that this “therapeutic alliance” is unique, deserving of the term “professional,” and inherently powerful. But what are the characteristics that make this relationship so special, so unusual and so powerful that it must be fenced in? The answer one frequently hears is that the “magic” can be attributed to such human factors such as trust and caring.

The Therapeutic Relationship and the Pretense of Power

British psychologist David Smail (1999, November) began a presentation recently by listing the following: “kind, sensitive, intelligent, cultured in the arts and humanities, intuitively perceptive, supportive without being obtrusive, attentive rather than talkative.” Only as he continued: “attractive, faithful, loves children, clean and an excellent cook,” did it become clear that he was listing not the characteristics of a “a good therapist” but rather those of “a good wife.” While acknowledging that specifying good wifeliness was particularly patronising and offensive, Smail had succeeded in making the point that, within the profession, there is held a predominant image of “a good therapist.”

It is this stereotype that makes it appear reasonable when Pope and Vasquez

(1998) assert, in *Ethics in Psychotherapy and Counseling*, that “the concept of trust is crucial for understanding the context in which clients approach and enter into a working relationship with psychotherapists” (p.41). But when they go on to declare that the patient’s trust in “therapy is similar to surgery” in that surgical patients allow themselves to be “opened up” by the surgeon while “therapy patients undergo a process of psychological opening up,” one should question what they are saying, especially because they:

- (1) assume that all psychotherapy is similar to psychoanalysis and
- (2) draw on Freud’s (1968) comparison of psychoanalysis and surgery in his lecture on “The Analytic Therapy” when he commented that psychoanalytic suggestion works “surgically” (p.458) and that “psychoanalytic treatment is comparable to a surgical operation...”(p.467).

Of course not all psychotherapists are psychoanalysts and even if they were, the analogy does not hold up because in neither case did Freud’s metaphorical expression have anything to do with Pope and Vasquez’s contention that special powers exist in the therapeutic relationship. In the first reference, Freud sought to clarify the difference between hypnotic suggestion (at least as Freud saw hypnosis) that he viewed as “working cosmetically,” and psychoanalytic observation which he considered to be effective at a deeper level. In the latter reference, addressing the external resistances or impediments to analysis and offering surgery as a contrast, Freud spoke with envy of the surgeon who does not have to deal with the interference of the patient’s family. “A surgeon is accustomed to making... preliminary arrangements – a suitable room, a good light, expert assistance, exclusion of the relatives,” he writes. “Now ask yourself how many surgical operations would be successful if they had to be conducted in the presence of the patient’s entire family poking their noses into the scene of the operation and shrieking aloud at every cut. In psychoanalytic treatment the intervention of the relatives is a positive danger and, moreover, one I do not know how to deal with”(Freud, 1968, p.467). Contrary to Pope’s belief in the therapist’s power, Freud saw, with annoyance and frustration, that his power was drastically limited.

Szasz, commenting on this contemporary misinterpretation of psychotherapy as a medical treatment, observes: “Because the therapeutic relationship is an intimate human relationship ... psychotherapy could not be more different from physical therapies in medicine. The proper treatment of diabetes does not depend, and ought not to depend, on the doctor’s personality. It’s a matter of medical science. On the other hand, the proper treatment of a person in distress seeking help is a matter of values and personal styles — on the parts of both therapist and patient” (Wyatt, 2000).

It seems that the inappropriate medicalization of the concept of psychotherapy, especially when carried to the extreme level of equating it with surgery, results in a manipulated, artificial image of therapists based on an illusory sense of power rather than on any specific skills, any genuinely human qualities or on any specialized body of knowledge.

Arons and Siegel (1995) describe the consequences for the therapist, when they write: “When we [psychologists] sit in our consultation rooms, we often try to present *a carefully sculpted image* to our patients... At times, we are much like the Wizard of Oz, trying to make an impressive presentation while hoping that the curtain we hide behind won't be pulled aside to reveal more vulnerable parts of ourselves” (p.125).

A study of 421 psychologists reveals that psychologists prefer the pretense, wishing to be seen as “irrepressibly superior;” as dependable, capable, conscientious, intelligent, friendly, honest, adaptable, responsible, reasonable, and considerate (Sharaf and Levinson, 1967). One female therapist adds: “My clients aren't particularly open-minded. I fear their rejection. Many wouldn't like me if they really knew me, and that wouldn't be very good for my practice.” This masquerade has become a cornerstones of postmodern psychotherapy.

Along with truthfulness, another essential aspect that has been sacrificed is confidentiality. Although the psychotherapeutic relationship would seem legitimately to have more to do with privacy than with power, no longer can it honestly be said that what patients say to their therapists - their fears, fantasies and self-accusations - are secrets safely uttered (Bollas and Sundelson, 1995). Szasz accurately portrays the current situation when he says that “what is truly ugly about psychotherapy today is that many patients labor under the false belief that what they say to the therapist is confidential, and that therapists do not tell patients, up front, that if they utter certain thoughts and words, the therapist will report them to the appropriate authorities, they may be deprived of liberty, of their job, of their good names, and so forth” (Wyatt, 2000). While therapists may protest that this responsibility is forced upon them by the State, it is only done so with the cooperation of Psychology.

So what are we left with? A profession that claims to:

- free society, especially women, from a perceived patriarchy while constructing a new version of inequality
- empower “victims” while all the while perpetuating a sense of weakness, vulnerability and dependence
- promote the ideal of freedom and individuality while shaping both therapists and patients to conform to prescribed roles
- uphold confidentiality while failing to protect privacy
- be powerful while concealing insecurities.

It is no wonder that Psychology is obsessed with boundaries for, in many ways, that's all there is - *the Clothes have no Emperor* – there is appearance without substance.

But these boundaries, while they may be artificial, have a profound effect on the way we practice. Childress and Siegler (1999) identify five possible metaphors and models of the doctor-patient relationships. The first metaphor, *paternal or parental*, assigns moral authority and discretion to doctors because their competence, skills, and ability place them in a position to help patients regain good health. The second model, *partnership*, is based on the language of collegiality, collaboration, association, and co-adventureship. The third, *rational contractors*, specifies that professionals and their patients be related to each other by a series of contracts which share responsibility, preserve both equality and autonomy under less than ideal circumstances, and protect the integrity of various parties. The fourth, *friendship*, holds that doctors are limited, special-purpose friends in relation to their patients. And finally, a fifth model views the professional as a *technician* (pp.134-137).

Any one of these models might apply to the therapeutic situation depending on who the therapist and patient are and the nature of the service being provided. But our

professional associations and licensing boards, cutting every therapist and every patient from the same cloth, ignore and confuse these choices. APA, for example, would have the public believe that “psychotherapy is a partnership”⁴ while, at the same time, imposing on us boundaries that make a partnership impossible and a paternalistic relationship mandatory. By imposing simplistic, autocratic, non-negotiable limits, Psychology removes any possibility for therapists and patients to entertain any fully human and responsible relationship.

THE DILEMMA

*“A choice that confronts every one at every moment is this:
Shall we permit our fellows to know us as we now are, or
shall we remain enigmas, wishing to be seen as persons we
are not?”*

Jourard (1971, p.vii)

Recently, a colleague contacted me writing: “I am a clinical psychologist with 23 years of experience... and I am currently in a most serious dilemma in terms of my private practice... I always perceived myself to be someone who would do his utmost not to influence my clients... however I may not have been always so noble... it is very difficult to be self-vigilant, to listen honestly to their needs attentively, follow my morals including keeping silent of my skepticism with Psychology, and also securing an income from people suffering.” And he continued: “...in my private practice, clients come to seek my services with a great deal of expectations that are so deeply entrenched in their minds... and, despite my best intentions, I cave in to their many and varied therapeutic expectations, albeit unreal, and end up working with them at the ‘mythical level’... I am considering ending my private practice slowly, but my family believes I should be able to sort this out with time and dedication...”

“Ah, there’s the rub” - how to practice with ethics in a profession that pursues power and artificially imposes boundaries that exaggerate the therapists’ authority and the patients’ vulnerability. How to maintain a viable practice and still be honest about expectations, skills and ability.

Given the current social and political climate and the restraints that stifle the individuality of psychologists and patients, I have doubts that there is an easy way to resolve his “most serious dilemma.”

Since 1996, when I began to express my concerns publicly, many psychologists have contacted me, describing similar levels of disillusionment and moral turmoil. Some have remained in touch while most, after a time, disappeared. Though I could be wrong, I assume that they managed to sort it out in some pragmatic fashion.

The simplest and, arguably, the most practical resolution is to just obey the rules, behave predictably and responsibly and uphold the image. After all, one can argue that being a psychotherapist is a job which, like any other job, involves rules and regulations with which one may, at times, disagree but still has to go along. That’s a view which family, friends and virtually every psychologist I know would consider sensible and justifiable even if it requires implicit acceptance that one’s professional position is one-

down in relation to the various licensing and governing boards, and recognition that one's patients are in what is effectively a two-down position, subject both to the mythological therapist power and to the statutory power of the Boards.

While a few concerned colleagues are openly challenging "the code of ethics" and its rigid rules on dual relationships – some calling the code itself unethical – there are no doubt many more who are silently disagreeing and who are choosing, on occasion, to "bend the rules" regarding boundaries. Those living in rural, military, deaf, spiritual or other small communities may simply find it unbearable, if not impossible, to avoid dual relationships. Those whose psychotherapeutic orientation would deem it not only appropriate, but beneficial, to interact with patients outside the office, may very well decide to go for a walk, golf, or embark on a charity effort with a patient. Countless others might ignore the rules simply because they seem silly, insulting, or intolerably degrading to specific individuals who are, or have been, their patients. These are the people who might decide to visit a dying former patient in the hospital, offering not services but friendship, or who, without thinking, might offer a stranded patient a ride or, on reflection, might agree to be operated on by a patient – just because that person happens to be the best surgeon in town.

"Breaking the rules" more often than not has nothing whatever to do with abusing, coercing or manipulating patients and everything to do with acknowledging them as fellow human beings. It also has to do with risk taking because, in reality, it involves shifting power in the direction of the patient, who can at any time and for any reason, lodge a complaint, claim to be a victim and cast the psychologist in an evil light.

Very few of us would be inclined to seriously consider another option but since I've opted for it, it seems appropriate that I end on it. A Canadian civil libertarian, Alan Borovoy (1991), calls this alternative "uncivil obedience", and describes it as "raising hell without breaking the law." Acknowledging that Martin Luther King taught us how to pleasantly disobey the law, Borovoy suggests that we can protest, also, by unpleasantly obeying the law. "There are ways," he notes, "of being miserable to government without violating the law." (Bindman, 1997 April)

Since I found it impossible to practice honestly and ethically given the mythical image of the psychologist as a powerful expert, as well as the bureaucratically imposed rules and standards, I stopped doing psychotherapy. Remaining a psychologist, maintaining my licenses and my memberships and, always being careful to conform to the rules, I became openly critical of the profession. On one occasion, an annoyed psychologist, after hearing one of my interviews on a national television program, lodged a complaint against me with my licensing board; as a "danger to the television watching public." A year and a half later, after thoroughly investigating me, the board was forced to concede that I had done nothing wrong and to acknowledge my role as a "social critic."

While the route I took is one virtually everyone would consider too radical, there are other forms of uncivil obedience which might serve to bring attention to the issues and discomfort to those who enforce the dubiously "ethical" codes.

One way is to define and delimit any psychotherapy provided to a focused dialogue between two independent and responsible adults. This is how, for 45 years, Thomas Szasz practised psychotherapy. Long ago, he and Hollender (1956) presented a forceful argument for describing psychotherapy as an adult-adult partnership. Their

understanding of the practise was based on a rejection of all efforts to view it within a medical model and an acknowledgement that there exists approximately equal power between therapist and patient. Operating in this style, confidentiality is an essential requirement and not only is no coercive (non-consensual) treatment allowed but the psychotherapist is not sanctioned to act as advocate or overseer when it came to matters outside of the therapeutic conversation. Actions, such as making referrals to doctors or lawyers, providing reports to insurance companies or giving testimony in court, would contravene these principles.

Contrastingly, one might consider advising patients of the existing rules as currently imposed by regulatory boards and require them to sign an informed consent. Such a form might indicate that by entering into a therapist/patient relationship, they understand that they are:

- not guaranteed privacy – all situations in which the right to confidentiality does not hold should be specified,
- considered less powerful than the therapist/parent and, like a child who might be influenced by a parent, viewed as incompetent to make independent decisions,
- forbidden to have any other mutual and consensual relationship beyond the therapeutic one, either business or personal, with their therapist now or at any time in the future

I can imagine how some of my former patients would have reacted. Many, especially those who were high status professionals, wealthy individuals, or celebrities, I'm sure, would have refused to sign. Sometimes I wonder what might have happened had these people become so outraged that they bombarded the institutions, licensing board, professional associations and governments with own human rights complaints.

When I faced this dilemma myself almost a decade ago, I handled it in my own way. My choice was consistent with who I am and with the skepticism I have harbored since the very beginning of my career. I would never suggest to another psychologists that he or she should follow my example.

While a few may choose to step outside of the boundaries and some may choose to ignore them, most of us will choose to obey the rules. But we need not do that obediently. We can question authority, both our own and that imposed by others. And, perhaps, if enough of us do, psychology will be, as my earliest teacher insisted it should be, "more than common sense."

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¹ Psychological Care of the Infant and Child (1928) "There is a sensible way of treating children: treat them as though they were young adults. Never hug or kiss them, never let them sit on your lap. If you must, kiss them once on the forehead when they say good-night. Shake hands with them in the morning. Let them learn to overcome difficulties from the moment of birth."

² For example, psychologists advanced the notion that the ills of the nation could be treated in the same ways as the problems of the individual by treating "a sick nation." Such an orientation was expressed by Myrdal who, in considering the problem of race relations in the U.S., suggested that every facet of black culture "*is a distorted development, or a pathological condition, of the general American culture.*" (Myrdal, G. An American Dilemma. p.928. Emphasis is in the original.)

³ Although Mayo's research was severely flawed and later judged invalid, the well-known and often misunderstood "Hawthorne Effect" became the precursor of a new method of human control: "the power of human relations," the human-relations movement.

⁴ "Psychotherapy is a partnership between an individual and a professional such as a psychologist who is licensed and trained to help people understand their feelings and assist them with changing their behavior." Retrieved from the APA web site: <http://helping.apa.org/therapy/psychotherapy.html>