The Use and Abuse of Power in Therapy

David Boadella

For me, coming from the realm of body psychotherapy, there is a polarity between the power of love and the love of power-over, as Gaie called it in the previous article. We deal with the power of love at the heart centre, and if we as therapists are able to be in touch with our own heart we can open up a relationship with our client which is built on compassion and co-operation. But if we lose that connection then we move into the emotional centre in the body, the area of the solar plexus which relates very strongly to fear and also to many other uncentred feelings such as anxiety, helplessness, anger, frustration, the wish to conquer the resistance, and maybe even the wish to conquer the client.

Sometimes when I am in supervision listening to therapists reporting on their battles with their clients it sounds more like a martial art than therapy — he's trying to get something out of me, I'm trying to get something out of him. What we often find in a therapeutic relationship is a kind of top-dog/underdog situation,

which mirrors the fact that the relationship is asymmetric.

Asymmetric Relationships

The therapeutic relationship is paralleled by a number of other asymmetric relationships where the theme of use and misuse of power is also very important: parent-child, teacher-child, police-member of the public, priest-member of the congregation, guru-follower, doctor-patient — all social relationships which involve use and possible misuse of power and which all have an asymmetry built into them.

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There can be a lot of confusion because we are both human beings, and in that sense it may be a symmetrical relationship, but in terms of the role that each person fills it is asymmetrical. Some of the confusions which occur in these areas result from misunderstandings of what is symmetric and what is not. When the asymmetry in the role becomes an asymmetry in the emotionality two very common patterns occur. These happen in all sorts of relationships, but I am interested in two ways in which they manifest in the therapeutic relationship.

One is a pattern where one partner assumes that the other has more of the power than is right and they themselves have less than they should have. The asymmetry is at the emotional level — it has nothing to do with the role. The second is where there is a competition for the top-dog position, with two people both wanting to know best, to control, to fight for this position. Sometimes this is a fight at the no-power position, with both therapist and client sitting feeling helpless and stuck, and somehow locked into the feeling that it's hopeless.

When I'm working in a training group, watching pairs in therapeutic interaction, I watch the body positions and look for symmetry and asymmetry in their body positions. A depressive client may be sitting telling his unhappy story while the rather depressed therapist is sitting listening to it; their body positions become collusive, and one of the most useful things that can then happen is that the therapist realises what is going on and that they are both disempowering themselves, and that she is taking on too much of the client's energy. If the therapist is conscious she can do something with it, otherwise the under-dog pattern spreads and can take over both of them.

This links with Paulo Friere's model from a totally different field — working with under-deprived countries and populations. He has a very interesting model which I apply to therapy — he talks about dialogue, deprivation, and invasion. Dialogue is a two-way flow, two people listening to each other. The therapist and client build a relationship which is empathic enough to allow for trust to grow and for the client's process to unfold. I would define the essence of such a therapeutic relationship as a relationship of transitional dependency which is designed to help the client to become independent of it. Therapy is designed to end itself — we don't want to be life-long caretakers, so we work with people to give them the power to say goodbye to us. Transitional dependency has the function of encouraging eventual independence.

In opposition to dialogue we have deprivation and invasion. In Paulo Friere's model, deprivation is everything you withhold that is necessary for well-being — this is an idea you can use in therapy or in any other social relationship. When the therapist is depriving they are not providing enough of the elements the client needs to change, they are too barren, lacking some quality, some energy, some response, and the client feels 'Why don't you give me more, why do you sit there like a blank screen?' There is a feeling that something is being withheld. The therapist isn't using enough of their power to help, but is waiting for the client to help herself — that's a misuse by de-

fault, not owning the power to help enough.

Then we have invasion. The therapist knows so well how to help that they come crashing in with all their best plans whether or not they are right. They push their techniques on to the client because 'It's good for you, all my clients do this, I know it's good for you'. I had a client early in my career who said to me 'Why don't you shut up? I want to get the insights too.' That was a little tap on the head for me, and I'm still grateful to that client.

Abusive Questioning

People are now starting to write books with titles like *The Violence of Interpretation*. This is quite strong language. In case you think it's not strong enough I'll give you a stronger one: it's a book being written called *The Obscenity of Asking Questions*. A question can pin the client down in the area the therapist would like to go and lead them away from where they want to go. I've become especially sensitive to this just recently as I've been introduced to some very valuable work on what is called clean questions. I had an example the other day, when I said to the client 'What are you feeling now?' She said 'I'm not feeling; I have an image'. If she hadn't been confident enough to tell me that, she might have come up with some feelings that she felt she was supposed to feel. In asking her 'What are you feeling?' I was directing her to where I thought she should go: I was interested in feelings but she had an image.

Parenting and Therapy

Daniel Stern has some very interesting work about mother and child which can be related to the therapeutic process. He talks about attunement and misattunement between the mother and the child. Attunement is a kind of matching, mirroring, responding to, while misattunement is shooting over the top or underneath. He describes it as over-stimulation and under-stimulation between mother and child. This idea seems to relate to Freire's invasion/deprivation model.

The over-stimulating mother is always whipping up the child's energy with new games that she has thought up; similarly the therapist can whip up the client's energy with new exercises. The under-stimulating mother leaves the child too much to its own resources, assuming it can get on with its own things, and doesn't give enough. So we can also look at the under-stimulating therapist, and how they may unconsciously keep the energy flat.

Four Levels of Therapy

There is a basic model of bonding which I use in my teaching and practice. It uses four developmental levels, which all of us experience as children. Often in the therapeutic relationship one or the other of these four levels will be the dominant bonding style in the contact between the therapist and the client. Each of these has a constructive role and a destructive role, according to how it is experienced.

We can start with the so-called Oedipal stage, around the third year of life, and work backwards. What is important in the Oedipal period is the power of love between human beings and the importance of the client's getting help in therapy to ensure his power to love. This brings up the issue of how the therapist

responds to the client's love impulses — and issues of sexuality, attraction, transference, counter-transference, incest . . . Freud was dealing with this last theme early in his career. He had the idea that incest happens between parents and children. Of course we're still discovering new things about that now. Then Freud changed it and said no, incest didn't happen between parents and children, children fantasise it. When a client talks about feelings around incest, where does the therapist stand? Do they follow Freud Mark 2, or Freud Mark 1, or do they try to tune in to the client? Maybe this last is what is needed — to listen with all senses to the story the client is telling.

The difficult task for the therapist in the Oedipal area is to do what the parent has often failed to do, to welcome sexual feelings without making either of two mistakes. One mistake is to take it as an invitation, and respond to it symmetrically. This will confuse the child and the client. The other mistake is to have sexual feelings, stiffen, get cold and uptight, and give the message 'Not OK'. The therapist in the Oedipal area is sailing between Scylla and Charybdis. Get too close to one rock and he's too stiff; too close to the other rock and he's too easy-going. One rock is the chair and the other the bed.

On the chair, very safe; in the bed, very dangerous; on the mattress, keep awake.

Going backwards in development, at the next level is the power of doing, of skill-learning, where the client can learn to say 'no'. This is a skill that some people never learn. Building boundaries and setting limits, these are things that the person with a weak ego may never have learned. Helping the client to set limits is an important part of this bonding style. The negative side of this is confrontation: therapist and client get locked in a negative pattern of fighting over time, money, the theme or whatever. It becomes a battle about control if the therapist has not done enough work on resolving their own stubbornness.

The oral, needy, stage is the next one. It's wonderful when the non-needing, over-independent, phallic, rigid man begins to discover he has needs, begins to discover there's some helplessness there. What does he need? He needs a therapist who will allow him to collapse, regress, give up the neurotic over-compensated independence and discover some of his early dependency in a safe way; then he needs a supportive therapist who can do something good around nurturing. It's a different story if the client presents in a helpless 'please-take-care-of-me' mode (a typical oral character pattern). This is probably how they have been living all their relationships, and what they want (rather than need) is a good mother therapist to come along and take over all the giving and caring and nurturing, and build what Laing calls a 'corded' relationship. This is the client who wants to stay forever on the lifeline. Something has gone badly wrong at the nurturing level.

If we go one stage earlier still we get to the uterine level of bonding, where the client is working with basic issues of 'Am I welcome in the world?' He doesn't want Oedipal explorations, he doesn't want to learn 'no', he doesn't even want feeding, he just wants to feel welcome. He just wants you to see him. The last thing he wants is for you to ask him to do something, he just would like to feel welcome in your presence.

It can be a very quiet, a very deep place of building trust without much activity. It becomes almost meditative. That's fine and wonderful if you can make that connection, but it's not so fine if the client wants to stay there forever and create a kind of womb therapy where he doesn't have to do much, where he can just lie around all the time feeling nice and welcome. The client is recreating a non-therapeutically helpful foetal state and creating the therapist as the super-parent: 'This is the only place in the world I feel safe.' One of the social forms where we often see that as a destructive pattern is in the attachment between guru and follower. We have the latest example in Waco in America just a few months ago, with total foetal dependency of adults on a super-leader who is making basic decisions about life and death. That kind of situation goes to the edge of a psychotic transference.