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REPAIRING THE BOUNDARIES OF THE SELF

AUTHORITY IN THE CLINICAL SETTING: THE THERAPIST'S RESPONSIBILITY

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Authority is not a popular word in our permissive democratic society. It carries an echo of abusive, dictatorial authoritarianism. As children we had to obey the rules of others and trust the guidance of those who were more powerful. These "rulers" may have been more or less reasonable, even abusive at times. Whether or not our experiences with authoritative or authoritarian figures were realistically abusive, it may have felt so to us due to our vulnerable, powerless state of being when we existed without an ability to comprehend, to protect or to defend ourselves.

Understandably, confusion remains regarding these terms. "Authority" and "authoritarian" are often used synonymously. Webster defines authority as "the power or right to give commands, enforce obedience, take action, or make final decisions. Or, power or influence resulting from knowledge, prestige. A person with much knowledge or experience in some field whose opinion is hence reliable. Expert." Authoritarianism is defined as "the principles, policy or practice of *unquestioning* obedience to the authority of a dictator or a small dictator group, or, believing in, relating to, or characterized by *unquestioning obedience* to authority rather than *individual freedom of judgment* and action." Authority implies power in decision making and knowledge, but not unquestioning obedience. Unquestioning obedience has no place in adult living, much less in psychotherapy. Authority based on knowledge and competence, however, is of crucial importance.

The success of psychotherapy involves using proper authority based on the role and knowledge of an expert who assumes responsibility for treating emotional illness. Much like a physician, the psychotherapist's task is to treat and hopefully cure the patient's emotional illness. Unlike a physician who has laboratory and test results, scanning and x-ray machines to assist him or her in diagnosis and treatment, a psychotherapist stands solely as the instrument of change. This includes the responsibility to be an authority in the clinical setting.

Much controversy has existed in the field of psychotherapy regarding the concept of authority and an authoritative approach. The Rogerian school objected to any use of authority in therapy. "Therapy and authority cannot be coexistent in the same relationship. . . . There cannot be an atmosphere of complete permissiveness when the relationship is authoritative" [Rogers, 1951, p. 109].

Rogers believed that accepting patients' feelings and clarifying, rather than interpreting or confronting them, eventually results in patients taking responsibility for themselves. He feared that patients would become dependent on the therapist, as he correctly identified the fact that most emotionally ill patients are looking for potential caretakers and masters to lead and protect them. He insist-

ed that all interpretive and authoritative comments are at best useless to the patient and at worst destructive to his or her growth. He also assumed that "complete permissiveness" should exist in therapy, an impossible as well as undesirable circumstance in any relationship.

Yalom (1975) summarizes the research of Lewin, Lippit and White on leadership styles and indicates that the Rogerian factors of empathy and unconditional positive regard are not enough to produce an effective group psychotherapist. He "warns" however that too much "executive function" results in an *authoritarian* group, thus failing to develop autonomy in group members. "Executive function" can be authoritative rather than authoritarian but Yalom does not distinguish between these terms.

Fromm (1947) correctly distinguished "rational authority" from "irrational authority." He suggests that the differentiation has to do with the intent with which authority is exercised. Rational authority has its source in competence. The person whose authority is respected functions competently in the task with which he is entrusted by those who conferred it upon him... Rational authority not only permits but requires constant scrutiny and criticism of those subjected to it; it is always temporary, its acceptance depending upon its performance. The source of irrational authority, on the other hand, is always power over people. This power can be physical or mental, it can be realistic or only relative in terms of the anxiety and helplessness of the person submitting to this authority.... Criticism of the authority is not only not required but forbidden. (pp. 9-10)

Fromm's emphasis on the importance of the reflective process that requires constant scrutiny of the authority by others is a most important and necessary principle for a clinician to follow.

Sullivan (1947) prefers to use the term "expert" rather than the term "authority." He questions whether or not it is really beneficial for the patient to meet an authority. He developed the idea of "consentual validation" which demands that the therapist's understanding and his view of reality need to be constantly questioned. Gill (1954) also challenges the traditional view of the psychotherapist as the sole judge of external reality. "We recognize that the patient and analyst could differ on their assessment of reality...." This implies that the therapist may also distort the clinical picture and his authority should be questioned.

Singer (1965) assumes that "authority and responsibility are always fraught with dangers and it is only too easy to rationalize one's needs to dominate and domineer as indices of genuine interest in the welfare of one's charges and of one's fellow men" (p. 257). The history of mankind is full of examples of blind obedience to the demands of authority figures and authoritarian leaders: Nazi Germany, Stalin's Soviet Union, the massacre of civilians in the village of My Lai. The well-known Milgram studies (1973) indicate that a majority of people are willing to induce pain in others if they are ordered to do so. The study was described as a learning experiment in which a subject was ordered to administer electric shocks

to a victim. At various points along the way some subjects refused to go on, but two thirds of the subjects obeyed the experimenter even when the "victims" screamed for help as they "suffered" painful shocks. Tendencies toward obedience and blind trust, even in the absence of physical force, are part of "human nature." Some people never overcome them as they grow into adulthood, and they remain emotionally immature.

Not surprisingly, the pendulum has swung to the other extreme. In today's world authority is generally distrusted, if not condemned. Often little or no respect is given to parents, teachers or law enforcement officers. *Authoritativeness* is mistakenly experienced as *authoritarianism*. The absence of trusted leaders and rational authority figures has led to a generation of young people who lack direction and a sense of personal responsibility, who appear to be lost and aimless, relying on their peer culture for guidance. In the absence of external structure and authority most people do not naturally develop internal structure and self discipline. Desperately needing guidance and direction and yet unable to accept external authority of any kind, many people end up having tragic, wasteful lives. "A legitimate strong authority is essential for the orderly and successful functioning of individuals, families and societies. They falter, and eventually fail in its absence" (Bar-Levav, 1988, p. 179).

In psychotherapy our goal is to help patients develop the *inner* authority to govern primitive and powerful urges and feelings that interfere with sound judgment. Once that is in place they do not need external authority to limit or guide their behavior.

CASE ILLUSTRATION 1

Kim came to therapy at the age of 38 after being fired from her job. She did not have any friends and after her work life came to an abrupt end, she felt worthless and desperately lonely. She thought seriously of suicide. One of three daughters who are all isolated, asocial and without families, Kim had accepted her lonely living more or less as a norm for years. Now feeling depressed and lonely, she did not know what to think or do about her situation. I saw her individually for two months, at which time a place in a therapy group became available. I approached Kim, saying, "I have a place for you in one of my groups. Group therapy is an essential component of your treatment." Kim became quiet. In the next individual session she looked anxious and stated that she wanted only individual therapy. She did not want or need strangers in her therapy. She had never gotten along with people and group therapy would be just a waste. I responded firmly, "I understand your feelings about group therapy, but as your therapist, I am prescribing exactly what I believe you need. As a matter of fact, without the group your treatment will be marginal. You need to be in a group."

Kim resisted going to group therapy, finding many excuses: her new job did not allow any flexibility; she did not want to drive to my office three times a week; she did not have the money; and she did not want to be "tied" to treatment. I held firmly to my treatment plan and Kim started group three weeks later. For

the first three months she fought it and wanted to leave, but I had insisted on a six-month commitment. She has now been in group for over a year and is finally seeing the benefits of her involvement. She looks forward to her group sessions, and she is slowly letting people into her life.

DISCUSSION

Kim's fear of group situations, especially of intimate involvement, was almost overwhelming to her. Her own family had not provided her with safety in close relationships. "We are all hermits," she would say. "The only thing we do is fight on the rare occasions when we do get together." Kim's best friend was her cat who was the sole recipient of all her love and tenderness. I was sure of my treatment plan. Kim's fear needed to be examined but not allowed to dictate her treatment. She needed a firm hand to overcome her feelings and her resistance. My calm, steady, authoritative stand helped her take steps away from her fear to discover experientially that her anxieties were irrational and did not represent reality. Her distorted view of people had to change for her to have a less lonely and isolated life. My knowledge and experience as a psychotherapist, including the fact that I had time and again helped patients overcome their fears, along with my theoretical understanding of the nature and origin of the irrational fear gave me the authority to maintain my position with Kim.

CASE ILLUSTRATION 2

Joanne, a 26-year-old recently divorced woman with a college degree, came to therapy in a panic. For nine months she had tried unsuccessfully to cope with being divorced and finally reached for help. Her marriage had lasted only months, but her inner turmoil continued. She was not working every day and her days off were spent in bed. In addition to her emotional troubles, she also had discovered that her Pap smear was abnormal and she needed surgery to remove cancerous or pre-cancerous tissue from her cervix.

As the third oldest of five children born about a year apart, she had not received adequate mothering from her overwhelmed and extremely anxious mother who reportedly was not able to be in charge of the home. Joanne remembers her mother constantly repeating: "Do not upset your father." The father is remembered as a militaristic man who was unpredictable and at times a harsh disciplinarian who lost his temper. "All I remember from my childhood is being anxious and worried."

Her initial treatment consisted of individual sessions twice a week. Joanne settled down without the use of medication, but six or seven weeks into her treatment, she came to her session again in panic. She cried hysterically, "I cannot believe I did this to myself, I am pregnant." She had had unprotected sex "on a lonely night" with a casual friend. Joanne sounded self-punishing, guilty and scared. After her emotional storm subsided she said, "I don't know what to do. I have done so many terrible things, I cannot have an abortion. I can't kill this baby, but I am such a mess."

Later, when she was better able to listen to me, I talked to her firmly and insisted that she take no action until her feelings decreased in intensity, and only then would we evaluate realistically what made sense. She agreed. For the next few sessions there was no major shift, and she continued to feel overwhelmed by feelings. Despite her confusion, she consulted her physician about her medical condition. The surgery was postponed while she was pregnant. Since cervical cancer reportedly had an eighteen month "window," surgery could safely wait until the current crisis was resolved. But still Joanne's anxiety did not lessen. After consulting with my supervisor and my co-therapy team, I decided to intervene.

Joanne's history indicated that she had a tendency to act impulsively when overwhelmed by her feelings. Leaving her job, moving, and getting a divorce were not thoughtful acts. She could impulsively terminate her pregnancy or she could "act in" and wait passively until time ran out; then she would have to continue her pregnancy without ever really having decided to do so. A patient's impulsive behavior should never be accepted in therapy (Shultz, 1991; Torraco, 1993). Joanne apparently knew no other options for dealing with her powerful feelings. She needed to learn to separate her feelings from her actions and become thoughtful and self-observant before her treatment could continue. My professional thinking was clear and I decided to intervene directly to try to bring her out of her confusion.

"Joanne, I think that you should not become a mother at this time." She started to cry softly, then her cry changed to deep sobs. Her crying was not hysterical and instead expressed her real pain. After she had cried for a while and appeared calmer, I spoke to her firmly. "Despite your confusion, you need to make a rational, adult decision about your pregnancy." I encouraged her to carefully consider my statement and agree to take no action until she had fully evaluated all her options. She agreed.

DISCUSSION

It is not the right of a psychotherapist to impose his or her will or value system on any patient. On the other hand, a psychotherapist must not avoid the role of an authority, stating professional opinions, making decisions and at times prescribing actions. Responsible psychotherapy rests firmly on a therapeutic contract which defines the relationship between the therapist and the patient. This contract should include a clearly understood, non-acting-out commitment: no action should be taken without thoughtful consideration, and none should be based on feelings alone. Since feelings are fleeting, not constant, and often distort reality, they are not reliable guides in making decisions. Feelings should not be ignored. In fact, they need to be safely expressed in order to reduce their domain and power, thus making room for thinking. Bar-Levav (1988) writes, "The non-acting out contract requires that all decisions be based on true deciding, the cool consideration of all the rational facts and choices" (p. 242). And he further states, "Feelings are relatively short-lived, sometimes only fleeting in duration. They result from the totality of a person's past experiences and do not usually reflect current reality accurately. It is best therefore not to connect them automatically

with any action whatsoever, as they are not in themselves an acceptable reason for any real-life decisions" (pp. 233-234).

Joanne's fear of abandonment, her guilt, and her harsh superego either kept her paralyzed or pushed her to seek relief through action. Her feelings did not leave much room for thinking, an evaluative process, or for sound judgment. She also wanted somebody to take responsibility for her dilemma and sometimes, unconsciously, she "waited" for someone to tell her what to do next, as her father often had. Furthermore, the absence of an internalized, solace-giving mother left her at the mercy of her panic. Her father's commanding voice had at least given her something to focus on and had relieved her of the burden of deciding and then taking responsibility for her own decisions. I was aware that stating my opinion could give rise to such a wish and I knew I needed to watch carefully for such a reaction. I was not her parent and I did not want and should not have the responsibility for her real life decisions. She needed to participate thoughtfully in the treatment and her healthy ego had to be in operation at all times. Patients like Joanne with prominent abandonment fears tend to try to please a therapist by quickly conforming and adapting to expectations because they are looking for protection and want somebody outside of themselves to take care of them. A therapist cannot accept this kind of conformity or blind trust but must, instead, demand cognitive evaluation.

As expected, Joanne felt great relief after hearing my opinion. She read into it a permission, an answer to her dilemma, which would give the final responsibility to some external source. It took repeated confrontations from me to help her accept the fact that *she* was the only one who could make this important decision. She was able to consider her medical condition and all her options — abortion, potential adoption or parenthood. She began to realize that I was neither her commanding father nor her inept mother who could not take charge of herself or her children. Instead, I was in charge of her *treatment*. I was "pulling" her out of her infantile regression and at the same time offering her a more adult, thoughtful partnership through our therapeutic contract and the real relationship that we had developed. I used my authority as her therapist to force her to become an authority in her own life.

CASE ILLUSTRATION 3

Karen is a 36-year-old housewife and mother of four. Two are stepchildren who have lived with her periodically for the duration of her second marriage. Karen's presenting problem was increasing conflicts with these stepchildren. "I am ready to explode!" Lacking education and marketable skills, she felt "trapped" in her roles as mother, stepmother and wife to a busy, "dictator-type" husband. She reported increasing use of alcohol and marijuana to cope with her difficulties.

Karen became involved in her treatment and never missed sessions. She seemed insightful and motivated. Although she reported still using alcohol and marijuana "to calm my nerves," she claimed that its usage was less problematic. However, her outside life did not improve. After two years of therapy her family life

continued to be chaotic. Karen's marriage and her relationship with her stepchildren continued to deteriorate. In therapy she was repeatedly confronted about her behavior and her role in the family conflict. She became defensive. Slowly she began to reveal her real dependency on marijuana. She had been afraid to tell me the extent of her self-abuse for fear that I would not continue to see her. She had been smoking four or five "joints" daily for over 20 years and did not want to stop.

After a careful evaluation of her background and treatment I decided not to continue her therapy unless she stopped using marijuana. "Karen, for your treatment to be effective and for us to continue working together, you must stop smoking pot. I urge you to go to an inpatient substance abuse program, and when you have successfully completed the program I will again be your therapist." Karen looked frightened, but also relieved. The issue was clear. I had taken a firm position. Now, she had to make a decision.

Karen started her substance abuse treatment approximately a week later and returned to her therapy, drug-free, as planned. Now two years into her drug-free life, her therapy is progressing well; she is in a twice-a-week group and is a serious college student approaching graduation. Her stepchildren no longer reside with her. Their relationship is civil but not close.

DISCUSSION

Karen's fear of rejection and abandonment interfered with her trust in her therapist. Karen had felt rejected by her mother who had favored Karen's older sister and brother. Overweight as a child and as a teenager she had perceived herself as "unwanted" and "not good enough." At fifteen she had run away from home and sought refuge with an older, religious lady in a distant part of the country. She started using marijuana to cope with her fear and pain. In treatment she made a connection with me, much like the one with this older woman who had given her a safe place to be in the middle of her emotional turmoil; but she did not trust that I would *really* accept her as she was. She tried to be a "good girl."

As I reviewed her treatment in my own supervision, I clearly saw how I had misjudged her involvement in therapy, seeing it as real and genuine rather than based on her fear of abandonment and rejection. I did not correctly assess her real-life difficulties as symptoms of her basic pathology. Karen often behaved like a deprived, angry child who could not tolerate frustration. I had overlooked the seriousness of her substance abuse and family problems and avoided any direct confrontation with her. Countertransference problems and characterological limitations of the therapist limit theoretical understanding and interfere with the therapeutic process. For example, the therapist's own unresolved issues relating to authority figures, unconscious fear of abandonment or overidentification with the patient may prevent the therapist from acting as an authority when the patient clearly needs to be confronted regarding self-destructive living.

Despite these deficiencies in her treatment, I also knew that Karen valued her therapy, and she trusted me enough to consider my words. She had enough

observing ego and real relationship (not one based on positive transference) to make a thoughtful decision. I knew that I could not continue treating her ethically without this intervention. As a clinician I needed to arrive at a correct diagnosis and take a firm position. Karen deserved no less. She did not have the internalized self-discipline that would have protected her from acting on her irrational feelings of fear, pain and anger. She needed external limits and an external structure to start gaining control over her life.

CONCLUSION

The therapist's authority is needed throughout the patient's treatment. It includes decision making regarding frequency of sessions, treatment modalities, and clinical interventions. At times, a therapist may prescribe treatment beyond medications, such as extra phone contacts or sessions, or give a firm injunction against self-destructive behavior. The therapist's confusion regarding the role of authority in general, and specifically within the therapy setting, can seriously hinder the progress and outcome of treatment. A patient seeks help from an expert, not from a peer. Even those patients who have a tendency to reject all authority need a place where they can safely examine their fears and learn to entrust their lives realistically—not blindly—to the hands of an expert. Those whose tendency is to attach themselves blindly to authority figures of all kinds need to be repeatedly challenged and "forced" into independent and critical thinking. Therapists must be able to use their authority properly so that patients can become mature, responsible adults who do not reject or accept external authority without the critical evaluation of all of the facts. In other words, patients need to become realistic authorities for their own lives.

Critical thinking and thoughtful questioning are essential ingredients in the assessment of authority. Therapists need to question themselves continually and expose their work to the criticism and evaluation of competent colleagues in ongoing group supervision. The willingness to be involved in these processes supports the position of the therapist as an authority in the treatment of patients.

References

1. Bar-Levav, R. (1988). *Thinking in the shadow of feelings.* New York: Simon and Schuster.
2. Fromm, E. (1947). *Man for himself.* New York: Rinehart and Company.
3. Gill, M., Newman, R., & Redlich, F. C. (1954). *The initial interview in psychiatric practice.* New York: International Universities Press.
4. Kaplan, H. & Sadock, B. (1993). *Comprehensive group psychotherapy.* Williams and Wilkins.
5. Milgram, S. (1973). *Obedience to authority.* New York: Harper & Row.
6. Rogers, C. R. (1951). *Client-centered therapy.* Boston: Houghton Mifflin.
7. Shultz, P. (1991). Power and the real relationship. *Voices, 27,* 22-31.
8. Singer, E. (1965). *Key concepts in psychotherapy.* New York: Random House.
9. Sullivan, H. S. (1947). *Conception of modern psychiatry.* Washington, DC: The William Alanson White Psychiatric Foundation.
10. Torraco, P. (1993). Changing relationships: from patient to friend, from friend to patient. *Voices, 29,* 34-40.
11. Yalom, I. (1975). *The theory and practice of group psychotherapy.* New York: Basic Books.

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