Professionalising therapy:
a strategy for power and glory?

Could therapy as an institution actually *perpetuate* societal inequalities by helping most those who need it least and in doing so be merely self-serving? **Gill Proctor** poses the challenge while continuing to work as a practitioner

The rise of therapy can serve a convenient purpose for those in power. The more people who see therapy as the solution to their life problems, which are caused by social and economic inequalities, the more these are concealed. Why, when most obvious causes of psychological distress are environmental, does therapy try to change the individual while leaving societal inequalities unchanged? And if so, then could the increasing professionalisation of counselling and therapy, far from its proponents' claim to help and protect clients, help and protect counsellors and therapists more?

Therapy: a response to inequalities?

The experience of powerlessness is one of the most significant causal factors contributing to psychological distress[1] as evidenced in the much higher prevalence of members of oppressed groups in the mental health system[2,3].

It is usually assumed that counselling is more benign, and less power-based than psychiatry; after all it is just talking! Indeed, the legal position with respect to power is different from that held by a psychiatrist or psychiatric nurse. There is potentially more choice in how therapists use or choose not to use the power given to them. However,

as Sanders and Tudor[4] point out:
Just as it is dangerous to assume that psychiatry is a benign force in social policy or that Home Secretaries know anything about personality disorder, neither should we accept or assume that therapy is in itself benign, useful or effective.

Miller and Rose[5] emphasise that 'we should be wary of celebrating psychological approaches as alternatives to psychiatry'. Psychological approaches can also be used as part of the armoury of power and control over the population, as Foucault particularly elucidated[6].

Ignoring and perpetuating inequalities

As in medical models of mental illness, models of therapy conceptualise the client's problem as individual, internal or intrapsychic, ignoring social causes; thus the danger is of therapy becoming a process of people learning to accept their oppressed position and keeping quiet about their powerlessness. Furthermore, as an institution it actually *perpetuates* such inequalities.

How do you become a client?

Even clients who voluntarily seek counselling do not make the decision that they need therapy simply by identifying some internal distress. Everywhere the media, internet and 'information' from mental health services have been expanding what

counts as a mental health problem or something in need of therapy[7]. The effect is an increasing medicalisation and individualisation of life's problems which diverts attention from social conditions and separates people from each other by consulting 'experts'. Whereas in the 1970s women went to consciousness-raising groups and discovered their commonalities in distress due to their treatment as women, now most go to individual therapists and see their problems as internal.

The dynamics of power

There are three aspects to power in the therapy relationship[1]. The first is *role power* resulting from the authority given to the therapist to define the client's problem and the power the therapist has in the organisation and institutions of their work. Various micro-environments affect how much role power a counsellor has in any one situation or work environment. This aspect of power is dynamic and relational; therapists use this role power differently and each client will have different views about and reactions to their own role power as a client. However hard the therapist strives for equality in the therapy relationship, the role of 'therapist' has power attached to it.

The second aspect of power in the therapy relationship is that resulting from the personal histories of the therapist and client and their experiences of

power and powerlessness. I call this *historical power*. These histories and experiences affect how individuals think, feel and behave in relationships. The final aspect of power, *societal power*, is the power arising from the structural positions in society of therapist and client, with respect to gender, age etc.

Historical and societal power are interlinked as there are likely to be more instances of historical powerlessness associated with being in a structural position of powerlessness, something that can exacerbate the power dynamic involved in the roles of therapist and client.

We are all influenced by society's messages about inequalities and absorbed stereotypes, assumptions and unspoken expectations or messages about how society is ordered. Awareness of our own socialisation can help a therapist understand their own conditions of worth in a social and political context and how their current behaviour and ways of relating are likely to be influenced by gender and other identity role expectations. Our structural identities have a big impact on who we are, how people treat us and how we relate to people, and understanding society's messages about these identities and how these are internalised (although responded to differently) may help us understand an individual more accurately situated within their cultural context. As society's messages are for the most part implicit and often denied, it is likely to be difficult for clients to be able to explain their impact on their way of viewing the world and themselves. If these messages are not understood, we run the risk of taking for granted socialisation of inequalities and what is 'normal' as an unquestioned part of our culture.

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Who are the therapists and who are the clients?

The evidence showing the inequality of the social structural positions between therapists and clients is well documented[9]. Therapists are more likely to be white and middle class, whereas clients are generally poorer, more disabled mentally and physically, older,

younger, more dependent and less socially supported.

Of course student counsellors, particularly in higher education establishments, see more privileged clients by definition, as students are much more likely to access degree courses if they come from a privileged background. However it is likely that those students who most need counselling in these settings are those who are the most oppressed or least privileged within the student population.

Therapy outcome

The results of 40 years of psychotherapy research have consistently shown that the most consistent variables related to effectiveness are the therapeutic alliance, goal agreement and empathy[10].

Research has consistently demonstrated a figure of around two thirds of clients who 'improve' on scales to measure what is considered mental health[11]. But what about the 33 per cent who do not 'improve'? These figures are based on clients who complete a course of

therapy, completely missing those who drop out along the way.

Statistics can be criticised on the basis of how 'improvement' is measured and that clients could benefit from therapy without showing any difference in 'symptom' ratings. Could this be a defensive response? More worrying are those who actually get worse[12], and contrary to the usual myth they do not always get worse before they get better[13]. Even therapists with the best intentions may damage clients.

Who does therapy not help?

Lambert[11] summarises the relevant commonalities found in research: namely negative expectations, lower social class and severity of problems. Lower social class is an example of an oppressed group in itself and I would suggest that high severity of problems and negative expectations are also likely to be associated with being oppressed.

I suspect therapy is most likely to help those most like their therapists, ie the more privileged. I argue this for four reasons: that the most oppressed are likely to have the least resources, are the least likely to access therapy, that therapists are better at understanding people like themselves, and that the most oppressed are most likely to say they feel better to please the therapist[3].

So who does therapy help?

Like many other industries, the therapy institution is set up to perpetuate the inequalities which gave rise to its need in the first place and producing more potential future clients. Perhaps the most unsavoury conclusion is that therapy most obviously helps therapists! It gives us an income, a sense of being helpful, being needed, being important and even indispensable. It may fulfil our emotional intimacy needs, or curiosity about how other people live. And the more we are unaware or deny our own needs which are met from being a therapist, the more we are in danger of hiding behind the mask of a benign healer, and projecting our own needs onto our clients. And it does not end there.

Professionalisation

As therapy becomes increasingly professionalised it has tended towards enshrining ethics in rules or codes of practice within regulatory bodies involving quasi-judicial complaints procedures. The claim is that it protects the client. In fact, research and experience have shown that it does not diminish the amount of abuse or harm caused by professionals[14,15] but serves to protect the power of therapists and their professional bodies.

Heyward[16] claims that:

professionalism is not simply a cultural attitude. It is an entire hierarchical system of value, status, and ultimately, of power. ... many therapists and counsellors ... in reaction to the pervasiveness of systemic violence among us, seem to be awash in a language of 'professionalism', 'boundaries' and 'safety'. I believe that this language, and the fear beneath it, have become excessive and are strangling our capacities to be genuinely moral with one another. That is, we are becoming rule-bound rather than ethical, obedient rather than struggling honestly together creating relational ethics that do not inhibit intimacy.

The danger is that both therapist and client can become so concerned with an 'external locus of evaluation' that they lose touch with a sense of their internal ability to evaluate and make decisions. Strict adherence to codes takes responsibility away from the two people involved leading to unthinking, unaware and therefore unethical practice. Webb[17] points to the danger of over-emphasis on ethical codes which she reminds us are culturally specific and open to modification and refinement. She suggests counsellors need:

to internalise and integrate a professional/personal value system that enables them to function appropriately without over-dependence on external constraints ... to think about ethical principles, not just 'rules', and to recognise both the possible conflicts between ethical principles and the ambiguities and

uncertainties in ethical decision-making.

Lazarus[18] dared to suggest that the emphasis on boundaries reflects a preoccupation with risk-management taking precedence over humane interventions. He argues against the idea of any one rule applying to every client or every therapy relationship and advocates instead that therapists need to calculate risks responsibly in each individual situation. Among the several published responses Brown[19] warns against 'ethical anarchy' locating the problem in the abuse of the power inherent in the role of therapist, and in ethics in therapy being treated as an additional consideration rather than embedded within its theories and practices. She advocates that therapists use ethical codes not as rules to be followed or broken, but as information for consideration and interpretation.

Professionalisation and regulation leads to therapy as an increasingly elite profession, bolstering claims to expert knowledge through university accredited courses and gate keeping entry, thus widening the gaps between therapists and clients, and protecting the expert status of therapists and arguments to justify their pay. I am not arguing that counselling should not be a paid professional activity, just that we should be aware and honest that the professionalisation and regulation agenda serves the profession – not clients. Perhaps this is another example of therapists' needs being denied and projected onto clients. We should also consider other effects from this move – unthinking rule following and the increasing placement of therapists and counsellors as educated experts, rather than companions in healing or concerned and caring people.

Wider impact of therapy on society

I am still a therapist and how I justify this is another dialogue[20-22]. I am a therapist to acknowledge, witness and respond to distress in the world the best way I can. However even if we can justify therapy as being possibly helpful for some clients who have suffered

from the way our society is structured, there are wider impacts of my choice to respond to distress by being a therapist, such as the impact on my personal relationships when much of my focus, attention and emotional energy is given to my clients. Would I be better off working harder at creating the best truly mutual relationships possible in my personal life rather than making the best of the limited relationships within therapy? Is this the general impact of the existence of therapy in society – that we can all let go of the responsibility to create healing mutual relationships with people and leave this to therapists?

Given that most clients and therapists are women, in what ways does therapy perpetuate or challenge gender role socialisation?[23] Could it be that in professionalising emotional nurturance this relieves women from their traditional role as care givers? Or does the necessarily unequal relationship in therapy perpetuate traditional gender roles and relationships based on dominance and submission? I believe it is the responsibility of each therapist to consider how they contribute to this or whether they can challenge these roles and how far it is possible to work towards therapy relationships based on a mutual recognition of equal subjects.

Conclusion

It is imperative not to forget that we are all part of an inherently unequal society with structures that damage us all. The therapy industry has mushroomed, taking advantage of the increasing numbers of people hurt by this society and looking for meaning in a world increasingly ruled by consumerism. Being part of this professionalising and increasingly powerful industry and institution means we have responsibilities for our part to examine ways in which we may contribute to these causes of distress, rather than hide behind the naïve hope that we are benign healers. I hope this paper has begun to consider ways in which we ensure that doing therapy does not further damage caused by inequalities and lead mainly to our own power and glory. ∎

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