Chapter 5

TRUST, POWER, CARING, AND HEALING

Psychotherapy is a remarkable venture. It harnesses three forces—trust, power, and caring—to help people heal. In our work, we face the ethical challenge of understanding, respecting, and handling carefully all three.

TRUST

When we apply to states and provinces for professional status via licensure and certification, we accept the responsibility that comes with that status. Society expects us to be trustworthy, to avoid abusing the trust that people place in us. Society depends on us to fulfill that trust for the good of our clients as well as society. Ethical dilemmas can arise from the clash between the client's interests and society's interests, or between the client's interests and the therapist's interests. In return for assuming a role in which the safety, well-being, and ultimate good of clients is to be held as a sacred trust, we are entitled to the roles, privileges, and power that governments and society entrust to professionals.

This concept of trust is key to understanding the context in which clients enter into a working relationship with us. Clients expect or desperately hope that they can trust us. Many fear we might betray their trust. Some agonize over trust issues. Others find barriers to trust almost insurmountable. And others, like Black, Indigenous People of Color (BIPOC) clients come to therapy knowing that the profession we represent has violated their trust many times throughout history. Still others come to therapy unaware of how their problems trusting others have made it hard for them to love, work, and enjoy life.

Trust is at the core of therapy and clinicians put it to good use. In therapy we expect clients to walk into the consulting room of an absolute stranger and say things that they would say to no one else. We therapists may ask questions that would get us slapped, punched, or sued if we asked them outside of therapy. What patients tell us in confidence carries potential to be therapeutic or harmful depending how we use that information and/or, whether we violate the client's trust by breaking the sacredness of confidentiality. This potential to help or hurt has led virtually all states and provinces to recognize some form of professional confidentiality and therapist–patient privilege. Laws prevent therapists, with some specific exceptions, from talking to others about what clients share with them during therapy.

Therapy, like surgery, relies on trust. Surgery patients allow themselves to be physically opened up in the hope that their condition will improve. They trust or may reluctantly trust surgeons not to take advantage of their vulnerability to harm or exploit them. Therapy patients undergo a process of psychological opening up in the hope that their condition will improve. They trust us or want to trust us not to harm or exploit them. Freud (1952) noticed this similarity. He wrote that the newly developed "talking therapy" was "comparable to a surgical operation" (p. 467) and emphasized that "the transference especially … is a dangerous instrument … If a knife will not cut, neither will it serve a surgeon" (p. 471). Recognizing and respecting the potential harm that could result from psychotherapy was, according to Freud (1963), essential.

> It is grossly to undervalue both the origins and the practical significance of the psychoneuroses to suppose that these disorders are to be removed by pottering about with a few harmless remedies … Psychoanalysis … is not afraid to handle the most dangerous forces in the mind and set them to work for the benefit of the patient.

As patients, only if we trust the therapist and their intentions are we likely to speak truthfully about—or even disclose at all—events and topics that make us feel fear, shame, guilt, anxiety, or all the other forms of discomfort and apprehension. Research by Farber et al. (2019) found that trust played a "role for clients concealing depression symptoms; 42% of respondents saw it as a way to foster honesty. Increasing trust was also important to clients concealing mistreatment in relationships and even for those lying about self-harm" (p. 3203–3204).

Our ethical responsibility includes respecting our clients' trust that we will do nothing that places them at risk for harm. When we betray the client's trust, they may lose hope in the system and profession we represent and not just in us as individual providers. When we betray our clients' trust, we can sometimes cause deep, pervasive, lasting damage. The poet Adrienne Rich wrote a vivid description of the effects of shattered trust.

> When we discover that someone we trusted can be trusted no longer, it forces us to reexamine the universe, to question the whole instinct and concept of trust. For awhile, we are thrust back onto some bleak, jutting ledge, in a dark pierced by sheets of fire, swept by sheets of rain, in a world before kinship, or naming, or tenderness exist; we are brought close to formlessness (1979, p. 192).

Research by psychology professor Jennifer Freyd and her colleagues (e.g., Freyd, 1998, Freyd et al., 2005, Gobin & Freyd, 2014, Platt & Freyd, 2015, Smith, 2017) has explored and described how *betrayal trauma* can result when our trust is violated. Freyd emphasized:

> Psychologically, betrayal is toxic to the mind and body. We know this from decades of research on betrayal trauma. People who are betrayed are likely to suffer mentally and physically. This is true whether the betrayer is a trusted person—like a psychotherapist or supervisor—or a trusted institution—like a clinic, hospital, or university. In the case of institutional betrayal, the harm can be particularly acute and even associated with increased thoughts of suicide (personal communication, August 7, 2020).

We all face the challenge of understanding what inspires and validates trust and what misreading, misunderstanding, or mishandling trust can mean for the client. For some of us, advanced degrees from prestigious universities, diplomate status and other certifications (often framed in the office), awards and honors (often framed even more prominently in the office), publications in respected journals on topics related to what we want to work on in therapy, fame, and even an office in an impressive building may inspire our initial trust in a therapist. Surely someone with all those accomplishments must know what they're doing, some of us might think, rightly or wrongly. For others the realities of intergenerational trauma and institutionalized forms of oppression experienced many times at the hands of those deemed experts rightfully detract from our ability to trust us. Clients may think that we may not know what to do with them. Others know that we too have biases that affect how we treat them, yet, despite these valid concerns, clients hope to be proven wrong. They hope we can be of help so they can feel better.

But for some prospective patients, these markers may be warning signs and even barriers to trust (Alire, 2019; Okun et al., 2017; Sue et al., 2019). These markers may suggest to members of historically oppressed communities that the therapist is a member of the establishment that has inflicted prejudice, discrimination, hate, oppression, and injustice. For instance, some BIPOC may understandably assume that a White therapist holds the same racist views and practices that so many White people have held for generations, given the many ways in which systems and institutions provide unearned advantages

(privilege) to White people. Some of these privileges include: hiring and promotion practices favoring Whites; juries less likely to convict White defendants or, after conviction, to impose the death penalty on White defendants for comparable crimes; and traffic stops being much less risky for White drivers than for Black drivers. BIPOC may believe that White therapists have accepted those views and enjoyed those benefits without acknowledging the taint, wrongness, and injustice of such unearned advantages, let alone working to dismantle racist or other oppressive systems.

A White therapist who reacts defensively to a client holding a version of such views—an extreme version might be "Why, there's not a racist bone in my body. I have no racist views"—or tries to block or shunt side dealing with such trust issues honestly and openly, is on the wrong track. A well-intentioned response to an experience about discrimination, such as "Oh, I am sure they didn't mean it that way" invalidates the reality and perceptions of the BIPOC client.

> Many minorities may perceive that the therapist cannot be trusted unless otherwise demonstrated. Again, the role and reputation that the therapist has as being trustworthy evidenced in behavioral terms. More than anything, challenges to the therapist's trustworthiness will be a frequent theme blocking further exploration and movement until they are resolved to the satisfaction of the client (Sue et al., 2019, p. 109).

Similarly, not talking or addressing issues related to racism, anti-Semitism, sexism, heterosexism, cis-sexism, gendered-racism and other forms of oppression may signal to the client that the therapist does not see these social problems as significant, real, or important to how they impact clients who are members of various minoritized groups. This lack of attention to the lived experiences of BIPOC and those who experience other forms of oppression may further negatively impact a client's ability to trust that the therapist will hear, understand, and respect their experiences. The heart of trust is not about our telling clients to trust us, the credentials on our walls, or the buildings where we practice—the heart of trust is about who we are, about whether we treat our clients with dignity and respect, and about our actions and inactions.

POWER

The trust that society and individual clients give to therapists is one source of power—for example, the power to respect and value that trust or to abuse and betray it. The role of therapist holds power ranging from superficial to profound, from fleeting to lasting. The following sections look at seven forms of power

including (1) power given by the state, (2) power to name and define, (3) power of testimony, (4) power of knowledge, (5) power of expectation, (6) power created by the therapist, and (7) the inherent power differential.

1. Power Conferred by the State

State and provincial licensing confers power. Licensed professionals can do things that people without a license cannot. With patients' consent, surgeons can cut human beings wide open and remove internal organs, anesthesiologists can drug clients until they are unconscious, and some therapists can recommend or administer mind or mood altering drugs to clients, all with the law's authorization. People will take off their clothes and willingly (well, somewhat willingly) submit to all sorts of indignities during a medical examination. They let physicians to do things to them that they would not dream of letting anyone else do.

Similarly, clients will open up and allow us as therapists to explore private aspects of their thoughts, feelings, and social lives, including their history, fantasies, hopes, and fears. Clients will tell us their most guarded secrets, material shared with literally no one else. We can ask questions off-limits to others. States and provinces recognize the importance of protecting clients against the misuse of this power to violate privacy. Except in certain instances, we are legally required to keep confidential what we have learned about clients through the professional relationship. Holding private information about our clients gives us power.

Through licensing, governments also invest us with the power of state-recognized authority to affect our clients' lives. We have the power to make decisions (subject to judicial review) about our clients' civil liberties. In some cases, we have the power to determine whether a person constitutes an immediate danger to the life of someone else and should be held against their will for observation or treatment. Alan Stone (1978), professor of law and psychiatry at Harvard University and a former president of the American Psychiatric Association, noted that in the 1950s the United States incarcerated more of its citizens against their will for mental health purposes than any other country, and that the abuse of this power later led to extensive reforms and formal safeguards.

The state has sometimes used the power of involuntary hospitalization to enforce social injustice. For example, in 1958, Black pastor and civil rights activist Clennon King "tried in vain to enrol at the all-White University of Mississippi" (Negro pastor pronounced sane, demands Mississippi apologize, 1958, p. 3). State troopers took him to a mental health institution where he was imprisoned against his will. Where he had been committed was kept secret from everyone for 48 hours. After being confined in the mental health institution for 12 days, he was released when a panel of 17 doctors declared

him sane. He regained his freedom only to face charges of disturbing the peace by trying to enrol in an all-White university and resisting arrest. He said, "My only fear of jail is what might happen to me in that jail—the authorities are the only ones who have threatened me" (Negro pastor pronounced sane, demands Mississippi apologize, 1958, p. 3).

In the 1940s and 1950s, the government of Quebec falsely diagnosed 20,000 Canadian children as mentally ill and imprisoned them in psychiatric institutions to enable the misappropriation of government funds (Boucher et al., 2008, Clément, 2016, Duplessis orphans seek proof of medical experiments, 2004). The children became known as the Duplissis Orphans, named after Mauric Duplessis, who governed as Premiere of Quebec for five non-consecutive terms between 1936 and 1959. These are only a few of the countless examples in which the field of mental health and therapists have acted in unjust ways causing harm to vulnerable populations, and engendering distrust in the mental health system.

2. Power to Name and Define

We hold the power of naming and defining. To diagnose someone is to exercise power. In an ingenious study, Lam et al. (2016) showed clinicians a video of a woman describing how she experienced uncomplicated panic disorder. They then asked the clinicians to rate her problems and describe her prognosis. Research participants had been randomly assigned to three groups. One was given the woman's personal details and background information, the second was also given a behavioral description consistent with borderline personality disorder, and the third was given one piece of additional information that included the label of a borderline personality diagnosis. The results showed the power of a diagnosis to affect perception and judgment. Their study found that "the BPD label was associated with more negative ratings of the woman's problems and her prognosis than both information alone and a behavioural description of BPD 'symptoms'" (p. 253).

In one of the most widely cited psychological research studies, "On Being Sane in Insane Places," Rosenhan (1973) wrote, "Such labels, conferred by mental health professionals, are as influential on the patient as they are on his relatives and friends, and it should not surprise anyone that the diagnosis acts on all of them as a self-fulfilling prophesy. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly" (p. 254).

Caplan's description (1995) of psychiatrist Bruno Bettelheim's analysis of student protesters reveals the potential power of diagnosis and other forms of clinical naming to affect how we view people:

> In the turbulent 1960s, Bettelheim ... told the United States Congress of his findings: student anti-war protesters who charged the University of Chicago with complicity in the war machine had no serious political agenda; they were acting out an unresolved Oedipal conflict by attacking the university as a surrogate father (p. 277).

The power of naming and defining has been particularly harmful to BIPOC and members of other oppressed social groups. For instance, naming "homosexuality" as a mental illness, being gatekeepers of gender-affirming terms for transgender people, over-diagnosing Black children with externalizing behavioral disorders and Black adults with more severe forms of mental illness (e.g., bipolar disorder, schizophrenia) has contributed to the pathologizing of communities who are already suffering as a result of discrimination and hatred.

3. Power of Testimony

We possess authority to change the course of lives when we testify as experts in the civil and criminal courts and through similar judicial or administrative proceedings. Our testimony can help determine whether someone convicted of murder is executed. It can be the deciding factor in whether a parent gains or loses custody of a child. It can shape a jury's view of whether a defendant was capable of committing a crime, was likely to have committed it, was legally sane at the time the crime was committed or is likely to commit similar crimes in the future. It can lead a jury to believe that an uncle sexually abused a young child or that the child either imagined the abuse or was coached as part of a custody dispute. It can help immigrant and asylum-seeking individuals regularize their status in the United States so they can live and work free from the fear of being separated from their families or deported to countries where their lives may be at risk. Our testimony can convince a jury that the plaintiff is an innocent victim of a needless trauma who is suffering severe and chronic harm or is a chronic liar, gold digger, or malingerer.

4. Power of Knowledge

Our role as therapist holds power beyond the power that a license creates. We hold power that comes from knowledge. We study human behavior, mental processes, and the intrapsychic and social factors that affect motivation, decision, and action. We learn methods to bring about change. Our research, writing, and our very words have the power of providing language and validation to experiences that have been marginalized, made invisible, silenced, and disregarded. Maintaining a constant, respectful awareness of the power flowing from knowledge and expertise is essential to avoid the subtle ways of manipulating and exploiting clients through our interaction with them or through our clinical documentation (treatment plans, progress notes, assessment report) and scholarship.

5. Power of Expectation

The process of psychotherapy itself creates and uses different forms of power. Most therapies recognize the force of the client's expectation that the therapist's interventions will be able to induce beneficial change. One aspect of this expectation is the placebo effect, a factor that must be considered when studying the efficacy and effectiveness of interventions. The client's investing the therapist with power to help bring about change can become a significant part of the change process itself. Conversely, the therapist's expectations, including optimism and belief in the client's capacity to change, are powerful as well. Miller et al. (1995) reviewed the research and noted that

> As a factor in outcome, technique matters no more than the "placebo effect" ... The creation of such hope is greatly influenced by the therapist's attitude toward the client during the opening moments of therapy. Pessimistic attitudes conveyed to the client ... are likely to minimize the effect of these factors. In contrast, an emphasis on possibilities and a belief that therapy can work will likely counteract demoralization, mobilize hope and advance improvement.

On the basis of their research, Connor and Callahan (2015) reported:

> Psychotherapists were found to hold significantly higher expectations for client improvement than anticipated, based on existing literature, and these high expectations were found to be positively correlated with clinically significant change in clients. Moreover, psychotherapists' expectations were found to explain 7.3% of the explainable variance in whether or not clients experienced clinically significant change during psychotherapy (p. 351).

Similarly, research conducted by Swift et al. (2018) found that student therapists' expectations were a "significant unique predictor of change. These results suggest that therapists should be aware of their own expectations when working with clients in order to make sure that any negative beliefs do not impact the quality of care that they provide" (p. 84).

6. Therapist-Created Power

In some approaches, the therapist works to create specific kinds of power. A family therapist may unbalance the equilibrium and disrupt alliances among

family members. A behavior therapist may create a hospital unit or halfway transitional house in which desirable behaviors bring a rewarding response from the staff (perhaps in the form of tokens that can be exchanged for goods or privileges); the power of the therapist and staff is used to control, or at least influence, the client's behavior.

Psychologist Laura Brown (1994) describes another domain of the therapist's power:

> The therapist also has the power to engage in certain defining behaviors that are real and concrete. She sets the fee; decides the time, place, and circumstances of the meeting, and determines what she will share about herself and not disclose. Even when she allows some leeway in negotiating these and similar points, this allowance proceeds from the implicit understanding that it is within the therapist's power to give, and to take away, such compromises (p. 111).

7. Inherent Power Differential

Power differential is inherent in psychotherapy. Although some approaches emphasize egalitarian ideals in which therapist and client are equal, such goals are viewed only within a narrowly limited context of the relationship. In truly equal relationships, in which there is no appreciable power differential, there is no designation of one member as "therapist" in relation to the other member, there is no fee charged by one member to the other for the relationship itself, there is no designation of the activity as "professional" (and falling within the scope of a professional liability policy), there is no license possessed by one member allowing initiation of a 72-hour hold on the other, and so on. A defining attribute of the professional is the recognition, understanding, and careful handling of the considerable power—and the personal responsibility for that power—inherent in the role. Regardless of how mutual, genuine, or egalitarian a therapist may choose to be, often utilizing humanistic, feminist (e.g., relational), multicultural orientations, some degree of power difference is unavoidable.

CARING AND HEALING

Both the individual client and society recognize the diverse powers of the professional role and place their trust in us to use those powers to help—never to harm, oppress, or exploit. We must match with our caring the trust that society and the individual client invest in us. Only within a context of caring and healing—specifically, caring about the client's well-being, and working to not just help cope or adjust to intolerable circumstances but actually helping clients heal their pain—are our professional status and powers justified.

Historically, professional status was not created or defined by charging high fees, spending long years in training, or reaching a high level of skill. The professional's defining characteristic was an ethic of placing the client's well-being foremost and not allowing professional judgment or services to be drawn off course by one's own needs and wants. A major purpose of professional ethics codes is to help us use our knowledge, skills, status, and other forms of powers to help our clients and not to take advantage of, endanger, cheat, undermine, abuse, or otherwise mistreat or harm them. "Professional ethics protect the public against the abuses of professional power, specialized knowledge, and prominent positions. They place protecting the public interest above advancing the profession's self-interest" (Pope, 2019, p. 186). Professional ethics help keep us from being biased or blinded by our own self-interest so that we can no longer see clearly or care about our clients, their legitimate interests, and our responsibilities to them.

The touchstone for the approaches discussed in this book is caring for and about our clients. This book's concept of caring avoids passive, empty sentimentality. Caring includes responding to a client's legitimate needs and recognizing that the client must never be exploited. Caring also includes assuming personal responsibility for working to help and to avoid harming or endangering our clients. Caring involves learning to contextualize experiences and realities that may be completely different from our own so that we do not pathologize, misdiagnose, or misattribute behaviors that may be culturally congruent or blaming our clients for their reactions to oppression. Furthermore, caring means that we work on addressing our biases and prejudices as a way to ensure that we are able to treat all of our clients with the same level of respect and dignity. Caring is being a healing presence in the lives of those we serve.

Unfortunately, the concept of caring may not receive adequate attention in graduate training programs. As Seymour Sarason (1985) wrote:

> On the surface, trainees accept the need for objectivity—it does have the ring of science, and its importance can be illustrated with examples of the baleful consequences of "emotional over-involvement"—but internally there is a struggle, as one of my students put it, "between what your heart says you should say and do and what theory and your supervisor say you should say and do." Many trainees give up the struggle but there are some who continue to feel that in striving to maintain the stance of objectivity they are robbing themselves and their clients of something of therapeutic value. The trainee's struggle, which supervisors gloss over as a normal developmental phase that trainees grow out of, points to an omission in psychological-psychiatric theories. Those theories never concern themselves with caring and compassion. What does it mean to be caring and compassionate? When do caring and compassion arise as feelings? What inhibits or facilitates their expression? Why do people differ so widely in having such feelings and the ways they express them? It is, of course, implicit in all of these theories that these

> feelings are crucial in human development, but the reader would be surprised how little attention is given to their phenomenology and consequences (positive and negative) (p. 168).

Sarason made some excellent recommendations for how to encourage and develop caring, compassion, and empathy in clinical training programs, and more recently other innovative approaches have begun to emerge (see, for example, Condon & Makransky, 2020; Fragkos & Crampton, 2020; Han & Kim, 2010).

We still have a long way to go in ensuring that clinical training programs, internships, professional organizations, clinics, hospitals, and other settings are doing all they can to support caring, compassion, and empathy among clinicians. Unfortunately, there is evidence that such qualities may actually decline in some settings (see, for example, Hegazi & Wilson, 2013; Hojat et al., 2004, 2009). In "Empathy Decline and Its Reasons: A Systematic Review of Studies with Medical Students and Residents," Neumann and her colleagues noted that the evidence of declines of empathy over the course of medical training, they describe:

> Some of the studies included in our review reported significant increases in cynicism among medical students. Crandall et al. also found students' commitment to caring for medically underserved patients to be greater when they entered medical school than at graduation. This result was independent of gender and curriculum type (problem-based versus traditional; Neumann et al., 2011).

Caring about clients and what happens to them is at the heart of the formal rules and regulations that are society's attempt to hold us accountable, of our professional ethics codes, and of our personal ethical responsibilities to each patient.