Psychotherapy and Politics International
Psychother. Politics. Int. 8(1): 44–58 (2010)
Published online in Wiley InterScience
(www.interscience.wiley.com) **DOI:** 10.1002/ppi.209

Boundaries or mutuality in therapy: is mutuality really possible or is therapy doomed from the start?

GILLIAN PROCTOR, Bradford and Airedale Community Health Services, Shipley

INTRODUCTION

In this paper, I write from two positions, both of which are aspects of me. The paper that follows is a discussion between me as a critical psychologist, critiquing the concept and enterprise of therapy from a social justice perspective, and *me as a person centred therapist (distinguished by italics) who practices therapy in as ethical a way as possible and believes from experience in its healing power, despite its potential for furthering oppression.*

First of all, I shall discuss the association of the experience of powerlessness with psychological distress with particular reference to women and argue that therefore taking more power-over people can hardly help.

I suggest that working from a relational ethic of mutuality will help therapists to minimize taking power-over their clients. The concept of mutuality in therapy comes from the traditions of relational psychoanalysis, feminist therapy and person-centred therapy.

I will discuss the notion of 'boundaries' in therapy and its role in increasing the therapist's role power and power-over the client, suggesting that therapists argue that self-protectionist strategies are for the benefit of the client.

House (2003, 57) compares boundary-mindedness which he describes as 'firmly rooted within the conventional modernist paradigm of Aristotelian categorical thinking' with 'New paradigm dialectical thinking which privileges intersubjectivity.'

Following this new paradigm thinking I shall privilege intersubjectivity and I will suggest that therapists should declare their own limitations and work from a relational ethic of mutuality in therapy.

But then I will turn to the enterprise of therapy itself and argue that the possibility of mutuality is seriously limited by the inevitable role power inequality in therapy.

I will work hard to defend why I continue to be a therapist and discuss how therapy can most minimize the dangers of perpetuating inequalities.

Correspondence: Gillian Proctor, Bradford and Airedale Community Health Services, Unit 4, Park View Court, St. Paul's Road, Shipley, BD18 3DZ.
E-mail: Gillian.Proctor@bradford.nhs.uk

DOI: 10.1002/ppi

But finally I will conclude by arguing that nevertheless, therapy may be a doomed enterprise and leave the reader to conclude which side of the debate you fall on – for or against therapy.

INTRODUCING THE POSITIONS

I am a clinical psychologist and person-centred therapist working in primary care in the NHS. From the beginning of my career I have placed myself fairly firmly in the critical psychology camp, being a clear critic of therapy and the helping professions, predominantly from the basis of the dynamics of power in such relationships. I have written and taught about such issues and basically spend most of my time talking and writing myself out of a job.

And I am a person-centred therapist who has striven to try and do therapy in the most ethical way possible, from the ethical belief in each person's right to self-determination, in us all being ordinary people trying to work our best path through life without having a clue what may be the best way for someone else. At the same time, like the critical Gillian, my ethical beliefs are founded on a belief in equality and wanting to stand against inequality and I try my best as a therapist to support and validate those who have suffered from the inequalities in our society. I want to try and do something to help rather than just criticize and I get annoyed by those from the critical psychology camp who criticize but still work with people but can't explain how. In all my work I have always spent time doing therapy with people, and have found from experience that many people seem to find this a helpful, affirming and validating experience, often helping people to make the most out of their lives despite their structural positions and resulting experiences of oppression.

THE RELATIONSHIP OF POWERLESSNESS TO THE EXPERIENCE OF PSYCHOLOGICAL DISTRESS

I argue that the experience of powerlessness is one of the most significant causal factors contributing to the experience of psychological distress (see Proctor, 2002a). Power, control and the experience of powerlessness are frequently mentioned in understanding all kinds of psychological distress. I'm not suggesting that powerlessness causing distress should be a new overarching theory that explains all distress, but I am suggesting that powerlessness is often a significant causal factor in distress and that therefore reducing powerlessness is likely to help people recover, whereas taking power over and control from people is likely to make things worse.

SO HOW DO WE HELP PEOPLE IN DISTRESS?

Given that power is such a key issue in the causes and experience of psychological distress, it is surprising that it is not considered more in models of helping distress. Psychiatric systems are set up around hierarchical systems of control and power; superficial and token ways of 'empowering' patients are sometimes considered briefly. Psychiatric systems are much more successful in controlling people experiencing distress than in helping to alleviate distress. Johnstone (1989, 116) notes that 'Sometimes the parallels between treatment and abuse are disturbingly close.'

DOI: 10.1002/ppi

POWER IN THERAPY

But surely therapy is the humane alternative to psychiatry? After all, therapy is just talking. Even service-user groups ask for more talking therapies.

But Miller and Rose (1986, 42) emphasize that 'we should be wary of celebrating psychological approaches as alternatives to psychiatry'. This is true even if the psychological approaches are not offered as part of a bigger mental health system. Psychological approaches can also be used as part of the armoury of power and control over the population, as Foucault particularly explains (see Proctor, 2002a). Heyward (1993, 204) suggests, about therapy, that 'sexual and power abuse are *inevitable* in a system so steeped in unquestioned assumptions of hierarchy and power.'

This is the reason for my use of the term 'therapy relationship' in all my writing instead of the more usual 'therapeutic relationship' as we really shouldn't assume that this relationship is necessarily therapeutic at all.

ASPECTS OF POWER IN THERAPY

I have identified three aspects to power in the therapy relationship (Proctor, 2002a). The first is the power inherent in the roles of therapist and client resulting from the authority given to the therapist to define the client's problem and the power the therapist has in the organization and institutions of their work. I have called this *role power*. Whatever the context of a therapist's work, there is still power given by society to those identified as therapists. Various contexts of work can add to the authority given to the therapist (such as the NHS in the UK).

The second aspect of power is the power arising from the structural positions in society of the therapist and client, with respect to gender, age etc. I have called this *societal power*. The final aspect of power in the therapy relationship is the power resulting from the personal histories of the therapist and client and their experiences of power and powerlessness. I have called this *historical power*. The personal histories and experiences will affect how individuals are in relationships and how they think, feel and sometimes behave with respect to the power in the relationship.

ROLE POWER

There is a clear political agenda in person-centred therapy (PCT) to eliminate the therapist's power over the client and it is revolutionary in the extent to which it manages to do this (see Proctor 2002a for a detailed discussion of power in person-centred therapy). Person-centred therapy is based on the philosophy of trusting the individual client to be the expert and radically shift the dynamic of power in the therapy relationship. Rogers (1978, 14) explains

> *the politics of the person-centred approach is a conscious renunciation and avoidance by the therapist of all control over, or decision-making for, the client. It is the facilitation of self-ownership by the client and the strategies by which this can be achieved; the placing of the locus of decision-making and the responsibility for the effects of these decisions. It is politically centred in the client.*

The non-directive attitude is a way for therapists to express their commitment to avoiding client disempowerment (Brodley, 1997). Natiello (2001, 11) explains ' Such a stand is in

DOI: 10.1002/ppi

radical conflict with the prevailing paradigm of authoritative power.' The person-centred approach stresses the therapist as a person not an expert and the idea of mutuality is at the basis of its philosophy.

Similar intentions are in feminist and relational psychoanalytical models of therapy. But however the therapist behaves as an equal person in the therapy relationship, therapy is still an institution and the role of 'therapist' still has power attached to it in society. I have suggested that person-centred therapists need to ensure they do not underestimate their role power as a therapist however much they behave as an equal person and non-expert.

Feminist authors also help us to understand the power in the institution of therapy. Chesler (1972) reminds us that the therapeutic encounter needs to be understood as an institution beyond how individual therapists are with individual clients and how this *institution* re-enacts the relationship of girls to their father figure in a patriarchal society. Although individual therapists challenge this hierarchical expert-based idea of therapy, therapy itself as an institution remains unnoticed, which is likely to be a major factor in clients not perceiving the therapy relationship as equal however the therapist behaves. There is a clear inequality in the roles of therapist and client which is not removed by any kind of therapist behaviour as a person.

The three aspects of power that I consider are interrelated, and all apply to the relationship between the therapist and client, rather than residing within either individual. In the rest of this paper I shall concentrate on role power.

MUTUALITY

Traditionally, codes of ethics in therapy have been based on a primary ethic of autonomy, one of the four principles forming the traditional approach to moral philosophy and biomedical ethics know as the 'ethics of justice'. Bond, a key writer and thinker in the field of therapy ethics in the UK has considered the significance of a recent shift from a primary ethic of autonomy to one of relational trust (see Keys and Proctor, 2007). This move parallels the feminist critique of the 'ethics of justice' as being focused on individuals and not concerned with humans as social and relational beings (Banks, 1995). Bond (2004a, 3) suggests that an ethic of relational trust 'focuses attention on adequacy of the relationship quality for therapeutic purpose'. The quality of the relationship needs to be sufficient to sustain the major ethical challenges of therapy 'arising from inequality, difference, uncertainty and risk'. Thus, ethical decision-making in this context is fluid and situational requiring continual ethical mindfulness with active responsibility and accountability throughout the whole process of the therapy relationship. Reliance on external rules is replaced by constant awareness and monitoring of the idiosyncrasies of each relationship.

I suggest that the ethics of mutuality are another way of talking about ethics of relational trust, based on real relationships between people, where each has needs and each has limitations and these are discussed openly and honestly. (For more examples of mutuality in practice see Proctor, 2004, 24–5.) There may also be roles but these do not prevent each person fulfilling a role from primarily being a person. Relationships based on mutuality emphasize equality of all and respect for all, rather than dominance and submission, the more usual model for relationships in our society (Benjamin, 1988).

DOI: 10.1002/ppi

BENJAMIN

Benjamin (1988) provides a critique of Freud's theory of dominance and power in relationships. She suggests that psychoanalytic theory provides the basis for the continuation of dualistic thought and relations, by the psychic structure in which one person plays the subject and the other must serve as his object, which forms the fundamental premise of domination. She suggests instead that there are two conflicting drives within each person: the drive to independence and autonomy emphasized by object relations theorists and the drive to recognition, for one's own individuality to be recognized by another individual who is also a subject in their own right, rather than an object of one's own needs.

Instead of domination and submission (or subject and object) she emphasizes the importance of intersubjectivity in all relationships including the therapy relationship. She advocates setting a model for relationships based on equality and negotiation rather than dominance and submission. If psychoanalysis includes the recognition of intersubjectivity, rather than the therapist being the object for the patient, this will change the power dynamics involved, encouraging a more mutual and less authoritarian relationship.

This is related to gender. She explains:

> What is extraordinary about the discussion of authority throughout Freudian thought is that it occurs exclusively in a world of men…woman's subordination to man is taken for granted, invisible …This assumption…provides…the ultimate rationalisation for accepting all authority. (Benjamin, 1988, 6)

Benjamin asserts that many psychoanalytic theories have missed the need for mutual recognition in their emphasis on the mother as the object of the child's needs: the child needs to see its mother as an independent subject, not just as an object. Psychoanalytic theories have emphasized the need for autonomy at the expense of mutuality. She suggests that the basic pattern of domination is set in motion by the denial of recognition to the original other, the mother, and that the resulting structure of subject and object is represented by male and female. Rather than being inevitable, she suggests that

> Domination…is the twisting of the bonds of love. Domination does not repress the desire for recognition; rather, it enlists and transforms it.…For the person who takes this route to establishing his own power, there is an absence where the other should be. (Benjamin, 1988, 217)

Benjamin contends that to halt this cycle of domination and submission, the other (the first other being the mother) must make a difference: women must claim their subjectivities. Whereas power is inevitable as the interplay and tension of the needs for recognition and independence, 'If the denial of recognition does not become frozen into unmoveable relationships, the play of power need not be hardened into domination' (Benjamin 1988, 223).

PSYCHOANALYTIC MODELS THAT EMPHASIZE MUTUALITY

In Proctor (2002a), I have suggested that the power of the psychoanalytic therapist can be abused in the transference relationship but that it is possible to minimize this power by paying equal attention to the real relationship between the therapist and patient, and

DOI: 10.1002/ppi

exploring feelings associated with this that are experienced by both the therapist and the patient. My belief in the importance of mutuality and the danger of role power in therapy was affirmed by my experience of therapy as a client with a psychodynamic therapist (described in Proctor, 2002b). Several models of psychoanalytic therapy have been developed that take this view of power very seriously and advocate the importance of the real relationship between therapist and patient. The main examples are the relational model (Aron, 1995), and the feminist model of the Stone Center (a collective of feminist writers and therapists begun by Jean Baker Miller and informed by the ideas of Carol Gilligan; see Miller and Stiver, 1997 and Jordan, 1991). These models have both been developed and used mainly in the US. The key emphases in relational psychoanalysis are on intersubjectivity and mutuality. Instead of the therapist being in a position of authority to define reality, for relational psychoanalysts, both the therapist and the patient have their own perspectives on the relationship, which are equally valid. Aron (1995) suggests that the concept of intersubjectivity should replace the concepts of transference and countertransference, as it does not imply pathology and does imply bidirectional and continuous influence. He defines mutuality as authenticity and genuineness, an absence of pretence. Similarly Stone centre theorists emphasize authenticity and mutual empathy.

Throughout his description of the relational model, Aron (1995) is keen to emphasize that, although the therapy relationship is mutual, it is not equal, because of the dynamics of power. He suggests that the abandonment of objectivity does not necessitate the surrender of ethical standards, professional responsibility or clinical judgment. He asserts that the essence of asymmetry is that analysts must be responsible to accept their own subjectivity, which forms their clinical judgments; to continue to make choices, but to take responsibility for these choices based on their values. Therapists need to be aware of their own subjectivities and abilities to reflect on their participation in relationships, while recognizing the limitations of their reflections.

Heyward (1993, 166) describes this honest engagement in responsible ethics as follows: 'I was coming to believe that the capacity to live in ambiguity, to accept it, to make ethical decisions in it and act on these decisions – rather than using ambiguity as an excuse for not taking stands – is a capacity born of wisdom and seasoned in courage.'

MUTUALITY IN PERSON-CENTRED THERAPY

Several person-centred theorists have recently suggested that person-centred theory needs to focus more on people in relationships rather than autonomous individuals. Recent theoretical writing does seem to be adopting this relational focus and is moving theory and hopefully practice away from the more historic and traditionally western preoccupation with autonomy and individuality (e.g. Schmid, 2007; Barrett-Lennard, 2005 and Mearns and Cooper, 2005).

'BOUNDARIES'

Having introduced the concept of mutuality in therapy, I now want to discuss the idea of boundaries in therapy and mental health services

One of the preoccupations of mental health services in the UK as well as risk assessment and management is the importance of workers 'maintaining boundaries'. House (2003, 52)

DOI: 10.1002/ppi

describes this as ' a certain obsession in the therapy world with 'boundary speak' in recent years'. Zur (2007, 3) suggests boundaries 'distinguish psychotherapy from social, familial, sexual, business and many other types of relationships.' The idea originates in psychoanalytic therapy, where boundary crossing was seen to interfere with the transference relationship (Zur, 2007). In addition the rhetoric around boundaries is often about making services safe for clients (e.g. Zur, 2007, 3). Clearly the notion that workers need to be aware of the vulnerability of clients and take care to not abuse or exploit clients in their relationship is paramount. But this focus on boundaries has other effects not as benign as avoiding exploitation, and in fact I will argue that the effect of the rhetoric of boundaries is more likely to have the opposite effect and increase the likelihood of abuse or exploitation of clients.

Owen (1997, 168) pulls no punches in his conclusion about boundaries saying: 'The use of strict boundaries may even be seen as part of an authoritarian and potentially exploitative mystification which invents artificial constructs that are discriminatory, judgmental and dehumanizing.' In the rhetoric of boundaries, the model is of an expert therapist, who can interpret and predict a client's needs, based on the traditional ethical principles from the ethics of justice of beneficence and non-maleficence (doing good and avoiding harm). Often a picture is painted of a client (usually diagnosed with borderline personality disorder (BPD)) 'pushing' the boundaries of a therapist or 'resisting' the therapist's boundaries and the usual advice given to therapists is of the danger of 'giving in' to the client. Heyward (1993, 142) describes this experience as a client as 'the trauma in having my passion treated as pushy and my pain as a manipulative ploy.'

This seems to be a response to the history of mental health services failing to offer a service that works for people who are often diagnosed as 'personality disordered'. When clients ask for help outside their allocated appointment times, or complain about the help they have been given or communicate in other ways that the services offered are not enough, the result has historically been for services to blame the clients for this response and constrain their services even further. The discourse of 'boundaries' serves to blame the clients for the service not working. Often appointments are offered at specified times in advance, which will not serve a need for a client in crisis, but when clients turn up to such services because no crisis services have been arranged, the clients are blamed rather than identifying a lack in care planning or services. When clients do not 'get better' in a specified timescale, rather than blame the lack of long-term services, the client is blamed for being 'unable to use a focused intervention'. For women with a diagnosis of BPD, this then justifies women with the diagnosis being blamed when the boundaries set by the services mean that services are not offering enough to help when a woman is distressed. Consequently, the woman herself is labelled as being 'too needy'. This message can reinforce how women may see themselves, as being unworthy of care, and can increase distress at times when women are in most crisis.

We all know that there are many clients who feel what we offer as therapists just isn't enough; with the huge amount of distress suffered by so many people in this world, an hour or more a week of even the highest quality of care is often just not enough. In addition, many clients feel uncared for however much we feel we have gone to our limits within the therapy situation. My experience is that when most therapists talk about these situations, it is usually the case that these clients are pathologized for being 'too needy'. I believe therapy is a limited enterprise and will not be enough for healing for many people however

DOI: 10.1002/ppi

much we try and offer. However, I also believe that we should not constrain ourselves by arbitrary or theoretical boundaries that restrict our human capacity to respond to people and care. Why should our boundaries be constrained any more than our own limitations of comfort within which we can look after ourselves and be able to honestly and openly respond to the needs of our clients?

In the standard 'professional' model of care, which ignores the subjectivity or personhood of the therapist or worker, the danger is that the ignored needs of the therapist/worker are projected onto the client and then used to justify the therapist's limitations as being 'boundaries for the good of the client'. For example, a worker with many responsibilities becomes increasingly frustrated with a client who regularly turns up in distress wanting to speak to only this worker. The worker decides the client is 'overstepping boundaries' and introduces a rule that the client can only turn up once a week, explaining to the client that these boundaries are for her benefit. The worker does not explain that she is unable to keep up with all her responsibilities and has reached a limitation. As Webb (1997, 181) suggests 'what counsellors may construe as matters of ethics often turn out to be more those of self-protection.' Indeed House (2003, 55) suggests that 'there may well be an intrinsic abusiveness in the formalized, professional preciousness with therapeutic boundaries that is so typical of profession-centred therapeutic practice.'

A major difficulty in discussions of 'boundaries' is the danger of workers constraining ourselves to avoid potential abuse, but totally missing the danger of neglect. Zur (2007, 11) suggests that a focus on conservative risk management 'can affect the quality of care negatively'. A refusal to be authentic and present in relationships can be experienced as abusive, and can result in harm. Heyward (1993, 137) notes 'It was becoming increasingly clear to me that abuse – damage, harm, violence – can result from a professional's refusal to be authentically present with those who seek help; and that such abuse can be triggered as surely by the drawing of boundaries too tightly as by a failure to draw them at all.'

Surely the bottom line of any attempt to help should be to avoid making distress worse. Therapists and any mental health service providers should not constrain ourselves by arbitrary or theoretical boundaries that restrict our human capacity to respond to people and care.

DEFENSIVE OR HEALING PRACTICE?

A far more honest way to deal with the inevitable limits to what services can offer would be for mental health workers to be honest about their own limits and express them as such without trying to pretend that these limits are good for the client. In the above example, if the worker could have been more honest that she has limitations on her availability, then the client's need for crisis services could be identified and filled elsewhere. With this honest and mutual exchange, there could then be real attempts to fill the gaps in services and try to provide what women say they need.

I believe that the principle of mutuality is an ethical principle to help us make ethical decisions in a more informed and committed way than to follow rules of boundaries. Zur (2007) distinguishes between boundary crossings and boundary violations, where boundary crossings are not necessarily negative or avoidable and boundary violations are exploitative. Brown (1994), a feminist therapist in the US usefully suggests three characteristics of

DOI: 10.1002/ppi

boundary violations that are exploitative and advocates that therapists consider the possibility of each in making ethical decisions. These are objectifying the client, following an impulse (which does not consider the client's potential reactions to this impulse) and placing the therapist's needs paramount. Each of these examples is an occasion where the relational principle of mutuality does not apply.

I believe that to take the ethics of mutuality seriously is a big commitment, emotionally and politically. It requires clear commitment to our own self-awareness and to discussing our ethical decisions and ways of being with clients in open and mutual ways in supervision and with clients. This will not be an easy or safe process. As Heyward (1993, 171) also notes: 'In our most creative, deeply mutual possibilities, we become dangerous people… "Dangerous" in that it threatens to transform us and the ways we work and love.' Furthermore, she notes that 'People cannot live this was without strong relational networks of support and solidarity' (Heyward, 1993, 167).

PROFESSIONALIZATION

House (2003, 52) claims that an obsession with boundaries in therapy 'is by no means a coincidence in terms of the professionalisation and commodification of therapy.' He explains that 'The fear saturating the nascent profession's need to bolster and legitimize its new status as 'profession' easily and surreptitiously leads to 'a search for a completely safe and protected position from which to operate (Hermansson 1997, 134)' (House 2003, 53).

Heyward (1993, 2001) claims that 'professionalism is not simply a cultural attitude. It is an entire hierarchical system of value, status, and ultimately, of power.' Furthermore, she explains the difficulties with this move to professionalization:

> many therapists and counselors who, 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. (Heyward, 1993, 13)

The danger with such rules 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 own internal ability to evaluate and make decisions. Strict adherence to codes takes responsibility for the relationship away from the two people involved leading to unthinking, unaware and therefore unethical practice. Hermansson (1997, 134) describes the result of a preoccupation with boundaries saying 'excessive caution can emerge, rigid rules can come to dominate, and simplistic thinking can prevail.' Webb (1997) also 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 that counsellors need

> to internalize 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 recognize both the possible conflicts between ethical principles and the ambiguities and uncertainties in ethical decision-making. (Webb 1997, 181)

DOI: 10.1002/ppi

Lazarus (1994) dared to critique the notion of boundaries, suggesting that the emphasis on boundaries reflects a preoccupation with risk-management taking precedence over humane interventions. He argues cogently 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. Included among the several published responses to his paper was feminist therapist Brown who warns against ' ethical anarchy' (1994, 277) but locates 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 the theories and practices of therapy itself. She further advocates that therapists need to use ethical codes not as rules to be followed or broken, but to inform us for themes for consideration and interpretation, to inform 'a careful, thoughtful exploration of the combined ethical and clinical meanings of a behavior' (Brown, 1994, 278).

Heyward suggests the alternative of a mutually derived ethics rather than rule-bound: 'No professional rules or theory could have moved us through this passage safely. Only a mutual authenticity could have provided a safe passage for us both, and this was not to be' (Heyward, 1993, 160).

MUTUALITY IN PRACTICE

I take my role as a therapist very seriously as it has great power attached to the role. However, I also aim to be myself as a real and authentic person in that role and to have a real relationship with my clients, which goes beyond our roles. I believe strongly in the power of this authentic person-to-person connection and the abuse of power in withholding our personhood from therapy.

I try to be flexible and dynamic in my arrangements with clients despite working within the structures of the NHS so also being clear about service constraints. I am always open to reconsidering any decision we have made concerning a therapy contract, in terms of timing of sessions or any other factors. This seems to be a realistic expectation that individual needs and relationships may change. Any requests that a client makes concerning a therapy relationship that I am unsure about, I respond by saying that I'd like to think further about the request and discuss in supervision. Then in supervision I try my best to understand the details and depth of my responses to the request to fully consider my response to the client.

I do not believe in a rule about the necessity to keep an authentic relationship which began as a therapy relationship within the constraints of those roles. I believe that to be open to not doing so involves risk, danger and a clarity of ethical commitment to oneself and others but I also believe that by not being open to that carries a risk and danger of restricting authentic real connection and potential healing. In discussing dual relationships, Webb (1997, 178) is clear that it is not the existence of dual relationships that is the problem as they are inevitable in many small communities but that 'Counsellors need to understand that it is the exploitation of power, derived from the counseling relationship and used in other contacts, that is the problem here.' She further discusses the necessity for counsellors of developing strategies to manage these dual roles. I also think this is a personal decision about recognizing our own limitations in relationships and their complexity.

DOI: 10.1002/ppi

I have experienced very positively a relationship with a close friend where our relationship has changed. We have negotiated the changes in our relationship through the roles of student-teacher, therapist-supervisor, colleagues in teaching and friends. We have often been in many of these roles simultaneously and we have experienced the power in being able to mutually and openly communicate about the effect of these roles on our relationship. I have experienced a client who wanted to continue a friendship after therapy and my clarity in not wanting to do this as our relationship did not feel mutual enough for me to want to do this and it seemed that she wanted to continue me to be there for her as a therapist rather than a more mutual friendship. I have also experienced an ongoing relationship with an ex-client through a process of us writing a paper about our therapy experience together and in that process creating an authentic relationship and friendship. I am glad that I am open to negotiating these possibilities in relationships in all areas of my life including therapy as I would not like to be part of an experience for a client of what Heyward (1993) describes with her therapist as a 'relational rupture… my experience of an authentic bond that had been broken, a love that had been disrupted…' (Heyward, 1993, 115.)

BUT IS MUTUALITY POSSIBLE IN THERAPY?

I've argued against the idea of 'boundaries' in therapy and suggested that therapists need to do what we can to minimize the possibility of taking power over clients, and that the ethical principle of mutuality could be useful here. But how possible are truly mutual relationships in therapy given the inevitable inequality in therapy relationships due to role power and in the increasingly rule-driven climate of professionalization? Are we in danger of comforting ourselves with the principle of mutuality and thus buying into an institution that does more harm than good?

As Willoughby (2008) states in his critique of my chapter: 'Psychological therapy exists principally, not to help people (it may or may not do that) but to maintain society's unsatisfactory values and priorities. This is accomplished by using therapeutic authority to manage and marginalise the inevitable casualties of what Gillian describes as our "sick society" (Proctor, 2006, 77)' (Willoughby, 2008, 1).

Furthermore, he states that 'Kindness and sincerity do not guarantee beneficial outcomes… Provide distressed people with comfort; organise collective support; access resources for those who need them; campaign for social justice. But don't do it in the name of "therapy"' (Willoughby 2008, 4).

SO WHY DO I STILL DO THERAPY?

My original justification for continuing to be a therapist in Proctor (2006) was correctly exposed by Chris Willoughby in a compelling critique as being rather unconvincing. At the basis of it, however, was my personal experience as a therapist of working with people who were clear how helpful they found therapy despite the socio-political reasons for their distress and how therapy has enabled people to make clearer decisions about what they can influence in their life. I was similarly informed by experiences with clients who had every opportunity and privilege in their life now but who had experiences historically which they

DOI: 10.1002/ppi

felt prevented them from making the most of their opportunities. So my next challenge was to try to more coherently make my clinical experience into academic argument (Proctor, 2008a).

I am a therapist fundamentally because I want to respond in some way to the pain of those who have been hurt by our society. I want to acknowledge this distress and try and give care and understanding to people who have suffered. This response is not contradictory to also wanting to change the conditions that caused the pain and these two responses are not, I believe, mutually exclusive. If a woman feels worthless and that life is pointless after living with a violent and abusive partner for many years, one response may be to help her leave the partner by providing practical and emotional support, and perhaps also to become involved in raising awareness about domestic violence to try and prevent other women staying in similar situations, or trying to change the law to improve convictions. However, it is likely that the woman may also still struggle with feelings of low self worth and lack of confidence after leaving the relationship (i.e. the cause of the problem). This, for me, is where therapy comes in.

As humans, we process the experiences we have, not just reacting to them but making sense of them and experiences of powerlessness can become embodied and thus affect how we make sense of and react to future experiences too. But, one of the many errors made by most theories of psychological therapy, and correspondingly enacted by most therapists, is to over-estimate the agency of individuals in the grip of oppressive systems.

I suggest that rather than focussing on either one or the other, we need to recognize the interaction between social structures and individual agency. As Miller and McClelland (2006, 129) suggest '…people are not passive in the face of trauma and oppression, but engage in "counter-power practices" or resistances.' Giddens (2006) suggests that society constrains us as individuals but does not determine our actions. He explains (2001, 668): 'As human beings we do make choices, and we do not simply respond passively to events around us. The way forward in bridging the gap between "structure" and "action" approaches is to recognise that we actively make and remake social structures during the course of everyday activities.'

So what is an appropriate response to such distress, which may be historically caused and embodied in individuals who have experienced socially induced misery? Willoughby argues cogently about the dangers of the idea of the institution of therapy as a response and I agree wholeheartedly with the dangers of suggesting the problem is within the individual and therapy is needed to help the casualties assimilate back into the sick or corrupt society. However I would argue that this is where person-centred therapy in particular occupies a particular political position and very different approach within the field of therapy as a whole. Rather than the correction of a defect, person-centred therapy in particular is a description of a particular kind of relationship for the purpose of healing or growth as opposed to cure. Other therapies that emphasize the principle of mutuality could have similar values at their core.

With these models of therapy, firstly and perhaps most fundamentally, therapists are not experts on the client and their main aim is to not take a position of authority but to facilitate clients to make their own sense or meaning of their world. For me, the trust in the client does not relieve me of any responsibility to help practically if I can. If I can use my role power rather than obscure it to help a client access platforms of power and opportunity or

DOI: 10.1002/ppi

resources I see that as absolutely my responsibility which comes with the power of the role I have.

However, Willoughby's biggest challenge is to ask me why I can't do what I do and not call it therapy? There are two main reasons for this. Firstly, if I didn't call it therapy, clients would not be referred to see me. I am aware that the danger with this is colluding with the referrers, media and clients buying into an individual model of distress but I cannot see how clients would come to challenge this without getting to see me in the first place! Secondly, person-centred therapy is an invaluable theory and ethical framework for me to focus how I am with a client in a therapy relationship – how best to be with a person in a relationship to promote connection and mutuality. The theory restrains my behaviour and ways of relating from all possible ways I could talk to someone and directs me in service of the client. I am paid as a therapist to put my feelings and concerns on one side when with a client and concentrate on the concerns of the client. Person-centred theory gives me clear aims of how I want to be with clients, i.e. valuing them as individuals, being myself as another equal human being and trying my best to understand them and their lives. However I see the therapy relationship as a start, which can lead to other more healing relationships in peoples' lives.

In summary, despite my belief that the main causes of psychological distress are environmental, I continue to be a therapist as a way of responding to this distress. However, I believe it be of utmost importance for therapists to be aware of the limitations of therapy with regard to changing the causes of distress and the danger of pathologizing or blaming clients for their circumstances. I do believe therapy based on ethics of mutuality can be used in a helpful way to support and validate people going through distress without pathologizing or blaming individuals for this distress and can facilitate people to resist oppressive structures of power wherever and however possible. But therapists need to remember both their own role power and the power of structures and the possibility of agency to resist and respond in peoples' lives.

IMPACT OF THE INSTITUTION OF THERAPY ON WIDER SOCIETY?

I have argued that I am a therapist to respond to distress, and that I experience that, sometimes, mutual therapy relationships can help people. However, there are also wider impacts of my choice to respond to distress by being a therapist. There are wider impacts for me in my life and in the whole of society due to the institution of therapy. I wonder about the impact on my personal relationships of my focus and attention and emotional energy given to my clients in therapy. 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 most therapists are women, in what ways does therapy perpetuate or challenge gender role socialisation? (Proctor 2008b). Could it be that in professionalizing emotional nurturance this relieves women from their traditional role as care givers? Or does the necessarily unequal relationship in therapy perpetuate traditional unequal gender roles and relationships based on dominance and submission? I believe it is

DOI: 10.1002/ppi

the responsibility of each therapist to consider how they contribute to this or whether they can contribute to challenging these roles and how far it is possible to work towards therapy relationships based on mutual recognition of equal subjects.

Ultimately how can we ethically judge the profession of counselling or therapy? Using the ethical principles of the traditional approach to ethics – the ethics of justice, we can ask if it does more good than harm? We can ask if it promotes autonomy and justice (fairness and equality)? Or from the feminist framework of ethics of care, or the more recent ethical framework based on relational ethics, we can ask if it promotes mutual relationships? For me, the critical clinical psychologist a*nd me, the person centred therapist,* the jury's out.

REFERENCES

Aron L. A Meeting of Minds. London: Analytic Press, 1996.

Banks S. Ethics and Values in Social Work. London: Macmillan, 1995.

Barrett-Lennard GT. Relationship at the Centre: Healing in a Troubled World. London: Whurr, 2005.

Benjamin J. The Bonds of Love: Psychoanalysis, Feminism, and the Problem of Domination. New York: Virago, 1988.

Bond T. Professional ethics: creating a secure base. Lecture at AUCC conference, 2004.

Brodley BT. The nondirective attitude in client-centered therapy. The Person-Centered Journal 1997; 4(1): 18–30.

Brown L. Boundaries in feminist therapy: a conceptual formulation. Women and Therapy 1994; 15(1): 29–38.

Chesler P. Women and Madness. New York: Doubleday, 1972.

Foucault M. Madness and Civilisation – a History of Insanity in the Age of Reason. London: Tavistock, 1967.

Giddens A. Sociology.5 edn. Cambridge: Polity Press, 2006.

Hermansson G. Boundaries and boundary management in counseling: the never-ending story British Journal of Guidance and Counselling 1997; 25(2): 133–46.

Heyward C. When Boundaries Betray Us: Beyond Illusions of What is Ethical in Therapy and Life. New York: HarperCollins, 1993.

House R. Therapy Beyond Modernity: Deconstructing and Transcending Profession-centred Therapy. London: Karnac, 2003.

Johnstone L. Users and Abusers of Psychiatry. London: Routledge, 1989.

Jordan J, Kaplan A, Baker Miller J, Stiver I, Surrey J. Women's Growth in Connection, London: Guildford Press, 1991, pp. 11–26.

Keys S, Proctor G. Ethics in practice in person-centred therapy. In M Cooper, M O'Hara, P Schmid, G Wyatt (eds) The Handbook of Person-Centred Psychotherapy and Counseling. Hampshire: Palgrave Macmillan, 2007; 353–65.

Lazarus A. How certain boundaries and ethics diminish therapeutic effectiveness. Ethics and Behavior, 1994; 4(3), 255–61.

Mearns D and Cooper M. Working at Relational Depth in Counselling Psychotherapy. London: Sage, 2005.

Miller P. Critiques of psychiatry and critical sociologies of madness. In Miller P and Rose N (eds) The Power of Psychiatry. Cambridge: Polity Press, 1986.

Miller P, Rose N. Introduction. In Miller P and Rose N (eds) The Power of Psychiatry. Cambridge: Polity Press, 1986.

Miller J, McClelland L. Social inequalities formulation: mad, bad and dangerous to know. In Johnstone L, Dallos R (eds) Formulation in Psychology and Psychotherapy. London: Routledge, 2006.

Miller J, Stiver IP. The Healing Connection: How Women Form Relationships in Therapy and Life. Boston: Beacon Press, 1997.

Natiello P. The Person-Centred Approach: A Passionate Presence. Ross-on-Wye: PCCS Books, 2001.

DOI: 10.1002/ppi

Owen I. Boundaries in the practice of humanistic counseling. British Journal of Guidance and Counselling 1997; 25(2): 163–74.

Proctor G. The Dynamics of Power in Counselling and Psychotherapy: Ethics, Politics and Practice. Ross-on-Wye: PCCS Books, 2002a.

Proctor G. My experience, as a client, of power in the therapy relationship. Journal of Critical Psychology, Counselling and Psychotherapy 2002b; 2(3): 137–48.

Proctor G. Disordered boundaries. Asylum Magazine for Democratic Psychiatry 2004; 4(3): 24–5.

Proctor G. Therapy: opium for the masses or help for those who least need it? In Proctor G, Cooper M, Sanders P, Malcolm B (eds) Politicising the Person Centred Approach: An Agenda for Social Change. Ross-on-Wye: PCCS Books, 2006; 66–79.

Proctor G. Disordered boundaries? A critique of 'Borderline Personality Disorder'. In Spandler H,.Warner S (eds) Beyond Fear and Control: Working with Young People who Self-harm. Ross-on-Wye: PCCS Books, 2007; 105–20.

Proctor G. Fly in the ointment: a reply. Person-Centred Quarterly 2008a; 5–7.

Proctor G. Gender dynamics in person-centered therapy: Does gender matter? Person Centred and Experiential Psychotherapies, 2008b; 7(2): 82–94.

Rogers C. Carl Rogers on Personal Power. London: Constable, 1978.

Schmid P. The anthropological and ethical foundations of person-centred therapy. In Cooper M, O'Hara M, Schmid P, Wyatt G (eds) The Handbook of Person-Centred Psychotherapy and Counseling. Hampshire: Palgrave Macmillan, 2007.

Shaw C, Proctor G. Women at the margins: a critique of borderline personality disorder. Feminism and Psychology 2005; 15(4): 483–90.

Showalter E. The Female Malady: Women, Madness and English Culture, 1830–1890. London: Virago, 1985.

Szasz T. The Myth of Mental Illness. London: Paladin, 1972.

Webb S. Training for maintaining appropriate boundaries in counseling. British Journal of Guidance and Counselling, 1997; 25(2): 175–88.

Wenegrat B. Illness and Power: Women's Mental Disorders and the Battle Between the Sexes. London: New York University Press, 1995.

Williams J, Watson G. Mental health services that empower women: the challenge to clinical psychology. Clinical Psychology Forum, 1994: 64

Willoughby C. A fly in the ointment: a critique of person-centred counselling. Person Centred Quarterly, 2008: 1–4.

Zur O. Boundaries in Psychotherapy: Ethical and Clinical Explorations. Washington DC: American Psychological Association, 2007.

DOI: 10.1002/ppi