

# The impact of power dynamics when counselling clients with problematic substance use

Louise Wilson 

Arts and Social Sciences, University of  
Aberdeen, Aberdeen, Scotland

## Correspondence

Louise Wilson, 20 Bonaly Gardens, Edinburgh  
EH13 0EX, Scotland.  
Email: [louisewilson4620@gmail.com](mailto:louisewilson4620@gmail.com)

## Abstract

The purpose of this study is to explore the power dynamic when working with clients who use substances in a problematic way. The concept of power, including the meaning and nature, has been widely researched and debated. Similarly, numerous studies regarding therapeutic work with substance users are also available. However, there is a lack of material which links the two fields. An implicit power imbalance exists between therapist and client that is particularly relevant to this client group; and the egalitarian nature of person-centred counselling seeks to minimise this disparity. This study seeks to identify the nature of power within a therapeutic context and explore the impact of power dynamics when working with clients who use substances. Themes identified are (1) Diverging definitions of power; (2) Power dynamics within therapy; (3) The stance of person-centred counselling; (4) Issues when working with substance misuse; (5) The importance of disadvantageous external factors on the experience of personal power and (6) The efficacy of the person-centred approach in this field. Findings revealed that power can be experienced implicitly as well as explicitly, and that therapist awareness of the power imbalance is crucial. Furthermore, clients with problematic substance use frequently experience adversity on several levels and have an increased vulnerability to feelings of powerlessness. This study contributes to the research into the efficacy of person-centred counselling when working with this demographic.

**KEYWORDS**

addiction, person-centred therapy, power dynamics, problematic substance use

## 1 | INTRODUCTION

'The context of therapy hugely impacts on the dynamics of power within the therapy relationship' (Proctor, 2017a, p. v). Clients with problematic substance use often feel disempowered on many levels and have frequently experienced a history of abuse, deprivation and a general lack of opportunity which is compounded by the challenges of addiction together with societal judgement and disapproval. The authority and professional status of the therapist is in sharp contrast and the imbalance of power is especially pertinent. This literature review critiques different paradigms of power and examines the writings regarding working with substance misuse. The concepts of influence and non-directivity are examined, as well as the efficacy of the person-centred approach when working with this client group. Finally, the relevance and significance of the analysis presented in the study are discussed.

## 2 | LITERATURE REVIEW

Debate regarding the nature of power has raged for centuries and there is a plethora of literature examining this topic. Structural theories of power, as derived from Thomas Hobbes, posit power as a negative force, wielded by the dominant faction within a group, institution or demographic (Proctor, 2017a). In structural determinism, individuals are a victim of their circumstances with little agency. Institutions are value-laden and perpetuate their own power and the process of power in this context is unidirectional (Proctor, 2017a). The most common historical discourse on power has been in terms of authority and coercion, although this gradually changed as the 20th century progressed. Hannah Arendt proposed that power was relational and could be a positive force. This was a departure from structural paradigms and Arendt highlighted the potential of power between individuals in relationships—a more collaborative form of power (Penta, 1996).

## 3 | FOUCAULT

Michel Foucault has been hugely influential in the fields of philosophy and the humanities. He challenged the concept of power as specific acts of coercion; and posited power as ubiquitous, fluid, and in a constant state of flux (Foucault, 2014). He argued that power was not a possession but embedded in individuals and institutions. For Foucault, power dynamics are ingrained so firmly in societal structures that they are normalised and accepted, even by those who are disadvantaged by them. In this sense, individuals are trained to accept and strive for what is perceived as 'normal'. This is a subtle form of power that produces an obedient society. Foucault (2014) used the term 'biopower' to describe the subjugation of bodies—essentially a form of social control and risk regulation in the pursuit of a healthy society. Man is, therefore, responsible for his own subjection. In this model, there is no need for authoritative power as oppression is internalised and people regulate themselves by conforming to social norms. I largely agree with Foucault regarding this concept, although I would argue that communities in general do require the implementation of social control which suggests that individuals are not entirely self-regulating.

In therapeutic terms, the client could be seen as internalising the values of the therapist. Within the context of substance misuse, the stigma and disapproval surrounding this activity are absorbed by the user, adding to existing low self-esteem and disempowerment. Historically, the goal of abstinence was paramount and individuals were

under huge pressure to abstain entirely. However, this discourse changed due to the AIDs crisis of the 1980s and a new approach of harm reduction emerged (Marlatt, 1996). Harm reduction acknowledged that complete abstinence on a large scale was impossible and instead promoted safer use of drug taking and sharing (Marlatt, 1996); a position aligned with the Foucauldian notion of pursuit of a healthy society. Such an approach is educational rather than punitive and controversial. The stigma and shame associated with illegal drug use was (and is) so entrenched that harm reduction policies such as the supply of clean needles were unacceptable to many factions of society (Stryker, 1989). The need for abstinence has been internalised by drug users who often find such a goal extremely difficult to achieve and the cycle of shame/relapse/using continues. In Foucauldian terms, this process is biopower in action; social control of the client who internalises the discourse on abstinence and the problem with substance misuse becomes an internal, individual issue as opposed to an external, societal one.

Foucault argued that power and knowledge are intertwined; power being constructed of accepted modes of knowledge and truth. Truth, in this sense, is the accepted discourse of the day, perpetuated and reinforced by political and social institutions. Foucault, 1978 suggested that 'Western Societies have established the confession as one of the main rituals we rely on for the production of truth' (p. 56). This is not limited to religious confession but also secular society including psychotherapy. The confessor reveals their inner self and produces a form of knowledge which can be monitored and often controlled (by the confessor as well as the authoritarian psychotherapist). Indeed, research itself has become part of the discourse surrounding confession. Foucault (1988) viewed the study of knowledge produced by the confessor as 'very specific "truth games" that human beings used to understand themselves' (p. 18). In this sense, the researcher would interpret the confession (information) from their value-laden perspective and create a 'truth' (social norm). It is important to note that Foucault understood power/knowledge as potentially liberating as well as constraining. He remains an influential figure in the discourse of power.

## 4 | POWER IN THERAPY

Gillian Proctor (2017a) examined the issue of power in a therapeutic context. She distinguished between power over, personal power and power from within. Proctor argued that viewing power as a possession identifies it as a negative force and ignores the relational, dynamic nature of power. Therapists have 'role power' attributed by way of their position in society and expertise as therapist. Furthermore, they tend to be middle-class and white whereas clients are more likely to be poorer, less socially supported, and have more physical and mental problems (Proctor 2017a). It is essential for the therapist to be aware of their power to avoid abuse and to foster a more equalised relationship, requiring collaboration rather than unidirectional authoritarian power. Natiello (2001) posited that such collaboration places power within a different paradigm. In such a model, power is fluid and can be positive. Power itself is not a moral concept; it is the way power is used that has moral implications. May, 1972 argued that power is neither good nor evil in an ethical sense although it cannot be neutral.

In psychotherapeutic terms, the concept of power has historically been viewed in the context of misuse; in particular financial, sexual, and physical harm. For Masson (1990), there is no way out of this inherent inequality:

The therapeutic relationship always involves an imbalance of power. One person pays, the other receives. Vacations, time, duration of the sessions are all in the hands of one party. Only one person is thought to be an 'expert' in human relations and feelings. Only one person is thought to be in trouble (p. 12).

For Sanders (2015), the inherent structural power imbalance within the therapeutic relationship is unavoidable but the non-directive stance of person-centred counselling can help maintain focus on the power dynamic. This attitude is non-paternalistic and anti-authoritarian and promotes therapist awareness of the client as expert.

Brodley (2011) argued the non-directive stance helps therapists avoid behaviour that unintentionally disempowers the client. For Proctor (2017b), the autonomy of the client is fundamental to person-centred therapy as opposed to the majority of therapeutic models which are based on the principle of beneficence. Beneficence is what the therapist deems is best, not the client.

## 5 | PERSON-CENTRED THERAPY

Carl Rogers proposed that the client was the expert in the relationship and the role of therapist was one of the facilitations. In this respect, person-centred counselling marked a radical paradigm shift from authoritarian models of therapy. 'If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth and change and personal development will occur' (Rogers, 2016, p. 33). Thus, Rogers transferred the power from the therapist; instead, prising the organismic experience and wisdom of the client (Tudor, Keemar, Tudor, Valentine, & Worrall, 2004). Rogers believed that personal growth and self-knowledge would occur and facilitate self-empowerment if the therapist provided the conditions of acceptance, empathy, and congruence; while Schmid n.d., stated that the expertise of the therapist lies in their ability to refrain from being an expert on the life of the client. Indeed, Merry (2002) argued that the only therapeutic goal of the person-centred counsellor is to create a relationship in which the client experiences psychological change by accessing their own internal resources.

For Proctor (2017a), the person-centred aim is to promote a climate of growth in which the actualising tendency can flourish, as well as exposing power dynamics created by conditions of worth. Bozarth (2013) argued that the egalitarian nature of person-centred philosophy is demonstrated by therapist willingness to follow the lead of the client. He viewed client and therapist as two equals within the relationship. Despite this intention, the structural or role power of the therapist exists, and the possibility of misuse is ever present. I would argue that Bozarth's statement is derived from the perspective of the therapist—it is far from certain that the client views the relationship as equal. Furthermore, this power imbalance may be obscured by the egalitarian nature of person-centred theory and the therapist may be unaware of the 'power-over' inherent in their role (Proctor, 2017a). I contend that therapist congruence is essential if personal power is to flourish.

Rogers (1985) described the *locus of decision-making power* as the source which regulated the feelings, thoughts, and actions of the individual. Power is used, shared, attained, or ceded by the individual in a relational context. The ethical stance of the person-centred approach is the facilitation of self-ownership and the locus of decision-making being "politically centred in the client" (Rogers, 1985, p. 14). Furthermore, person-centred therapy was a radical departure from authoritarian paradigms of therapy in that its approach was not to give power to the person; rather, to never take it away. Rogers became increasingly aware of the threat that moving the centre of power to the client constituted to the reigning psychological establishment. At the Menninger clinic, around 1950, he was warned that his approach would result in the production of a dangerous psychopath unable to control their naturally destructive core (Rogers, 1985). For Rogers, movement towards independence from external control was the normal state of the organism. McMillan (2004) stated that by trusting the ability and resources of the client to change, the person-centred therapist can be seen as facilitating a reunion of the client with their own inherent capabilities.

The person-centred therapist, as facilitator, supports and liberates the individual to trust their own valuing system through a process of collaboration rather than cure or even telling him 'how to cure himself' (Natiello, 2001, p. 26). Natiello (2001) argued that client empowerment and self-esteem are seriously undermined by dependency on an expert therapist for growth and healing wherein therapy is something done to the client by the therapist. The therapeutic conditions present in person-centred therapy foster independence and empowerment. However, Proctor (2017b) argued that this emphasis on equality can obscure the power dynamics in therapy and aspects of structural positions of power can be ignored. For Proctor, there is a danger in the assumption by the therapist that the client perceives the conditions when a history of low expectations and powerlessness prevent them from doing

so. Totton (2009) stated that being aware of their higher ranking in the therapy room is a challenge to which therapists must pay attention.

Natiello (2001) argued that in order to connect with the client and enter their world therapists must relinquish their power, privilege and position as expert. However, I would argue we must be aware of our own positionality in the therapy room. Perhaps a different perspective on the word 'expert' would be helpful. Freeth (2017) stated that terms such as expert and expertise give an impression of coercion and control, in the same way as words such as power and authority. Freeth argued that such an impression prevents the definition of these terms being refined and leads to condemnation and generalisation instead of developing a broader conceptual analysis. We may not be experts regarding our clients but we have expert knowledge of a robust psychological theory that enables us to use our skills and training to support individuals towards healing and growth. I would posit that the harnessing of personal power does not end with the client. In our role as therapists, we have a responsibility to use our power and knowledge to help the individuals with whom we work.

## 6 | NON-DIRECTIVITY

Person-centred therapy is driven by the client regarding what they wish to explore in therapy, and the role of the therapist is to provide the necessary conditions for growth. 'The organism is self-controlled. In its normal state, it moves towards its own enhancement and towards an independence from external control' (Rogers, 1985, p. 240). Merry (2002) stated that the actualising tendency drives the natural process of change and the content varies according to the needs of each unique individual. To direct the client is, therefore, counter-therapeutic and disrupts the natural process which Tolan (2007) compared to a roller-coaster, both exhilarating and scary. The therapist is not in control and cannot play safe and drive the roller-coaster as the actualising tendency cannot be steered. Any attempt to do this would be akin to abandoning the person-centred approach (Tolan, 2007). Rogers did not elaborate on the influence of oppressive external factors, although Kearney (1996) argued that he did recognise that external oppression (such as conditions of worth) could still be applied and internalised even when that oppression is no longer present in our lives. I agree with Kearney, but would argue that Rogers neglected to fully examine the powerlessness derived from external oppression and abuse.

Non-directivity by way of empathy, acceptance and congruence enable the therapist to remain within the frame of reference of the client. Masson (1990) argued that empathic responses are therapist interpretation, and dismisses the egalitarian nature of person-centred therapy: 'it is the nature of therapy to distort another person's reality' (p. 247). Lietaer (1987) also pointed out that the focus is shifted from the narrative to the feelings and that therapists choose which statements of the client to focus on. However, this denies the client agency as to what they are prepared to accept or reject. Bozarth (2013) believed it is the client who controls the therapeutic process and this is only limited by the ability of the therapist and situational demands. I argue it is both—the therapist has role (and personal) power in their responses and the client has agency. The therapeutic relationship is dialogical and power is exerted by both parties in different ways. Furthermore, as each relationship is unique the power dynamic varies accordingly. Totton (2009) posited that identifying and exploring power struggles in therapy is essential in order to unfold and understand the client's process. It can be incredibly difficult to sit with someone in so much distress, who is disempowered on so many levels, and not want to *do* something to help. Therefore, therapists are also subject to feelings of powerlessness. Indeed, by focussing on the empowerment of the client, it is easy to lose sight of our own power in the therapy room. Mearns and Thorne (2000) posited that in our 'desire not to *abuse* our power, we have somehow lost the ability to *exercise* our power' (p. 217).

Non-directivity does not mean that the therapy is aimless (Rogers, 1942); rather, that the client directs the process by choosing their own goals even if the therapist would have chosen differently. Sanders (2015) argued that this helps to prevent client dependency on the counsellor and keeps the power issue to the fore. The structural power imbalance is inherent but the nature of non-directivity maintains therapist awareness of power dynamics.

## 7 | INFLUENCE AND AWARENESS

The nature of influence is also pertinent to the question of power and non-directivity is sometimes confused with non-influencing. If the therapist influences the client, could that be construed as directive use of power? Schmid (n.d.) pointed out that therapist activity always has an impact or effect on the client but this is not the same as the deliberate intention to produce a specific effect. As soon as we enter into relationship we have an influence, but the non-directive therapist uses their power to enhance the self-power of the client. The essence of person-centred therapy is, therefore, based on the self-direction of the client rather than the non-directivity of the therapist (Schmid, n.d.). Client self-direction is the ethical foundation of the theory. 'No one else's purpose will do. We have to find our own meaning of life and follow our own sense of direction. We have to be the author of our own destiny' (Van-Deurzan, 2002, p. 61).

Self-awareness of the personal/structural/role power of the therapist is essential as even the most nuanced exchange can transmit our views to the client with or without intention. Totton (2009) argued that power dynamics are everywhere; there are those that we bring into the room and those that are created by the nature of therapy. For Totton, human differences are imbued with power differentials (i.e., class, income and gender) which signify rank. Therapists must be aware of their ranking and the relative power implied. Kearney (1996) stated that empathic responses are more likely to be gender, race or class-based if there is a significant difference between therapist and client with regard to social characteristics. Kearney argued that this makes it more likely that the client will feel disempowered and unable to dismiss or reject such therapist interventions. A lack of awareness can reinforce the power imbalance. Roberts (2004) pointed to the power-knowledge relationship; the therapist has a theoretical understanding of the process and interprets it accordingly. Material disclosed by the client is not fully formed and is brought into awareness and understanding by therapist interpretation and assimilation. I would argue this is partially true, although therapy is co-created and the client also contributes to the acceptance or rejection of therapist reflections.

Power is complex. Therapist awareness of their power to influence and direct is essential; however, the client also has power with regard to payment, attendance at sessions and responding well to the therapist. Indeed, Cooper (2009) posited that client factors are responsible for 75% or more of the changes which occur in therapy. This suggests agency and self-direction—power as a personal attribute. May (1972) viewed power not as a theory but a continual reality in which individuals must encounter and struggle with or enjoy every day. Spinelli (2006) posited that it is not possible to be in a relationship and remain neutral, as the ebb and flow of power is intrinsic to relationships. The non-directive therapist is fully aware of their power and uses it carefully to foster self-actualisation, by trusting the resources of the client (Schmid, n.d.).

## 8 | SUBSTANCE USE AND POWER

The dynamics of power are especially pertinent in the context of substance misuse, and clients who misuse substances (opiates in particular) are often judged and condemned by a wide number of societal institutions. Wilders and Robinson (2006) posited that the role of clients within many addiction services is to passively receive the expertise of others. They argued that significant figures such as social workers and general practitioners further serve to exert external authority and power, however beneficent. Evaluations from such professionals can themselves be introjected as additional conditions of worth, adding to existing societal conditions of worth; that is, the attitudes and discrimination that society holds towards those it designates as junkies and drunks (Wilders & Robinson, 2006). This relates to Foucault's biopower and the internalisation of social norms. Speedy (2008) posited that the meaning given in western culture to the nature of the individual often hides the historical and social causes of what are generally viewed as personal issues. Proctor (2017a) goes further, claiming the system that contributes

to socially derived psychological distress is maintained and perpetuated if we neglect to view therapy in a socio-political context.

Clients generally misuse substances to self-medicate due to traumatic or difficult life circumstances. Lockley (1999) stated that many people who use drugs are able to remove themselves from their drug taking behaviour and view it as an external factor which they have no control over. Lockley argued that external events do not determine drug use although may have some relevance. However, Lockley fails to appreciate just how disempowered and vulnerable these clients are. Problematic substance use often leaves those affected unable to work leading to financial difficulties.

*People in lower socioeconomic positions have a triple burden: They have more problems to deal with; their personal histories are likely to have left them with a deep sense of powerlessness; and that sense of powerlessness discourages them from marshalling whatever energy and resources they do have in order to solve their problems. The result for many is a multiplication of despair* (Mirowsky & Ross, 1986, p. 30).

The language around drug use is also problematic; the word 'clean' suggesting that individuals who use are somehow dirty. Such individuals may lack the emotional skills to cope with the emotions they are experiencing and often have limited practical resources at their disposal. Those with a background of deprivation often do not have the tools or support available to the middle and upper classes and are unable to get the help they need. It is not uncommon for such individuals to become involved in criminal activities which serve to fund their drug use. Clients in this group are generally unable to pay for therapy and most organisations provide limited counselling sessions. Natiello (2001) posited that the responsibility inherent in claiming power can instil fear in individuals who are used to being subordinate. Thus, the need for a caring and congruent therapist. When a professional therapist strives to understand client's world, as opposed to trying to change them, clients can feel empowered and experience an increased sense of self-worth (Natiello, 2001). It can be the first time the person has allowed themselves to experience their feelings, particularly when substance misuse began at an early age and emotional development has been stunted. Bryant-Jeffries (2003) suggested that such feelings may be alien to the client as they emerge. A non-judgemental, congruent companion can facilitate empowerment as the individual feels accepted for who they are.

Lockley (1999) stated that the impact of therapy can be twofold as the client struggles with the impact of withdrawal and the resurgence of past difficulties. Not only are potentially overwhelming feelings coming to the fore, but the individual is trying to cope with them without drugs. The focus on abstinence in the discourse on substance use adds further pressure. Many counselling organisations insist that clients do not attend sessions while under the influence. Wilders and Robinson (2006) claim such a requirement is frequently unachievable for individuals who spend most of their time intoxicated and can lead to feelings of failure, adding to their existing misery.

*It is as an expression of external directivity that a theoretical philosophy has emerged around the concept of 'relapse', which means 'to degenerate' or 'go back' is imbued with judgement. Although some clients may at times wish to achieve certain goals, there is a world of difference between understanding our client's goals, whether fixed or transitory, and leading our clients toward them or supporting them with a partisan attitude that inhibits and curtails clients* (Wilders & Robinson, 2006, p. 14, p. 14).

## 9 | THE EFFICACY OF THE PERSON-CENTRED APPROACH

The discourse around person-centred therapy has changed and what was formerly a radical threat to the psychological establishment is now frequently dismissed as what Wilkins (2017) termed "psychotherapy lite" or "therapy for the worried well" (p. 39). Substance users are frequently viewed as requiring 'extra' help and the resultant health problems from drug use means they are often firmly entrenched in the medical model of diagnosis and medication. Addiction treatment within this model frequently combines individual and group therapy with skills and tools for recovery. These recovery tools are viewed as important for providing clients with alternatives to drug

taking when faced with difficult life situations (Miller, 2019). Behavioural therapies (especially CBT) are, therefore, favoured as they have a clear purpose in the provision of strategies which can replace drug use with other activities. Such response to addiction is very much treatment based and often involves the use of alternative medication to mitigate the effects of withdrawal. Bryant-Jeffries (2003) acknowledged that medication may be required in tandem with therapy. The natural growth process driven by the actualising tendency can be affected by a reduction in drug use and disturbing memories which have been suppressed can come to the fore when the chemical barrier is removed. Other medication combined with the healing potential of the person-centred relationship can help clients cope with this challenging transition.

Therefore, medication can assist the therapeutic process by reducing overwhelm and the need to use. For alcohol and opiate users in particular, the combination of therapy and substitute medication has greater efficacy than either treatment alone (Wanigaratne, Davis, Pryce, & Brotchie, 2005).

A combination of medication and therapy may be more successful than the latter alone but there is no evidence specifically comparing the person-centred approach with other modalities. Unfortunately, there is very little information available regarding the effectiveness of any particular approach and most of the data available is from the United States. The National Institute on Drug abuse (2000) concluded that the efficacy of the different counselling approaches used in various treatments had not been determined. Wanigaratne et al. (2005) contended that the limited data available suggest that no one particular therapeutic model is more beneficial to clients.

The absence of specific research on substance use and person-centred therapy renders it difficult to determine efficacy. Individuals with problematic substance use are rarely (if ever) offered person-centred therapy within the medical model. Freeth (2017) argued that the person-centred approach has been marginalised and dismissed by mental health services and is often viewed as a set of listening skills rather than a philosophy. Joseph (2017) stated that the person-centred stance of providing a relationship in which the client directs their own change runs counter to the narrative of substance users requiring extra intervention whether through the use of recovery tools or medication. For Joseph, the person-centred community has been marginalised and isolated by its inability to demonstrate the efficacy of their approach with people who have acute psychological issues.

Another complication is that measuring efficacy in a therapeutic context is controversial. 'Phenomenologically, it is futile to apply objectivity to something which is subjective by nature. The only true source of therapeutic impact is the experience of the client. However, most outcome research remains (implicitly) dominated by the medical model' (Macran, Ross, Hardy, & Shapiro, 1999, p. 330). Randomised control trials (RCTs) are often viewed as the 'gold standard' of research and are the dominant method of obtaining empirical evidence of effectiveness (Persons, Davidson, & Tompkins, 2009). However, the dominance of RCTs has been challenged and research from the University of Gissen found researcher bias in that only 17% of the RCTs were of 'high quality' (Jackson, 2018, p. 8). Furthermore, status as the 'gold standard' results in a funding bias towards quantitative-experimental researchers (Grant, Townend, Mulhern, & Short, 2010). The reliable data that are available consistently shows what is known as the Dodo Bird verdict—'that all therapies are for the most part equally effective' (Bohart & House, 2009, p. 190). An excess of 100 meta-analyses show a consistent, significant correlation between the therapeutic relationship and successful outcomes (Hawkins, 2017). However, there are no studies which examine power as a relational aspect.

Qualitative research may provide more insight regarding the therapeutic relationship and substance use. However, that is fraught with difficulties in the context of power dynamics. Qualitative research is ethically more problematic than quantitative. It is not possible to identify individuals from statistical data whereas a narrative account can lead to recognition of client details and therefore exposure of the individual concerned. Protection of confidentiality within counselling is essential and is mirrored in current societal concern around data protection. Furthermore, awareness has increased regarding power dynamics and the potential for abuse in the therapeutic relationship (Bondi & Frewell, 2016). Anonymity has long been used as a way to protect the identity of research participants but fictionalisation goes a step further to protect identification and balances the sharing of knowledge with protection of the individual. Despite the protective intention of fictionalisation, it can be in danger of



paternalism (Caine et al., 2016). Even pseudonyms are value-laden and researchers may choose a name influenced by their own linguistic and cultural perspective which silences the social and cultural context of the client. Confidentiality is paramount; however, it is important to use narrative to increase awareness and knowledge. The quality of the relationship is also pivotal but our work will be inhibited if we are silenced by such concerns (Bondi & Frewell, 2016).

Awareness of abuse of power in therapeutic relationships has increased since the beginning of modern psychotherapy. Bondi and Frewell (2016) argued that as practitioners we have a heightened sense of responsibility to honour the trust placed upon us by clients and satisfying our own research goals is contrary to the primary purpose of therapeutic work which is prizing the needs of the client. Clients may permit the use of the work for research but by doing so the nature of the therapy and the relationship will change, thus influencing the research outcome (Bondi & Frewell, 2016). Asking clients with problematic substance use, who are disempowered on several levels, to tell their story could be viewed as an abuse of power. They may feel obliged to help and unable to refuse. However, perhaps by assuming client vulnerability we are refusing to acknowledge their agency in decision-making. Speedy (2008) argued that research allows the voice of those on the margins of society to be heard. Perhaps we are neglecting our own power to tell the story of individuals who are rarely acknowledged. Research is the purpose of the therapist not the client but if the research is to benefit (arguably empower) the client then it could potentially be seen as collaborative.

The situation is further complicated by what is termed successful therapy. During the course of a 5-year study, Elliott, Greenberg and Lieter found that a significant number of clients found counselling either helpful or very helpful, despite no improvement or very little improvement in how they felt when therapy had finished (Gibbard & Hanley, 2008). This suggests that clients may find aspects of counselling beneficial even if 'symptoms' do not reduce, which can be particularly pertinent to substance users who are stuck in a long-term cycle of abstinence and relapse as well as disempowering life circumstances.

Cooper, O'Hara, Schmid, and Bohart (2013) argued that a critical factor in client empowerment is the belief of the therapist in their capacity to make successful changes. For Brodley (2011), person-centred therapists are exclusive in their efforts not to disempower clients. However, other modalities have a different perspective. Behavioural therapies, such as CBT, aim to empower the client to be their own therapist (Beck, 1995). If we accept the Dodo Bird effect then perhaps, as Cooper et al. argued, 'Who you are and how you relate to your clients is far more important than what you do' (p. 371). Therapist presence facilitates client growth—being accepted and valued is empowering.

We must be mindful not to *overestimate* our impact and influence. Cooper (2009) pointed out that successful therapeutic outcomes are closely aligned with client motivation and involvement in the therapeutic process. Van Deurzen (2002) argued that for individuals to benefit from person-centred therapy, they must be prepared to take responsibility for themselves and believe that talking about their feelings is crucial for beneficial change to occur. Clients who are passive and expect the therapist to provide solutions are less likely to find the person-centred approach helpful. This can posit a challenge for those substance users who are used to being told what to do by external influences, in particular those in the medical professions.

## 10 | CONCLUSION

'For the therapist, power is everywhere and unavoidable' (McDonnell, 2013, p. 3). Power is complex and multi-faceted. It ebbs and flows within individuals, institutions and individual relationships. It comes in many forms—implicit and explicit. The therapist can be adversely affected by feelings of powerlessness but does have role power and this must be acknowledged. Person-centred counselling seeks to empower the client; however, the impact of external events cannot be underestimated. The non-directive nature of the approach can be challenging for the therapist when faced with such destructive and despairing behaviour. There is a lack of data regarding the

efficacy of the person-centred approach when working with this demographic and further research would be useful. This study demonstrates the complexity and subtle nature of power relations and would be useful for counsellors working with substance misuse and those with an interest in power dynamics.

## ORCID

Louise Wilson  <https://orcid.org/0000-0002-9878-1815>

## REFERENCES

- Beck, J. S. (1995). *Cognitive therapy and beyond*. New York, NY: The Guilford Press.
- Bohart, A. C., & House, R. (2009). Empirically supported/validated treatments as modernist ideology: Alternative perspectives on research and practice. In R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* (pp. 188–201). Ross on Wye, UK: PCCS Books.
- Bondi, L., & Frewell, J. (Eds.). (2016). *Practitioner research in counselling and psychotherapy: The power of examples*. London, UK: Palgrave.
- Bozarth, J. (2013). *Person-centred therapy: A revolutionary paradigm*. Ross on Wye, UK: PCCS Books.
- Brodley, B. T. (2011). *Practicing client centred therapy; selected writings of Barbara Temaner Brodley*. Ross on Wye, UK: PCCS Books.
- Bryant-Jeffries, R. (2003). *Counselling a recovering drug user: A person-centred dialogue*. Florida: Radcliffe Medical Press.
- Caine, V., Murphy, S., Estafan, A., Clandinan, J., Steeves, P., & Huber, J. (2016). *Exploring the purposes of fictionalisation in narrative inquiry*. Sage Publications. Retrieved from <https://doi.org/10.1177/1077800416643997>
- Cooper, M. (2009). *Essential research findings in counselling and psychotherapy: The facts are friendly*. London, UK: Sage Publications.
- Cooper, M., O'Hara, M., Schmid, P. F., & Bohart, A. C. (2013). *The handbook of person-centred psychotherapy & counselling* (2nd ed.). London, UK: Palgrave MacMillan.
- Foucault, M. (1978). *The history of sexuality volume 1: An introduction*. New York, NY: Vintage Books.
- Foucault, M. (1988). Technologies of the self. In L. Martin, H. Gutman, & P. Hutton (Eds.), *Technologies of the self* (pp. 16–49). Amherst, MA : Massachusetts Press.
- Foucault, M. (2014). *Discipline and punish: The birth of the prison*. Retrieved from <https://rampages.uk/oculist/wpcontent/uploads/sites/499/2014/08/panopticism>
- Freeth, R. (2017). Towards a person-centred psychiatry. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice*, (pp. 355–375). Monmouth, UK: PCCS Books.
- Gibbard, I., & Hanley, T. (2008). A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care. *Counselling and Psychology Research*, 8(4), 215–222. <https://doi.org/10.1080/14733140802305440>
- Grant, A., Townend, M., Mulhern, R., & Short, N. (Eds.). (2010). *Cognitive behavioural therapy in mental health care* (2nd ed.). London, UK: Sage Publications.
- Hawkins, J. (2017). Living with pain: Mental health and the legacy of childhood abuse. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice (Chapt. 16)* (pp. 275–295). Monmouth, UK: PCCS Books.
- Jackson, C. (2018). It ain't what you do. *Therapy Today*, 29(4). <https://www.bacp.co.uk/bacp-journals/therapy-today/2018/may-2018/it-aint-what-you-do/>
- Joseph, S. (2017). Mental health and the person-centred approach. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice* (Chapt. 1) (pp. 3–9). PCCS Books Ltd.
- Kearney, G. (1996). *Counselling, class and politics - Undeclared influences in therapy*. Manchester, UK: PCCS Books.
- Lietaer, G. (1987). Unconditional positive regard: A controversial basic attitude in client-centred therapy. In B. F. Levant & J. M. Schlien (Eds.), *Client-centred therapy and the person-centred approach: New directions in theory, research and practice* (pp. 41–58). Westport, CT: Praeger Publishers.
- Lockley, P. (1999). *Counselling heroin and other drug users*. London, UK: Free Association Books.
- McDonnell, M. (2013). Power and the person-centred therapist. *Person-Centred Quarterly*. Retrieved from <https://www.the-pca.org.uk/images/files/extracted/McDonnell-Mark-2013-Power-and-the-Person-Centred-Therapist.pdf>
- Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8(4), 325–337. <https://doi.org/10.1080/09638239917256>
- Marlatt, G. A. (1996). Harm reduction, come as you are. *Addictive Behaviors*, 21(6), 779–788. [https://doi.org/10.1016/0306-4603\(96\)00042-1](https://doi.org/10.1016/0306-4603(96)00042-1)
- Masson, J. (1990). *Against therapy*. London, UK: Fontana.
- May, R. (1972). *Power and innocence: A search for the sources of violence*. New York, NY: W. W. & Company.

- McMillan, M. (2004). *The person-centred approach to therapeutic change*. London, UK: Sage Publications.
- Mearns, D., & Thorne, B. (2000). *Person-centred therapy today: New frontiers in theory and practice*. London, UK: Sage Publications.
- Merry, T. (2002). Classical client-centred therapy. In P. Sanders (Ed.), *The tribes of the person-centred nation* (2nd ed., pp. 21–45). Ross on Wye, UK: PCCS Books.
- Miller, L. (2019). *Types of therapy used in treatment*. Retrieved from <https://americanaddictioncenters.org/therapy-treatment>
- Mirowsky, J., & Ross, C. E. (1986). Social patterns of distress. *Annual Review of Sociology*, 12, 23–45. Retrieved from [www.annualreviews.org](http://www.annualreviews.org)
- Persons, J. B., Davidson, J., & Tompkins, M. A. (2009). *Essential components of cognitive-behaviour therapy for depression*. Washington, D.C: American Psychological Association.
- Natiello, P. (2001). *The person-centred approach: A passionate presence*. Ross on Wye, UK: PCCS Books.
- National Institute on Drug Abuse. (2000). *Approaches to drug abuse counselling*. Retrieved from <https://archives.drugabuse.gov/sites/default/files/approachestodacounseling.pdf>
- Penta, L. J. (1996). Hannah Arendt on power. *Journal of Speculative Philosophy*, 10(3), 210–229. Retrieved from <https://vdocuments.site/hannah-arendt-on-power.html>
- Proctor, G. (2017a). *The dynamics of power in counselling and psychotherapy; Ethics, politics and practice* (2nd ed.). Monmouth, UK: PCCS Books.
- Proctor, G. (2017b). Clinical psychology and the person-centred approach: An uncomfortable fit? In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice* (pp. 333–354). Monmouth: PCCS Books Ltd.
- Roberts, M. (2004). The production of the psychiatric subject: Power, knowledge and Michel Foucault. *Philosophy*, 6(1), 33–42. Retrieved from <https://onlinelibrary.wiley.com/doi/full/10.1111/j.1466-769X.2004.00196X>
- Rogers, C. R. (1942). *Counselling & psychotherapy*. Boston, MA: Houghton Mifflin.
- Rogers, C. R. (1985). *On personal power*. London, UK: Constable & Co Ltd.
- Rogers, C. R. (2016). *On becoming a person*. London, UK: Robinson.
- Sanders, P. (2015). *The person-centred counselling primer*, Monmouth: PCCS Books Ltd.
- Schmid, P. F. (n.d.). *Facilitative responsiveness: Non-directiveness from anthropological, epistemological and ethical perspectives*. Retrieved from [www.pfs-online.at/1/papers2/paper-nd.pdf](http://www.pfs-online.at/1/papers2/paper-nd.pdf)
- Speedy, J. (2008). *Narrative inquiry & psychotherapy*. Basingstoke, UK: Palgrave MacMillan.
- Spinelli, E. (2006). *Demystifying therapy*. Monmouth: PCCS Books.
- Stryker, J. (1989). IV use and AIDS: Public policy and dirty needles. *Journal of Health Politics, Policy and Law*, 14(4), 719–740. <https://doi.org/10.1215/03616878-14-4-719>
- Tolan, J. (2007). *Skills in person-centred counselling and psychotherapy*. London, UK: Sage Publications.
- Totton, N. (2009). Power in the therapy room. *Therapy Today*, 16–19. <https://homepages.3-c.coop/erthworks/power.pdf>
- Tudor, L. E., Keemar, K., Tudor, K., Valentine, J., & Worrall, M. (2004). *The person-centred approach – A contemporary introduction*. New York, NY: Palgrave MacMillan.
- Van-Deurzan, E. (2002). *Existential counselling & psychotherapy in practice*. London, UK: Sage Publications.
- Wanigaratne, S., Davis, P., Pryce, K., & Brotchie (2005). *The effectiveness of psychological therapies on drug misusing clients*. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.456.6753&rep=rep1&type=pdf>
- Wilders, S., & Robinson, S. (2006). Addiction: Is counselling sufficient? *Therapy Today*, 17(2), 11–15.
- Wilkins, P. (2017). Person-centred theory and mental illness. In S. Joseph (Ed.), *The handbook of person-centred therapy and mental health: Theory, research and practice* (pp. 39–56). Monmouth: PCCS Books.

## AUTHOR BIOGRAPHY



**Louise Wilson** is a psychotherapist based in Scotland and runs a private practice in her hometown of Edinburgh. Her masters research at the University of Aberdeen focused on problematic substance use and she has extensive experience working with individuals struggling with addiction. She is a passionate practitioner of the person-centred approach.

**How to cite this article:** Wilson, L. (2021). The impact of power dynamics when counselling clients with problematic substance use. *Psychotherapy and Politics International*, 19(2), e1572. <https://doi.org/10.1002/ppi.1572>