Work in Progress

Telling the Truth About Power

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Telling the Truth About Power

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About the Author

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Abstract

In this culture, those in power do not usually talk about it and the rest of us tend not to recognize it either. A similar situation exists in therapy, where the therapist herself may not be aware of her own power-over tactics. This paper suggests methods that may help therapists to acknowledge their power and also to change from power-over actions to mutually empowering relationships. From this line of thinking, there follows an exploration of altering the concept of boundaries in therapy into mutually constructed agreements between patient and therapist. This paper was presented at the Summer Training Institute of the Jean Baker Miller Training Institute, June, 2003.

Hidden Power

They tell women not to begin by apologizing, but after working on this talk, I do think I have to amend the title to "Telling Some Truth about Some Kinds of Power." You'll see why.

Many of us in this society (and in some others too) are mixed up about power. Yet power is very real and is operating right in front of us all the time. Quite amazingly, those who have the most power in our society almost never talk about it and even more amazingly induce many of the rest of us not to recognize it either.

As an example, when I was a kid, my friends and I adored going to the movies. We'd go every Saturday afternoon, and for five cents we'd always see two full-length films, a cartoon, a newsreel, and an episode, or what we called a "chapter," of some long ongoing adventure story, which was almost always a Western. Every week we'd see the "bad guys," the so-called Indians, portrayed as strange-looking, fierce, uncivilized, savage murderers who were threatening the White cowboys. While I must say that we girls did not join in, the theater rang with ear shattering cries, cheers, whoops, and whistles when the cowboys hurt or killed the Native Americans.

It never occurred to us that it was the White people who had taken power by force, robbing the Native Americans' land and destroying their cultures, even calling them by a false name. We absorbed these untruths routinely every week. Thus, you can see how I was drawn into disparaging and even fearing these powerful, violent people (from where I lived in the heart of New York City). I don't remember history classes in elementary or high school changing these images, and I can't recall how old I was before I was shocked to learn the truth that we, Whites, had brutally taken power over the Native Americans. Likewise, we never saw any other people of color portrayed with any truth. This is an easy example of how the "cultural materials" of a dominant group

mystify its operation of power. While everyone may fail to recognize this power-over situation, those closest to the dominant group may be the most likely to do so, e.g., White, middle- or upper-class women.

Is it not similar in therapy? Clearly, the therapist has a huge amount of power over the patient but traditionally has not talked about it. Alfred Adler drew attention to the topic of power early in the history of the psychoanalytic movement, but he was cast out by Freud, and little was heard about it after that. It was really the feminist therapy movement and the movement by therapists of marginalized groups that opened up this whole topic only fairly recently. It makes sense that this was the case.

A group that becomes dominant in any society tends to divide people with less power into groups for various historical reasons. These less powerful groups can include divisions by race, class, gender, sexual preference, and the like. The dominant group often gains tremendous power over the less powerful groups in all realms, including economic, social, political, and cultural. But dominant groups do not usually say, "I have great power over your life; I want to keep it and if possible, increase it because I'm afraid of losing any of it to you."

Now, here comes a tedious part. Along with the obscurity surrounding power comes confusion in the usage of the word. Without reviewing everyone else's definitions, let me say that we have used the phrase "power-to" to mean the ability to make a change in any situation, large or small, i.e., the ability to move anything from point A to point B without the connotation of restricting or forcing anyone else. For the later forms of power that imply force, we've used the term, "power-over."

In a basic sense, power-over usually follows from the structural situation whereby one group has more resources and privilege and thus, has more capacity to force or control others. This is the structural power I just referred to above.

Structural power is most influential and most important to recognize. However, in a complicated society there may be variations within, for example today, when an African American woman supervisor may have some power over a White male worker, this usually exists only in the workplace and not when they step outside. Also, even if a dominant group has overwhelming amounts of power over subordinates, subordinates often find some means of exerting power. These can be power-over attempts or power-to actions. For example, in the play, *The Servant*, British playwright Harold Pinter portrays a clever "man servant" gradually gaining total power over his master. The master is an aristocrat who is reduced to complete dependence because he has been so advantaged that he has not learned how to operate in the world. Such an example, however, does not change the situation of structural power in the world.

At times, subordinates can find the power to resist the force of the dominant group and also add to their power to move toward some structural change, as in the example of Rosa Parks, who began by resisting the insult of bus segregation. That act became a major step in the civil rights movement. What's more, although history books often lead us to believe that resistance to the dominant group is principally achieved through the separate acts of heroic individuals, this, as in the case of Rosa Parks, is a simplistic understanding. It is important to note that Rosa Parks was not alone in her efforts, but was working with others in her community as a long-time active member of the NAACP.

Rethinking conceptualizations of power, Judith Jordan (1986) and Jan Surrey (1987) have developed the concept of *mutual empowerment*. This is different from the idea of empowerment and is a complicated concept. I think we can most readily understand it in an example I will use below; so I'll hold it until then. So much for definitions for now, but it's even more complex with the many intricacies to be explained at another time.

Clearly, the members of subordinate groups could benefit by joining together within each group and across groups to create change in their conditions. However, in addition to material force, dominant groups usually manufacture false belief systems that act to keep them apart. These belief systems operate in many ways.

Preventing Change

For one thing, dominant groups tend to protect the advantages, rewards, and spoils of disconnection by erecting barriers to change. They usually create a whole social structure and culture based on fear—fear of economic suffering, social ostracism, political deprivation, and more. It becomes more complex if we add psychological dimensions. Patricia Hill Collins, an African American sociologist, gives us a basis for understanding these dimensions (1990). In prior work, we have discussed her concept of *controlling images* (CIs). Dominant groups tend to create sets of images about themselves and each of the "subordinate" groups, e.g., those savage Native Americans, the "Black Mammy," the "China doll," and the like. As Collins says, these images are always

false but exert a powerful influence and act to hold each group in its place, that is, they act against change. We all absorb these images about others and ourselves, usually without fully realizing it, as in the example of the Native Americans above. Thus, we think we know (usually wrongly) what it would be like to be a member of any of the groups other than our own. Both dominants and subordinates are thereby held in place.

For dominants, the great threat is to be reduced to being like one or more of the subordinate groups. Peggy McIntosh (1995), a White writer brought up in the upper-middle-class, wrote that she now realizes her whole upbringing was really based on the premise that if she didn't behave properly, that is, live up to the CIs for her class and race, she would become like one of those "lesser people." So those closest to the dominant group live with the threat that one can always be cast out of the group of the "desirables."

For subordinates, there are always the threats of direct loss of the small amount of status or resources they may have, even if they are scant. For example, White women were often made to feel they would not be real women if they did not adhere to the stereotypes of a "proper woman"—a heterosexual good mother. They would lose the advantages they gain by being linked to White men. In a different situation, such as in the novel, *The Women of Brewster Place*, Gloria Naylor (1983) portrays a young African American activist woman, Kiswana Brown, who is trying to organize a neighborhood of poor Black women. Her mother, Mrs. Brown, a woman who has become middle class, comes to warn her that she should stop this work now that she could have more in life. Thus, power-over societies mystify their practices to entice many of us, all the less powerful, into cooperation with them, as Maureen Walker has said (2000c).

Hidden Power in Therapy

Clearly, therapists have more power than patients. We and others, especially feminist therapists and therapists from marginalized groups, have discussed this in prior writings (See for example Brown, 1994; Lerman & Porter, 1990; Comas-Diaz & Greene, 1994; Pinderhughess,1989; Veldhuis, 2001). I won't review all of the valuable writing here but will mention a few examples of the points they've made. For example, the patient is asked to reveal a great deal about her most intimate, painful or shameful thoughts, feelings, and behaviors. She is therefore in a much more exposed and vulnerable position. She is presumed to be the "sick" person while the therapist is presumed to be "healthy" and psychologically mature. The therapist is assumed to be the expert; thus she is in command of the discourse. If the therapist is from a class or racial group that has more status in society, this will add to the power differential and the patient's difficulty in addressing it.

Sometimes, most powerful of all, the patient cares more about the therapist than the therapist does about her. She knows that the therapist is at the center of her life but assumes she is only one of many to the therapist (Eldridge, Mencher, & Slater, 1997). Feminist therapists, for example, Laura Brown (1994), Hannah Lerman and Natalie Porter (1990), and more recently Cindy Veldhuis (2001) have described many other ways—verbal, nonverbal, obvious, and subtle—in which this power is reinforced. They have emphasized that therapists may fail to recognize their power and act in "power-over" ways without realizing it. They believe that this may be the most destructive use of power.

Because of the history of often feeling powerless or even because of their egalitarian ideology, White women therapists may have a particular tendency to deny their power. For example, Cindy Veldhuis (2001) wrote:

> Therapists who fail to recognize their own place of increased power in the relationship in effect negate a client's reality (Brown, 1994). Clients typically see us as having some structural or symbolic power, and when we deny that, we deny their reality, and are at risk for losing our ability to understand the relationship from their perspective. When we are aware of our power, we are consciously aware of how our actions, or inactions, affect the client. We recognize that even a brief discontinuation of eye contact may signal something profound to the client….If that eye contact flickers, and we see the impact in the client's face, we can use our power to attend to the moment, and discuss what happened. In doing so, we introduce a new power into the relationship, the power of mutual respect (Siegel & Lawson, 1990). (p. 53)

I think this is a most cogent short summary of the idea, but we have to note that holding eye contact is not something that is done in all cultures.

Thus, like members of the dominant group, therapists can deny our power and act to prevent change in therapy. Last year, at this Institute, we explored the ways in which we as therapists can turn to power-over maneuvers rather than toward

connection, especially when we, ourselves, feel inadequate, anxious, exposed, shamed, or similar difficult feelings (Miller, 2002). I want to explore some more of the hidden ways in which we use power-over maneuvers in therapy that prevent change.

As an example we can use the video that Judy Jordan role-played (1998); I think many here have seen it. If not, you can probably follow the idea. In it, the patient, Martha, becomes angry and quite insulting to Judy. Judy could have said something like what therapists often say, "I see you're angry. I was just trying to give you a helpful suggestion." Instead, Judy says that she sees how she may have sounded like the patient's unhelpful family members and friends. Thus, she acknowledges that there may be reasons for Martha's anger when seen within Martha's experience. Judy importantly adds that she, Judy, may have been unhelpful in what she said and tells the patient that she feels bad about that. After a few more exchanges, Martha and Judy become more responsive and more connected.

Here we see an example of how a therapist could easily have used the power of presumed expertise to make a patient feel even more irrational, angry, confused, or sicker. Judy could have been even subtler in her power-over response, e.g., asking the patient to explore her anger further. Depending on how it is done, such a question can convey that there is something wrong or unhealthy that should be examined. In any case, it may not be the best step toward building connection *at that moment*. By contrast, Judy uses her truly valuable expertise, that is, her empathy, authenticity, openness, and trying to move toward connection. She demonstrates that she has heard Martha, and as a result, Martha sees she has had an impact and thus feels more power in the relationship.

All this brings up the question of the goals of therapy. I would suggest that the first goal is that patient and therapist feel more connected through the patient feeling that the therapist is empathic, understanding, and responsive. This is essential for the work of therapy.

Second, if the patient feels more connected, she becomes more able to explore painful and difficult feelings. The therapist grows as well, but not at the expense of the patient. Rather, she has *participated* in moving toward more connection and toward the patient's increase in power and growth. This participation always adds to the therapist's growth. All of this is to say that both people and the relationship, as in the example with Martha, have moved toward more effectiveness and power—what we have called mutual empowerment, not one person up and one down.

Here again, I think I need to review some definitions. There is great confusion around our use of the term "mutual empowerment." In all relationships such as parent-child, teacher-student, therapist-patient, and the like, one person clearly has more power than the other; they are not the same, nor are they equal along various dimensions, e.g., age, experience, knowledge of a certain field, etc. Note—these forms of unequal relationships are not the same as the inequalities forced upon certain social groups. In unequal relationships like parent-child, teacher-student, and therapist-patient relationships the goal is for the more powerful person to foster the growth of the other person, that is, to move *toward* change and toward equality (Miller, 1976). This movement may take a long time as it does in the parent-child relationship.

Even without equality there can be mutuality and movement toward more mutuality, as we use the term. Mutuality means joining together in a kind of relationality in which both (or all) participants are engaged, empathic, and growing (Jordan, 1986). Martha and Judy offer an example. Likewise, a parent and child and also the people in other unequal relationships may participate in many moments when they join in mutual engagement that is benefiting them both, though usually not in the same way or on the same level. We can see this even in studies of mother-infant interaction, e.g. in Tronick's (1998) and others' work. Obviously the two people are not the same, nor are they equal.

Most importantly, in the therapist-client, the parent-child, and other similarly constructed unequal relationships the more powerful person must take primary responsibility for developing the relationship. The more powerful person has to keep trying to find ways to make the interactions growth fostering, i.e., moving toward fuller mutuality—and eventually equality. We don't know fully how to do this in any of these unequal relationships, including therapy, but we see it as our task to continue this search. I do believe that one central problem is that we carry over the ways of behaving that we've learned from the power-over structure of our society, again, often without recognizing it (Miller, 1976).

Some Practical Steps in Therapy

In a previous paper we've described what we've called "creative moments in therapy" (Stiver, Rosen, Surrey, & Miller, 2000). These are moments when the

patient presents us with a difficult dilemma and we are forced out of our usual comfort zone and into thinking and doing something new. These steps often make us feel vulnerable, at risk, and as if we are stretching ourselves psychologically. As a result, we often found we've moved into better connection, a bit like the episode in Judy's video mentioned earlier. I wonder if we can explore some specific steps or guides that we might build into therapy that would increase the patient's power and challenge us to recognize our own power all along in therapy? These guides would make working with power dynamics a recognized central part of what we do in therapy all the time, rather than something we do in response to crises. The power of the therapist is so much greater than the patient's that perhaps it is important to create some standard overt safeguards and guides for ourselves. We've talked about mutual empowerment, but we need to delineate better how to actually bring it about.

Joyce Fletcher (1999) has described a similar process in the workplace, calling it "fluid expertise." This process explains how both employees and supervisors have something to contribute, and that these contributions can pass back and forth between them rather than being fixed in one person. This interaction increases the employee's power in the workplace. In addition, in this form of interaction, two or more people can create something new, more than either one would be able to create alone. They also find a new kind of relational experience, the experience that comes when two or more people engage together and find the vigor of this kind of connection, what I'd call the *five good things* that come with this mutual experience (Miller, 1988; Miller & Stiver, 1997).

Can we find specific ways that would encourage movement toward greater mutual empowerment in therapy? Last year we began such a list (Miller, 2002), and today perhaps we can add a few more. For example, can we begin at the first session? We all try to explain to clients how we work in therapy and gear the session to the specific person. For example, I could say something along the lines of an introduction to my approach to therapy that stresses the mutual nature of the experience: "What we do is talk together and try to find out what's making you feel anxious, depressed, etc., and how we can change that. This may sound different from other kinds of treatment you've had, but it's important that you try to say what you think and feel. I will respond as honestly as I can. From this back and forth we often discover what will help. So what you say is really important." We then have to talk about time, money, and the like; I will add more about that below. For people from cultures that have a very different expectation about treatment, the therapist has to discuss much more about this form of therapy and also make more adaptations to cultural beliefs.

Would it be possible to add some thoughts that may help the patient feel more power in the relationship, such as, "If I say anything that you don't understand, please tell me." Or, "If I say anything you don't like, it would be very good if you can let me know. This will help our work." Or, "If I say anything that bothers you in other ways, it's important that you say so." Here, again, such questions may be too different from the expectations of people from some cultures and the therapist will have to adapt accordingly.

Other questions might include, "What is your greatest fear? What is your greatest fear in the outside world? Here in therapy? What is your greatest wish? In the outer world? In here? If patient and therapist are from different class, cultural, or other backgrounds, or have different sexual preferences, such questions may lead into talking about these differences. If they don't, therapists can raise their thoughts and questions about these differences either in the first session or as soon as they feel they are appropriate. As therapy proceeds, therapists should continue to discuss these differences, for in this society, they always contain issues of power. We are stressing how all patients experience the therapist as so much more powerful; this differential can be much greater if the patient has been made to feel less worthy and powerful because of the societal CIs forced upon her.

I'm certain that all of you can think of more and better questions. More important than their specific value, these questions may convey a general *attitude* that invites the patient to take more power in the relationship. In addition, we can ask ourselves all along in the course of therapy if and how our power is operating in some power-over way, especially but not only when therapy may not be moving well. We can ask the patient directly if she is feeling some effects of this power. But it may not be clear to her or she may not feel able to answer, so we have to work at finding out together. Obviously, such questions would have to be geared to each individual person, but we could develop an overall framework that we then use in future cases.

Boundaries

This discussion may have led some of you to think

about boundaries. I would like to explore the question of boundaries as another example of the ways we may use them (or something like them) to increase the patient's power. I believe that the traditional concept of boundaries can be another example of obscuring power in therapy.

Again, feminist therapists (See, for example, Brown, 1994) and members of the JBMTI have discussed several valuable ways of exploring the concept. For example, Judy Jordan has described boundaries as really about clarity and most of all about boundaries as places of meeting rather than separation (Jordan, 1995; Jordan & Hartling, 2002; Miller et al., 1999). She has explored several ways of examining them, especially illuminating the ways therapists may use boundaries to obscure their use of power, that is, ways that really protect themselves rather than serve the patient. But patients violate boundaries too or at least we say they do. I will address that issue.

Further, the concept of feminist ethics is closely related to the topic of boundaries. Along with other feminist therapists, we have discussed framing the ethics of therapy in a positive way rather than as a set of prohibitions (Brown, 1994; Lerman & Porter, 1990). I believe a positive approach can be translated into the question: *how do we build mutually empowering connections that lead to healing and growth?*

Usually the therapist decides what a boundary is and what a violation of it is. Is it possible for this to become a more mutual process? I believe so, but want to repeat that the therapist always has the responsibility of making this and all parts of the relationship growth-fostering.

The Underlying Basis of "Boundaries"

Any concept of boundaries rests on an underlying theory of therapy and of development and growth. A central tenet of RCT is the *Central Relational Paradox* (CRP), which is the idea that people yearn for connection and also fear it or parts of it because they have had hurtful, frightening, humiliating, or sometimes terrifying relationship experiences in the past (Miller, 1988; Miller & Stiver, 1997). People who have suffered trauma or severe psychological isolation may fear it most intensely, but we all do to various degrees. As a result, we continue to try to find connections though we also develop *strategies of disconnection* (SDs; Miller & Stiver, 1997). These are the psychological strategies we use to keep parts of ourselves out of connection, the parts that we have come to believe are unacceptable. Many, not all, so-called boundary violations are reflections of the CRP and are analogous to SDs. They are attempts to maintain connection in the only way a person can find in the midst of great fear.

The therapy situation especially lends itself to this kind of fear and confusion because, in addition to the other reasons for feeling the therapist's great power, the patient may begin to feel some possibly deeper, more true connection. Then she begins to fear that this openness to connection will lead to the kind of harm that occurred when she was open to connection in her prior experience. She may also fear that her SDs, which she desperately believes are so essential, are at risk, i.e., the powerful pull toward connection is now so much stronger yet she so fears losing what seem like her only protections. She tries to do the only things she can in the face of this intense dilemma.

At such times, people's actions usually grow out of the confusion about what connection can lead to. People are usually not aware of or at all clear about this complicated mixture of feelings. For example, in another paper, Judy Jordan (2003) described a patient who told everyone in the hospital about Judy's so-called "mistakes" and "bad treatment." It eventually became clear that this patient deeply yearned to connect with Judy, but she was simultaneously using a strategy to protect herself from the imagined dangers of being alone with Judy by publicly criticizing Judy's work. Not surprisingly, this woman had been severely and secretly abused as a child.

I had a patient who soon into therapy, began to phone me repeatedly after every session feeling very disorganized, panicked, and sometimes suicidal. It seemed that our meetings made her worse! Much later we were able to clarify that her father, a man with serious and chronic illness, often acted in a seemingly interested and loving way but sometimes also terrified her with the accusation that she made him feel tired and sicker. Later in her childhood he died. As she moved into connection and began to feel that I had real interest and concern for her, she equated those feelings with the confused expectation that she would make me sick and weak. This meant that I would then abandon her. I think she may also have felt angry that I now seemed to have so much power over her. Thus, the possibility of connection can create a sense of vulnerability for all of us and we may not be at all clear about this. For some people it can be extremely confusing and frightening.

SDs often contain an aspect of coercion because they can be attempts to use power-over tactics, which are then called boundary violations. These strategies may be the only source of power the patient can find

in her confusion and fear. They are also power maneuvers in the sense that they interfere with the forward movement of therapy because this movement can seem as if it is leading to such dire consequences. This is really saying that they are attempts to use power-over actions to counter what feels like the threat that the therapist's power will be like the power-over actions in her past.

Exploring Alternatives

What is the answer? I think it is to try to find the ways that the patient can find legitimate power to face this threat. She will then not need coercion for protection. This will not work all at once, but perhaps if we think of it this way, we can work toward this empowerment.

How to do this? Can we think in terms of "agreements" rather then boundaries? (I don't want to suggest new words now but perhaps we should eventually do so. I think the word "boundaries" is misleading and comes out of one kind of theoretical thinking. At the beginning of therapy, patient and therapist can set up their agreements about their work together. These could include, for example:

- The therapist can explain how she works, including the things we usually say about the framework of therapy as mentioned above, e.g., confidentiality, time arrangements, money, cancellation policy, and the like. She can ask the patient if she can agree with these arrangements. Are there some different arrangements she'd prefer? If the therapist can't agree to the patient's requests, she should say so and explain why. As Judy Jordan (Miller, et al, 1998) has suggested, the therapist should say if her reasons are based on her knowledge in the field or even just her own personal desires or limits, and not that the patient has asked for something excessive. One way of fulfilling this approach would be for the therapist to say that she believes meeting only every two weeks will not be enough to help or that the therapist can't make evening sessions because of her other obligations.
- The therapist should say that agreements can be altered by joint discussion as therapy proceeds. This would put these changes in the realm of discussion rather than some sacred mandates. It would indicate that the patient can have an effect on the relationship.
- The therapist should include here all of the things she will not do that would harm the patient, e.g., violate confidentiality, engage in other relationships with the patient outside of therapy, engage in sexual relations with the patient, etc. I think this is still important to say very concretely.
- Later, if violations occur, these agreements can be referred to. Again, we can help the patient explore whether she feels that some change in the arrangements can help rather than make the patient feel she has violated some sacred rules. Of course, the patient may still feel compelled to try to violate the agreements in a non-direct way, but at least she has more of a chance to move toward more direct power.

It will often be possible to make some change in the agreements that can begin to allay the patient's fears if we stay open to hearing them. For example, regarding the illustration above of the patient who phoned me repeatedly after every session, the patient and I made an agreement that she would phone once at a set time after each appointment. If that did not feel to be enough, she would leave messages after the first call; we agreed that I would not return those calls unless she specifically requested it. She felt she could legitimately ask to talk with me at those times, rather than feeling she was always wrong to call and yet calling repeatedly. She almost never requested more than the one call; this agreement seemed to be enough, as it is for some people. Also, it may have relieved her fears that she was hurting and weakening me. Often just the discussion of these issues within connection can afford some relief. It can open up some of the whole realm of terror and isolation in which they are encased. In this instance we made this new agreement long before we understood exactly what lay behind this woman's great fears.

Incidentally, this vignette offers an illustration of the ways in which the theory of therapy can guide us to constructive or destructive ways of working. In traditional terms, this patient could have been seen as "very demanding" (based on orality, dependence, etc.). As Irene Stiver used to say, such formulations do not give you much help in discovering what to do (1984).

As indicated above, patients often cannot tell at these times what they are feeling and why. If that is the case, at least the therapist is conveying that there's a reason for her feelings, whatever they are. This can contrast with many discussions about boundaries that make patients feel even more irrational, disturbed, ashamed, guilty, and often angry with the therapist for making her have all these dreadful feelings.

Even before patient and therapist fully understand the issue, they can often find some interim way of trying to deal with the difficulties, such as with the phone call plan in the illustration above. If this plan isn't working, perhaps together they can come up with other attempts, e.g., rather than immediately phoning, a patient might try writing for three minutes about what she feels like doing or what she wishes from the therapist, or the like. The act of writing may lead her into some understanding of a workable plan. In any case, such a discussion about alternatives can demonstrate that the therapist wants to keep trying to find the ways to increase the patient's power.

Along with these efforts, the therapist can keep examining whether she is using power in a way she herself may not recognize. Sometimes power-over strategies may arise from the therapeutic CIs, that is, therapists' notions about the images they must uphold, as discussed in prior papers (Walker, 2002b).

Thus, a seeming paradox, but not really—the way to prevent or reduce what are called patients' boundary violations is to work to increase the patient's power in the relationship but power-in-connection rather than power that is coercive arising out of fear. I believe this discussion illustrates the point Jordan made that the concept of boundaries is anchored in a model of separation (Jordan, 1995). By contrast, I am suggesting a concept based on a model of connection. So, in summary, perhaps we can change the concept of boundaries into a joint endeavor that patient and therapist develop together, rather than one in which the therapist is laying down laws. Even the attempt to do so may keep therapists focused on questions of power and help us to overcome our own denial and mystification.

Conclusion

Because we live in a culture that operates on a power-over basis and also tends to obscure the use of power, we are very likely to act in these ways ourselves in therapy, especially in times of difficulty, feelings of inadequacy, shame, or fear. As Maureen Walker has said, this is so likely to be our "default position" (Walker, 2002c). So our constant endeavor must be to seek the ways we, as therapists, are acting that are not mutually empowering, especially when we may not be aware of these, and most especially, because they may be culturally syntonic and "therapeutic culture syntonic."

I believe we need ongoing education on this issue and we need to create more specific "forms," or ways of thinking and acting that will help us to see what we may not be seeing. The issue of power may constitute another reason why we should all continue in ongoing peer or supervision groups because alone, we cannot easily become aware of what we're not aware of. We all need other people's input. Peer groups could add the stated goal of doing this inquiry about power for each other.

In saying all this, we are really talking about trying to work beyond the values of our society, that is, when we talk about bringing authenticity, mutual empathy, and mutual empowerment to the relationship. Even in its origins therapy was seen as unearthing aspects of life that society kept hidden. With Freud it was sex. Later therapists found it was not sex alone but a whole context of relationships, although these were initially discussed in terms derived from sex and drive theories, such as oral or dependency needs. Today, perhaps more basic than all, we are beginning to recognize the forms of power by which one group of people keeps others from full development and seduces us all to cooperate and collude in doing so both on the larger social scene and also in our most intimate relationships—even in therapy, the setting in which we are trying to be healers.

It is not that the patient's greater power will mean less power for the therapist. As we've said, that kind of thinking usually follows from a notion of a "zero-sum game." It follows from patriarchal, power-over thinking. Instead, it is a question of reframing the issue altogether in different terms.

The answer is not to just flip over whoever is in the position of power so that the subordinates gain more power but continue operating in the same old dominant-subordinate framework. The issue is to create a new structure altogether. I think we can see this quite clearly in therapy. The goal is to enter into connections that facilitate the patient's growth. As the patient grows, she does not gain more "power-over" but power to enter into better and deeper connection, the most valuable power of all. We have to keep trying to find more and better ways to do this. As we do so, we do not become less powerful, but more powerful in terms of our knowledge, our capacities, and the growth that comes from participating in growth-fostering connection.

Because we work at this intersection where change and growth occur, perhaps we can illuminate further the ways to do this on the larger scene, where they are so sorely needed. Certainly, we pursue similar goals in child rearing, teaching, and the like. But maybe we can contribute on an even broader scale in public life.

Perhaps we can help to find the ways whereby less powerful groups of people can not only gain power but recast the operation of power, transform the very nature of power. This transformation would change life for all of us.

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