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Patients' perception of psychotherapists' authority: Qualitative analysis of group analytic process in hospital setting

Pacientovo doživljanje psihoterapevtove avtoritete:
Kvalitativna analiza skupinsko-analitičnega procesa
v bolnišničnem okvirju

POVZETEK

Namen kvalitativne raziskave je bil ugotoviti, kako pacienti v skupinski analizi v bolnišničnem okvirju doživljajo avtoriteto terapevtov. S pomočjo metode utemeljene teorije smo ustvarili splošne in specifične kategorije, ki zajemajo različne vidike avtoritete in reakcij nanjo. V prispevku na teoretičnem nivoju ločujemo tri vire avtoritet: realno, transferno in socialno pogojeno. Osredotočili smo se predvsem na socialno pogojeno avtoriteto, ki ima vire v vtisu, ki ga na paciente napravijo strokovni status terapevta, sloves inštitucije, aktualni socialni diskurz o psihoterapiji, napajajo pa ga tudi predznanstvene, na verovanju temelječe predstave o zdravlilcih. Podali smo primere izjav, ki ilustrirajo socialno pogojeno avtoriteto. Ugotovili smo, da je na doživljanje avtoritete močno vplivala majhna aktivnost psihoterapevtov, ki je napravila vtis o skritem znanju in modrosti. Neaktivnost terapevtov se je izkazala kot frustrirajoča za paciente, ki so uporabljali različne strategije, da so se s pristopom sprijaznili ali ga sprejeli. Kratko smo se posvetili tudi evalvaciji uporabljenega psihoterapevtskega pristopa.

Ključne besede: skupinska analiza, avtoriteta, socialno pogojena avtoriteta, utemeljena teorija

SHORT ABSTRACT

The goal of our qualitative research was to investigate how patients experience their therapists' authority during group analysis in a hospital setting. The patients were interviewed using grounded theory approach. General and specific categories with respect to authority and patients' reactions to it were formed. We theoretically distinguished between real, transferential and socially conditioned authority but in the article we pre-

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dominantly dealt with socially conditioned authority, which theoretically stems from the patients' impressions, mediated by the social and professional status of therapists and the institution, actual social discourse on psychotherapy and also prescientific imaginaries in regard to various faith-based healing. It was our goal to confirm that this type of authority is present and that influences the patients. Besides, we wanted to give concrete illustrations of the otherwise abstract concept. We also found that patients' perception of authority was shaped by the therapists' relative inactivity that gave an impression of hidden knowledge and wisdom. Inactivity turned out to be frustrating to the patients and they employed various strategies to come to terms with the approach or accept it. We have also made a short evaluation of the chosen group-analytic approach.

Keywords: group analysis, authority, socially conditioned authority, grounded theory.

Introduction

I wish to start my investigation with the following proposition : »The therapeutic relationship is in its definition an unequal relationship, which means that the therapist has a position that provides him with power« (Bouwkamp, 2003, p. 31). Power in psychotherapy is linked with many other similar concepts like authority, suggestion, manipulation, influence etc. In this article although I will generally speak of the authority of the therapists it is in connection with the above-mentioned phenomena.

Authority's presence and influence in the psychotherapeutic process can be seen in different ways. Authority can be manifested more or less directly; it can be used or misused; it can be covert in the form of a therapist's silence that gives the impression of inner power and hidden knowledge; it can be consciously denied but still exert its influence and power.

There exist forms of psychotherapy where authority is to some degree unreservedly manifested and is the key to success, like in the treatment of alcohol and drug abuse, treatment of adolescents and incarcerated persons or in highly structured therapies for obsessions and compulsions, where the therapist offers the particular method and demands from the patient that they follow specific rules and fill in worksheets in their spare time. Then there are approaches where authority is under the therapist's constant scrutiny and where authority is unwelcome as a lever of influence, as in most dynamically oriented therapies that build on a mutual, democratic and egalitarian relationship. These psychotherapies see the absence of authority not only as the therapeutic factor *per se* but also as the necessary prerequisite for fuelling a process of relaxed communication and revealing of the patient's inner world. In this article I will be looking in detail at the group-analytic approach which falls into the latter category of therapies. The main principle with which I approached interpretation of patients' experiences of group analytic therapy can be concisely expressed as follows: »... [A]lso the unilaterally defined democratic, egalitarian attitude can represent a manipulation, therefore an illusion« (Fugeri, 1992 in Borštner & Močnik Bučar, 2003, p. 9).

To put it less radically, even in therapy, which in its theory and practice emphasises the need to reflect authority and create as much democracy as possible in the group, therapists' authority is inevitably present, be it through non-reflected stances of the therapists

or through the needs and transferences of the patients. In this article I will deliberately avoid interpreting authority as part of the transference phenomena. The reason for this lies in my aim to reveal new insights, different from the meanings which group analysts would normally assume. In this respect I will use the results of my grounded theory research supplemented by theory from various fields of psychology and social psychology.

Types and role of authority and power in psychotherapy

Psychotherapists generally accept the fact that there is a power differential in the therapeutic relationship and that this differential should be acknowledged and reflected upon. There are many sources contributing to this inequality: the therapist is a professional; patients come for help in a state of weakness, vulnerability, helplessness and need; some patients may not be accountable for their decisions; patients develop transference that launches some degree of regression, sometimes even to the child phase; in some cases the psychotherapist holds legal power. For some psychotherapists this power differential exerts its influence even after the therapy has been concluded (Zur, 2018). But power differential as a general state of affairs is a myth: »A more inclusive look at power reveals that the power differential in some instances is completely valid, but in many other instances it is a myth. The error is to see the power differential as always relevant - as if all clients are the same and all therapist-client relationships identical« (Zur, 2018). The author gives examples of patients that hold different types of power, like education, wealth and position in society. There are also patients who come to psychotherapy not because of distress but in search of quality life. Zur looks at power as a dynamic rather than static force (Zur, 2018).

Zur (2009, 2018) writes about nine types of psychotherapist's power, from which I would like to highlight the following:

- a. Expert-Knowledge power relates to the individual's knowledge, information, proficiencies, and skills gained through education, training and experience.
- b. Professionalism power relates to the "aura of power" of healing professions that has its roots in a prescientific era of witch doctors, shamans and the like. This power derives from the respect - and consequent influence - engrained in many societies for the professional role itself.
- c. Referent power or the power of admiration derives from people's liking, admiring, being attracted to, or desiring to be like another person and results in them being willing to follow that person and obey his or her requests, wishes or orders. Referent power is often fuelled by the person's charisma, social or economic status, or capacity to persuade, influence and manipulate.
- d. Manipulative power is linked with the fact that many forms of effective therapy involve manipulating clients to act in ways that the therapist determines as healthy. Manipulation in this respect is considered beneficial and not malign as would be the case in the more narrow definition and everyday meaning of manipulation.
- e. Positional role as power refers to the power of an individual because of the relative position he or she has in the professional hierarchical relationship (i.e., doctor-patient, therapist-client).

We think that all psychotherapists inherently and in all cases hold the above mentioned types of power of which patients and therapists are generally more or less aware. This assumption is the core thesis and interest of my research and I propose the term “socially conditioned authority” to cover all of the above mentioned (a) to (e). I hold that these aspects of authority are in the most part hidden from consciousness (or better: while it may be in consciousness, the person does not have an understanding of its influence), because they abide in a social discourse, which is uncritically accepted. The concept of social unconscious is in close connection with our understanding. This concept cannot be exclusively ascribed to one author because many have written about it. I will make use of Hopper’s definition, based on his discussions of Foulkes, who in turn introduced the concept in group analysis. Social unconscious thus means »... the existence and constraints of social, cultural and communicational arrangements of which people are unaware; unaware, in so far as these arrangements are not perceived (not known), and if perceived not acknowledged (denied), and if acknowledged, not taken as problematic (“given”), and if taken as problematic, not considered with an optimal degree of detachment and objectivity« (Hopper, 2006, p. 10). Socially conditioned authority falls into this wider phenomena.

Societal and primeval aspects of authority

Frank and Frank in their influential book *Persuasion and Healing* (1991) make a parallel between psychotherapy and some other healing practices like religious and magical healings, cults, rhetoric and pharmacotherapy. All these practices share similar elements and evoke in patients similar mechanisms that lead to change. Specifically for psychotherapy Frank and Frank (1991) indicate that it evokes a person’s expectations, hope, inner potentials and powers of the mind, stemming in part from the placebo effect. The authors attribute important influence to the suggestive power of the psychotherapist² and the willingness of the patient to depend on the therapist. Expectations of the therapist and self-fulfilling prophecy are another aspect of the therapeutic action as well as the feeling of affiliation with the group or the therapist and his “ideology”. Among the effective features the authors consider: the emotional and trusting relationship with the helping figure; the setting of space, which mediates the meaning of the therapist as an expert (diplomas, books, couch) and specific rational explanation, conceptual scheme or myth that promotes some kind of explanation for the problems and determines a specific ritual to solve them and in which they both believe.

There also exist even more similarly obscure but scientifically proved mechanisms that promote change. For example, there is the phenomenon of cognitive dissonance: the more the patient experiences the therapist as a figure of expertise, trustworthiness and credibility, the more he or she is inclined to balance this impression with his progress in therapy (Strong, 1968 in Frank & Frank, 1991). We can see a similar mechanism in the phenomenon of “contextual cue” (Schafer, 1965), where the person experiences a particular situation or physiological state depending on the meaning that is ascribed to it. This may be one of the main reasons why negative emotional states»...carry a therapeutic

2 Psychotherapists subtly, on the basis of barely noticeable nonverbal cues of approval or disapproval, influence patient’s production. There is evidence that disapproved patient’s productions drastically decrease. That was demonstrated even in the case of Rogerian nondirective psychotherapy (Murray and Jacobson, 1971 in Frank, 1991).

meaning, just as a patient will take a bitter medicine because he or she associates the bitterness with the medicines curative power« (Frank & Frank, 1991, p.59, 60). Here we enter the field of placebo effect. Placebo effect is considered as one of the most prominent agents of change in psychotherapy. Frank & Frank (1991) see placebo in psychotherapy in the power of words, expectations, image of the therapist, therapist’s interest in the person and similar elements that create some positive meaning for the patient.

The authority of psychotherapy as a profession

In recent decades psychotherapy has strived to position itself as science. There have been many reasons for scientific validation to be undertaken, among which pragmatic reasons also played a part, namely the urge to keep pace with pharmacotherapy and take its share of insurance money as well as the rivalries between various modes of psychotherapy (Herbert, 2003; Elkins, 2007; Henry, 1998). Psychotherapy can be and should be researched. But as in all research, even in hard sciences, the results depend on subjective factors, as was, for example, proven by the phenomenon of observer-expectancy effect (Frank & Frank, 1991). I believe that all kinds of research help psychotherapy grow as a discipline but wish to share the view that in the actual work with patients non-scientific elements prevail. Fancher’s (1995) view corresponds with this. He examined mental health care in the USA and concluded that various forms of psychotherapy and to some extent even pharmacotherapy claim scientific authority which in fact is false. Fancher (1995) treats psychotherapies not as sciences but as cultures. As the author claims, culture may contain elements of science or may tend towards science, but is actually grounded in experience, wisdom, guessing and believing. The effects of psychotherapy rest mostly on factors that have little to do with narrowly defined theoretical assumptions and scientifically proven methods. Its effects are also dependent on the authority of the profession and the professional (Fancher, 1995).

I am aware that such assertions are not directly empirically tested and derive mostly from the author’s impressions, observation and experience. They must also be understood in the light of theoretical postulations of various psychotherapeutic modalities about quite specific therapeutic agents. But there is nevertheless some confirmation of such views in Yalom’s (1985) investigations pertaining to the different views of therapists and patients about what it is that had worked in psychotherapy where, from patients’ experiences, common factors gained precedence over specific techniques, intricate theories and concepts. Also other contemporary research shows that the therapeutic relationship is the most prominent factor that brings success. Many authors have touched on this subject (Wampold, 2001, Frank & Frank 1991; Yalom, 1985). The core qualities of the therapist that enhance a good therapeutic relationship are considered empathy, acceptance, warmth, understanding, authenticity etc. Such factors can hardly be considered as scientific methods or techniques but have more to do with personality factors and subjectivity.

RESEARCH PROBLEM AND HYPOTHESIS

The author’s doctoral thesis on negative outcomes in psychotherapy was grounded on qualitative research that aimed to explore negative experiences of group analysis in a hospital setting with both the patients and the therapists. An important part of that research was to explore not just patients’ experiences and perceptions of the therapists

but also patients' reactions to the perceived characteristics of the therapists. In the course of the interviews many topics concerning authority came to be mentioned. The material therefore provided ample evidence on the importance of authority for the patients. For the purpose of this paper I limited my research to the investigation of experiences with therapists' authority. I was interested in:

- a. the nature and facets of the therapists' authority as perceived by the patients;
- b. the manifestations of authority;
- c. the influence of authority on the therapeutic process;
- d. patients' perception of objective, subjective and social aspects of the experienced authority and
- e. reactions to authority.

My hypothesis rests on a theoretical understanding of the socially conditioned aspects of authority and can be formulated as follows: the authority of the therapist is an important aspect of the therapists' role as well as an important issue to deal with in therapy. Patients have their own subjective views on the strength and nature of the therapists' authority, these views being based on real events happening in the group but modified by the patients' transference. Additionally, patients have views on authority which are not underpinned by the real events happening in the group but are in some way to a certain degree concealed and stem from the structural role of the therapists, i.e. from the inherent authority of the professional, expert or institution and also from cultural influences and pre-set images about psychotherapists. I term these sources of authority "socially conditioned authority." It is thus important for the purpose of this paper to emphasize the influence of the therapist's or institution's cultural image (or meaning) that operates even before a patient crosses the door of an institution or an office. All the above mentioned aspects of a total healing situation are not usually acknowledged by the professionals.

The question then arises - why is the therapist's awareness of socially conditioned authority important and consequently my research justified? First, it is my view that every awareness of hidden forces in therapy helps the professional to understand the process and the patient better, especially when no school of psychotherapy deals with such aspects. Secondly, it may help professionals to distinguish between real, transference and socially conditioned authority aspects of patient's interaction in therapy. And thirdly, I have found no research literature that deals with socially conditioned authority and find it important to concretize and illustrate the concept with specific examples using the words of the patients themselves.

METHOD

Setting

The unit for psychotherapy of personality disorders (PPD) is one of the units in the Centre for Mental Health (CMH) which is a part of the University Psychiatric Clinic of Ljubljana. Persons diagnosed with personality disorder and/or persons with neurotic, stress and somatoform disorders (F40-F48), mood disorder (F30-F39) or substance abuse (F10-F19) in remission are admitted into the unit. The overall treatment lasts approximately three months. The patients are usually hospitalized for two months after which they come as

outpatients on a daily basis. There are a maximum of ten patients hospitalized at any one time in the PPD. Group analysis is the main group therapy, running four times a week, but there are also many other therapeutic activities: occupational therapy, music therapy, psychodrama and expressive movement therapy. All therapists meet regularly to discuss patients and groups. Group analysis is conducted with two or three therapists. At the time of my research two therapists had a group analytic education and one of them was in training.

I do not intend to depict the therapeutic approach in detail. From my experience I can say that it follows the traditional lines of group analysis, based on Foulkes, with emphasis on few and short interventions, therapists' neutrality and anonymity, therapists' encouraging group interaction and using the group's own healing potential. Patient's reciprocal mirroring is frequent and transference interpretations are given but are not the main tool. I think this general depiction goes hand in hand with the one that my respondents have provided as will be seen later in the article.

Sample

The sample consisted of ten patients, five women, five men. Mean age was 35 years, ranging from 25 to 46. All except two patients had personality disorder diagnosed. One patient had a substance abuse disorder, currently in remission. One patient was diagnosed with depressive disorder, one with anxiety-depressive disorder and one with anxiety disorder. I used convenient sampling. The psychiatrist asked all the discharged patients if they would be willing to participate in the research. There were two patients who declined and one who did not show up at the interview.

Procedure

The author has never worked in the PPD unit but had some knowledge of the treatment and knew all the therapists on a professional basis.

The patients in the sample were hospitalized in the period June 2009 to September 2010 and participated in the interviews one to two months after they had completed their treatment.

The research was approved by the Commission on ethics in medicine within the Medical faculty of Ljubljana University. All the patients signed the informed consent with the researcher.

Semi-structured interviews were carried out by the author. The interviews lasted approximately 1.5 hour, were recorded and transcribed. The interview and analysis of the data were accomplished with grounded theory approach and methodology (Glaser and Strauss, 1968 in Mesec, 1998; Strauss and Corbin, 1990 in Mesec, 1998; The Sage encyclopaedia of qualitative research methods, 2008). Although I was interested more in negative experiences and disturbing elements, I always began my investigation by asking neutral questions about the patient's views of the therapists, for example: »How did you experience the therapists? Who were the therapists for you? What did you think and feel about them? How did you see their approach to group treatment?« Later in the interview I asked specifically about the negative side: »What didn't you like, what disturbed you,

what was stressful for you about the therapists and their approach? What would you like to be different? What didn't help you?» Finally, I asked questions about the way the patients handled their anxieties and dilemmas regarding the therapists and their approach.

In accordance with grounded theory the researcher should let the material speak for itself. This applies to the phase of coding the material but also partly to the interpretative approach. The researcher should therefore keep to the descriptive level and refrain from speculations that are not grounded in the material (Mesec, 1998). Although I followed these instructions I also allowed myself to interpret some of the findings with the help of psychoanalysis and social psychology. In effect I tried to stay on two tracks simultaneously.

All the coding phases were duly completed – open, axial and selective. The result was the taxonomy of different categories.

Results

The presented categories, relevant for the current research problem, are taken from the original broader research and taxonomy. The categories are not changed but their order is rearranged to fit the present subject. Categories are ordered from general to specific level and the number of patients reporting the specific phenomena is shown in brackets.

Therapists' functioning in the group meeting (10)
Inactivity (10)
SILENCE (10)
<i>Therapists are silent</i>
<i>Unresponsiveness to expressed needs and wishes</i>
<i>Unresponsiveness to formal questions</i>
LACK OF INTERVENING (5)
ALOOFNESS (6)
INACTIVITY (GENERAL) (5)
Activity of the therapists
<i>Various therapeutic interventions</i>
<i>Returning of questions to patients</i>
<i>Nonverbal activity</i>

Table 1: Categorized statements of the patients regarding authority in psychotherapy. Number of patients reporting is in the brackets.

Reactions to therapists' inactivity (10)
Tendencies to activate the therapists (6)
COMPLAINTS (4)
Attraction / animation (1)
Questions addressed (3)
Coming to terms with it (5)
Making sense of it (10)
Patients' own explanation (10)
Rational explanation (10)
Irrational explanation (10)
Acceptance of therapists' explanation (5)
Not coming to terms with it (1)
Silence (1)
Blaming / nonexpressed inner conviction (2)
Detailed observation of therapists' behaviour (1)
Patients' views of the therapists (10)
Therapists' authority (10)
Therapists are professionals (6)
Therapists always know what they are doing (3)
Therapists' words are precious (8)
Therapists are indisputable authorities (6)
Demystification of therapists' authority (3)
DISTURBING CHARACTERISTICS OF THE THERAPISTS (7) ³
POORLY SELECTED PATIENTS (4)
INHUMAN APPROACH (5)
<i>Disrespect</i>
<i>Violation of patients' rights for information</i>
LACK OF PROFESSIONAL AUTHORITY (4)
OTHER RELEVANT BEHAVIOUR OF THE THERAPISTS (4)

³ Category "disturbing characteristics of the therapists" contains categorical and stark criticism; however many other characteristics also disturbed the patients (i.e. aloofness, silence etc.) but to a lesser degree and more in the sense of having dilemmas that can be processed.

INTERPRETATION

In the course of interpretation I give citations from the patients. The person that stated it is marked in the brackets: 1 signifies a woman; 2 signifies a man; a letter of the alphabet signifies a specific person. In the text I also use abbreviations for the therapists: T1, T2, T3.

Functioning of the therapists in the group meeting

Functioning can be roughly divided into active and inactive.

Therapists' inactivity was the topic that every patient was occupied with and in the interviews they spoke about it more than about anything else. Inactivity was disturbing for all the patients. They did not expect such treatment and they did not understand it. They expected more structure from the therapists. On the one hand they expected and wished for a more authoritarian leadership, but on the other hand they desired also a more caring attitude. The patients dealt with inactivity in their own minds, they spoke about it in informal interactions between themselves and expressed their dissatisfaction in the group. Inactivity was like a mystery that had to be understood and resolved. All patients had a feeling that they would have gained more from the treatment if the therapists' role was more active.

Inactivity manifested itself as silence, lack of feedback, lack of intervening and aloofness.

In this category silence was the topic most spoken about: »Nearly everybody - say 90%, not to say 100% - wanted more feedback« (F2). Patients expected that the therapists would be spontaneously proactive but the therapists remained silent even when they were directly addressed with questions, wishes and needs. The patients would have liked advice, opinions and judgements about the correctness of patients' views or they would have liked general information about the organisation of the hospital and specific procedures in the ward. In this sense the therapists were unresponsive. I give some examples:

»I asked but the questions were blocked. When I asked about why I was admitted to the hospital therapists evaded somehow, they didn't answer me straightforwardly as I expected« (H2).

»The one thing that disturbed everybody was if someone expressed a wish to prolong the treatment, the person didn't get any answer or the therapists asked him why he was asking this; none of the patients knew whether they will prolong it, they didn't even know on the their last day« (H2).

»There was a blockage in the communication about the drugs, diagnosis and treatment. We patients have the right to know that but that simply wasn't there« (B1).

Very rarely the therapists clarified their silence and unresponsiveness.

The therapists did not intervene in certain tense moments, for example, when the group was in chaos or conflict or when somebody expressed marked distress: »The girl just stood up and was somewhat angry and said she was going to cut herself. The therapists said, "well, see you tomorrow, goodbye", and they left« (A1).

The patients experienced the therapists as aloof. Some reported that the therapists were "observers", "indifferent", "emotionally disentangled", "as if they weren't present", that "they cut like a sharp knife": »They looked at us like at mice; how we react, how we compete with each other, at least I saw it this way. After all they make conclusions from

the conflicts what kind of people there are in the group; do we laugh, have fun ... ; they see who we are in conflict situations and how everybody reacts« (F2). Remoteness can also be desired: »I liked that they didn't respond emotionally, that they were remote, as if they observe some foreign animal species. They were very much above us, they have to, I assume. On the other hand I would have liked somebody to emotionally engage, I can't really make up my mind« (I2).

The therapists' activity was seen in therapeutic interventions. They were few and short. The patients were bothered when the therapists returned questions in the same form to the group or the patient. Here I recognize a classical psychoanalytic approach intended to deepen the process and introspection. Furthermore, the patients were most irritated when the questions concerning the formal aspects of treatment were not answered.

»When we had concrete questions concerning the system of the hospital, sick leave etc., there was no clear answer but more in a sense: what do you think about it? « (C1).

»I know in the group it is also about saying things out but this goes by sending the questions back. And ... how can it be ... if I have asked you for individual consultation and you would say, yeah, why!? Well, I wouldn't tell you why. Because I need it, of course!« (E1).

Some patients maintained that in some cases patients' rights were violated.

Reactions to therapists' inactivity

This category depicts how the patients responded to and tried to solve distress, anxieties and frustrations concerning therapists' inactivity in the group. Reactions derived from subjective perception of discontent and from the desire for greater activity from the therapists. The goal of some of the reactions was to change the behaviour of the therapists.

We noticed that the patients with previous psychotherapeutic experience had fewer problems with inactivity. The problem was bigger at the beginning of the treatment. The patients expressed their discontent in the group sessions or/and they sought clarifications and reassurance with the other patients alone. Longstanding patients tried to reassure the newcomers; they tried to explain that the method won't change or they explained the reasons for such an approach. This was followed by patient's coming to terms with it or an endeavour to make sense of the therapists' actions and patient's participation in such a process.

Attempts to activate the therapists was the most common way of handling the problem in the early phase but could persist even later in the treatment together with an endeavour to comprehend. Patients complained in the group session about the inactivity of the therapists; they raised concrete questions or actively approved therapists' interventions with the motive to activate them.

Gradually some patients came to terms with this state of affairs and they stopped caring, this sometimes resulting in a lowering of expectations. Coming to terms with it is an adaptation reaction that can include denial, ignoring or repression of feelings and needs that are connected with expectations from the therapists as strong transference figures. This is the way the process continues despite discontent and despite specific needs that are being frustrated.

Some patients tried to find an explanation for such therapists' behaviour. I distinguished between rational and irrational explanations (In the sense of psychologically sound

and solid or psychologically weak and false deductions) and further divided rational explanations into those that came from the patients and those that the patients adopted from the therapists. Patients mostly created an understanding by themselves or at least perceived it as such.

We were able to detect that some rational explanations show a good understanding of the logic and ethics behind the analytical approach:

- »Therapists think that self-exploring is the most valuable.«
- »A given psychodynamic answer can trigger defence or a person misunderstands it.«
- »Therapists don't intervene in conflicts so as to not hinder their natural development.«
- »One goes through the process alone.«
- »Therapist doesn't want to be authority.«
- »They are not supposed to involve emotionally or take sides but must stay neutral.«
- »Because it is very easy to just ask a doctor to give his opinion, because he has authority, in a sense - aha, that is it, ok! But this is not my own opinion but the doctor's! I think that they don't tell it so that we can create our own picture or maybe learn to see through the eyes of others« (D2).

Patients created their own rational explanations via several different routes:

- "personal explanation proper" came out of personal insight into the method and by recognising beneficial and facilitating effects of the method;
- observing which behaviour the therapists reinforce or inhibit on the verbal and nonverbal level and
- adopting the culture⁴ of the ward that lives on through generations of patients.

Patients also adopted the therapists' views or at least took them into account. But only rarely the therapists explained their actions: »And then T1 explained somehow that it is not disrespectful when they don't answer questions and that by doing this they would have to get closer or move away from the patients which wouldn't be good and that they have to stay neutral for that reason« (A1).

Considering the fact that the therapists' words were generally valued very much, I speculate that such explanations infiltrate into the therapeutic culture in the ward⁴ and create a certain pool of possible explanations that the patients can use.

Irrational explanation is practically identical with blind faith in a method without trying to understand its premises. I give some examples:

- »I somehow believe that everything is thought out carefully here, every therapy to the point.«
- »Rules of the game say that the therapists don't give feedback.«
- »Therapist's distance is a matter of technique.«
- »Silence is a mode of therapy.«
- »Silence is thought out.«

⁴ By "culture in the ward" I have in mind the existent therapeutic motivations, explanations, values, standpoints and attitudes regarding the treatment, created and carried on by previous generations of patients. The culture is a dynamic and constantly changing force.

- »Therapist's tolerance and allowance is a principle.«
- »I'm convinced that the lack of feedback is good but I am not able to express why.«

Only one patient in our sample didn't understand or accept therapists' inactivity and considered it non-therapeutic.

Some patients condemned inactivity. They thought that silence is torture and that such behaviour is obnoxious and shows disrespect.

One patient told us that she had been helping herself with detailed observation of the therapists' nonverbal reactions, face grimaces, gestures etc. This helped her to comprehend their emotions and attitudes.

Inactivity and its influence on the therapeutic process and views on authority

We can conclude from the testimonials that the therapists followed strict rules of group analysis with the emphasis on abstinence, neutrality and few interventions. There was little readiness to adapt to patient's expectations and needs. Patients were expected to adopt the logic of this approach and not *vice versa*. A classical group-analytical approach is without doubt complex for the patients. It is natural for patients in the hospital setting to expect more structure, authority and leading. The majority of the patients did not accept such an approach but everybody found something in it for themselves.

Our patients were preoccupied with the inactivity of the therapists which consequently brought more chaos and confusion into the group, thus making psychotherapeutic work occasionally impossible. Group analysts in general have a therapeutic understanding of such situations but we must recognize the fact that the theory deals with long term psychotherapy. In a long term setting a group has the time to work through such resistances. It is my opinion that the therapists in the given hospital setting could and sometimes should intervene more actively and decisively, thereby creating a suitable working environment, especially in periods of turbulence. Instead the therapists held on to technical rules formulated for long term analysis. In this sense they did not follow trends in working with severe personality pathologies where an active, structured and more empathic approach is desirable (Stiwne, 1989; Nehls, 1991). There was an impression that a method, invented to create an intensive therapeutic experience and help persons on a deeper level, obliterates itself. Three months is also a very short time for the patients to really understand and feel through the beneficial aspects of such an approach.

There is another interesting point to be made, illustrated by one of our respondents: »After I spent a couple of months in the ward, T3 several times expressed his discontent with what was happening in the group – that it doesn't function well – and maybe he became more active because of that, or maybe with the absence of T1 ... I don't know, maybe it is about peer to peer pressure. I know, for example, that T2 was always active but many times T3 looked angrily at him. It is one thing when the patients evaluate you and another when co-workers do it« (H2).

If this holds true then I can conclude that the therapists check on each other as to what degree they follow the principles of work. Deviations are not permitted, thereby maintaining the agreed principles. In this way the principle of work is superimposed on

the therapists as a kind of ideal that bonds the therapists. A therapist, when alone with the group, can deviate from these rules.

Within the analytical approach there is a certain ethical position that our respondents also noticed. It is about a principle of patients' autonomous functioning and therapists' non-authoritarian functioning in the sessions. (In the PPD such principles are also apparent in the lack of therapists' uniforms, by not sanctioning a breaking of the rules of the ward and in the general lack of control – at least such was the impression of the patients). Onto this base the patients brought their own neurotic but also practical and realistic needs (for information, for example). The patients wanted to be led and supported. In this light I understand the silence of the therapists as a message that the way to health leads through being responsible for themselves and through independence of thinking and functioning. Does the silence terminate or create authority? I think that silence diminishes explicit authority but creates a more masked, less palpable authority. Silence caused the patients to value the therapists' words even more and made patients more suggestible. The rarity of words also intensified the placebo effect. It gave an impression that there is much more knowledge and wisdom in the therapists. On the other hand silence made the patients preoccupied with the therapists and thus did not divert attention from the therapists but the opposite.

Patients' views of the therapists

This category contains patients' views about the therapists as experts and as persons in the group sessions as well as in other more or less formal settings.

The category "therapists' authority" consists of heterogeneous impressions about the therapists as authorities that gave the patients a feeling of safety, had answers to their dilemmas, were expected to perform miracles, incited apprehension and awe and whom the patients trusted and believed unconditionally. Subcategories in this category correlate considerably.

Patients voiced their view of the therapists as professionals. The professionalism manifested as: a) having knowledge and information about the patients, b) giving attention to the patients, c) monitoring the patients, d) meticulous insightfulness, e) refusal to give credence to appearance and superficial phenomena and f) intelligence. It is about the impression that the therapists master their job.

Some patients had the impression that the therapists knew well what they were doing, even though the purpose of their doing was not understandable to the patients. This applies to the therapists' inactivity as well as to the whole group treatment model. Some patients even felt that the therapists sometimes did something deliberately with the intention of helping some process to be resolved in the patients. In this way one of the patients assumed that she had been given a male roommate so to work through her relationships with men in her life. Whereas another patient thought that the therapists encouraged conflicts to create more dynamics in the group and that to frustrate is their job.

Therapists' words made a strong impression and had profound influence. As Borštner and Močnik Bučar assumed in general: »Words can seduce, arouse false hope, they (i.e. patients, that the authors mention) would sooner consider the therapist's words than their own, the therapist's words take you into different directions, even in such not to your liking« (2003, p. 12). Therapists' words were even more valued, because they were

rare. Words were smart, genuine and hit the point. Many patients wrote them down or processed them for a long time and remembered them even after the hospital treatment. Some were irritated by words but words made them think. I assume that the patients came to a deeper understanding of the therapists but also that the paucity of words and the fact that they come from professionals made an even stronger impression.

An almost religious attitude to words (i.e. »my companion treated all therapists' words as true«, »I remembered therapists' remarks for all my life«, »I often remembered the words after the treatment and they helped me«) testifies that some patients put the therapists in the role of undisputable and unmistakable authority. Everything that a therapist did was by definition correct and had some purpose even if it might be obvious only to the therapists.

Hence, there existed an unconditional recognition of authority. The following statement illustrates this: »I felt certain authority through the whole process. I felt that they had certain knowledge and capabilities. That is why they are here. I think that they didn't lose even a bit of authority in my eyes when they weren't saying anything. But there was a period in between when I thought, hell, you don't have a clue and everybody can trick you« (D2).

Demystification of the therapist was also present:

»In the end they are also humans, as are we, and they have problems at home. Interesting, when you say "therapist" - this is what remains. But he is a human! He or she has the same needs, wishes. But only this – therapist! One expects something, something big. He tells you that something is right; if you are unstable, you believe him immediately and don't think if something is really right or not for you« (G1).

The manifested unrealistic elements of authority, contained in some of the above mentioned subcategories, are connected with an impression of the therapists as remarkable people, especially in the sense of possessing purpose and truth. I propose that this impression derives from two sources. First, I recognize transference onto the person of the therapist. I assume a type of transference, originating from impressions about the parents and other grown-ups as omnipotent and omniscient. I think that such an impression is only partially dependent on the reality of parents' handling and behaviour and that it is relatively universal. This unconscious image can be employed later in life under various circumstances in search for an omnipotent figure. I believe that in our patients it constitutes a part of the whole transference but nevertheless a part that obscures the more realistic impression of the therapists. It is a part of a transference that readily comes to life in contact with experts, especially from the field that deals with human relations and understanding of life. It is more often triggered in contact with persons who have charisma or act in an enigmatic way (Varjačić Rajko, 2012). In our case the therapists who say only few words and make short interventions impress the patients who feel that there is much more knowledge and wisdom hiding in the background. The second important aspect comes from outside of the person, i.e. from a socially transmitted meaning and status, which I have called "socially conditioned authority." These two aspects intertwine. I return to this subject again later in the article.

Some patients were disturbed by the inappropriate selection of the patients. For many it turned out that they were unmotivated, unprepared, non-cooperative, thereby hindering other patients from gaining more.

Approximately half of the patients expressed that they experienced certain actions of the therapists – silence, lack of response, unwillingness to give information about the treatment – as inhumane, i.e. as disrespectful, inappropriate and rude:2 »In the beginning I complained in the group – no, we had a picnic then – that I find inappropriate if I ask something and they don't answer. I remember that I asked about the therapist's education« (A1). The therapists also did not give information about pharmacotherapy, organization of the treatment, duration of the treatment for specific patients etc. Patients were bothered when the therapists failed to respond to grave anxieties of specific patients and when they gave vague answers.

Some patients wished for more authority and expertise from the therapists. They thought that vague interventions and lack of expert opinion in the group does not create authority. In some cases inactivity was also seen as a sign of lack of expertise (but the majority experienced it as a sign of authority).

Limitations of the study

My original research was focused on negative experiences with psychotherapy so my results here are likely to be inclined to the negative side, i.e. the patients felt that they can and should speak of the negative experiences. However, I feel that in the interviews some positive aspects of the therapists' authority were also expressed and even dominate in the connotation of the socially conditioned authority concept. Overall, even in the case of uneven emphasis of patients' experiences, I do not find the quantitative aspect important. The aim of the study was to show and illustrate an aspect that is present in every psychotherapy and was hitherto theoretically grounded. I can only speculate that my results would be different if I limited my research to persons with psychosis or some organically caused psychological disturbances that seriously damage reality testing.

Conclusion

Based on my research I have confirmed the existence of various types of socially conditioned authority, namely therapists' entitlement to heal, the influence of the mere name of the profession, social images about the profession, also the ones that evoke magical expectations, deriving also from the prescientific era of healers. I did not encounter any direct proofs of the influence of the institution. Socially conditioned authority cannot be reduced to transference (though it intertwines with it) or explained merely with realistic behaviour of therapists. Rather it stems from a pre-set culturally transmitted image of the psychotherapist and psychotherapy. Theoretically I assume several sources of socially conditioned authority: a) current locally and globally conditioned social discourse regarding psychotherapists and psychotherapy, b) social image of the profession, c) social status of the profession, d) psychotherapist as an expert, e) authorized institution as a guarantee of expertise and f) residues of prehistoric imageries with regard to healers.

We believe that the recognition of these aspects of authority is important to our work. First, it is important to differentiate between the sources of our influence. Practically speaking, we should be able to understand that patients' enchantment over our job and persons (when present) is not always a case of transference though it may be intertwined with it. Especially in the early stages of the psychotherapeutic process it can express culturally transmitted meanings or the influence of recommendations and opinions

of friends and relatives. Secondly, such recognition can serve professionals to abandon inauthentic attitudes that imitate some stereotyped image of the healer as, for example, mysterious, distant, secluded, full of empathy or too wise.

With regard to the inactivity of the therapists I recognized a "classical" group analytical approach, based on few and short interventions. I cannot objectively evaluate the usefulness of such an approach for this specific setting and can only have theoretical and ethical reflexions in this respect. Questions such as the therapists' rigidity vs. flexibility, consideration vs. ignorance of patients' needs, consideration of specific hospital setting etc. can be addressed. As Goolishian and Andersen wrote (1988 in Borštner and Močnik Bučar, 2003): "... [T]herapists must be able to let go of old meanings just as we expect our clients to be able to do so" (p. 11). I can say for sure that the authority, which by this approach is meant to be reduced or evaded, is very much present and felt. It may be more hidden and masked than in more structured and active approaches. Furthermore, it was my impression that the hospital setting is not suitable for an approach that was invented for long term outpatient psychotherapy and that some patients might have gained more with a more active and supportive approach. In my research it was clear that the therapists adhered more to "the book" than to the patients. On the other hand the patients experienced this approach as something special and unique for our health system and we must not forget that generally they were satisfied with the overall treatment.

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