Hierarchy: The Imbalance of Risk

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My reactions to Simon's article, "Revisiting the Notion of Hierarchy" (1993; this issue), are similar to the reactions I had after reading another recent article of his, "Having a Second-Order Mind While Doing First-Order Therapy" (1992): both of them draw upon a common set of assumptions in addressing issues of hierarchy and control in therapy. Since I have had the opportunity to publish my reactions to Simon's assumptions previously (1992), I will refrain from repeating myself here, and instead will use this opportunity to lay out my own assumptions on the issue of hierarchy. In this commentary, I offer five assumptions that guide the way I participate in therapy situations to which the term "hierarchy" has been applied. These assumptions have evolved from my clinical practice and my experience as a human being in general.

It seems to me that the central issue in discussions of hierarchy concerns the balance of risks to individuals involved in relationships. If the balance of risk in a relationship is equal for both individuals, I assume that the relationship can be best described as "heterarchical." In heterarchical relationships, both persons feel equally able to say "no" (Andersen, 1992). If the balance of risk in a relationship is *unequal,* I assume that the relationship can best be described as "hierarchical." In hierarchical relationships, individuals do not feel equally able to say "no." Often, one party stands to lose more than the other if problems arise in the relationship.

I assume that I am often in a position of elevated influence.

I believe that the term "hierarchy" is often a fitting description for the relationship between myself and my clients. I think my clients often see themselves as having less knowledge, emotional maturity, and/or stability than they ascribe to me. They often fear my disapproval more than I do theirs, and perceive themselves as more emotionally vulnerable than I am. Consequently, they attribute more value to my assumptions, opinions, and reactions than they do to their own. Whether they *should* do this or not is another question. What seems most critical to me is that they often do, whether I like it or not. I don't think that this assumption *always* fits, but I've come to think it's best to assume that, as therapy begins, clients may be elevating me to a position of increased influence.

I assume that I often cannot avoid being in a position of elevated influence.

I further assume that I cannot avoid

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being put in a position of elevated influence, even if I work very hard to avoid it. Indeed, I strive to do all I can to lower the real and perceived risks to my clients for disagreeing with me or upsetting me. I work at stepping out of the role of an expert with regard to my clients, and encourage them to follow their own voices. However, if clients enter therapy with the assumption that I will be an expert on them, even if I communicate clearly that I will not accept this responsibility, they may still elevate my values and assumptions over their own.

I think this is a very important point. In the past, I have tried to deny, nullify, ignore, or change my position of elevated influence. Sometimes I think I have been successful, but other times I think I have fooled myself, wanting to believe that my clients were perceiving me the way I wanted to be perceived. Occasionally, I have had the sobering thought that my attempts to minimize my elevated position paradoxically only raised my position in the eyes of my clients. They had even more respect for my authority once they saw that I didn't particularly care to have it.

I assume that it is possible to abuse my elevated position of influence.

The critical question for me is not whether I am in elevated positions of influence (I often think I am whether I like it or not), but whether I abuse this position. In past years, I believe that I have sometimes inadvertently abused my position, and I suspect that such abuse is common. In general, I assume that abuse of therapist position occurs when therapists engage in deception, facilitate dependency, or act in ways that lead clients to feel degraded or rejected if they do not accept the therapist's influence. I believe there are many forms such abuse takes. I will mention only a few.

1. *Implying that there is obviously only one explanation for the client's situation:* I assume that it is my responsibility to inform clients about the diversity of assumptions among professionals in our field, and to be clear that my way of working is based upon premises that are not uniformly shared (Atkinson, 1992). Unless I am clear about this, I believe my influence may be based on deception, and will be potentially abusive.

2. *Failure to own my observations:* I assume it is my responsibility to be clear that my observations are primarily information about my myself. If I imply that my observations say more about my clients than about me, I assume that I am abusing my position of influence.

3. *Pathologizing clients who disagree:* If I imply that those who disagree with my assumptions are "resistant," "in denial," and so forth, I assume that I am abusing my position of influence.

4. *Facilitating dependency:* If I mislead clients about what I am experiencing in order to make them feel better or more trusting of me, then I assume I am abusing my position of influence. In such situations, my influence is based on deception rather than authenticity. I think I have done this in many ways. At times I have acted as if I were interested in what my clients were saying when I was not. I have refrained from telling clients my honest reactions to them and instead told them things that I thought they could handle. I told myself that my deception was for *their* good, but I suspect that there was another reason—I did it to maintain my credibility (and, thus, my influence). I thought that if I were honest about my experience of them, they might not feel as safe with me, and they might *protect* themselves and be less willing to be vulnerable in therapy. I didn't think of it this way at the time, but now I see this as abuse of hierarchy. It was dishonest, patronizing, and facilitated de-

pendency based on a false experience with me. It helped create an artificial sense of security that led clients to be more dependent and vulnerable. As my clients came to count on me to put their comfort above my honesty, their dependency on me increased, making it more difficult for them to be willing to upset me by finding their own voices.

I assume that the appropriateness of my influence is closely related to the degree of congruence between my conscious posture and my more basic emotional reactions.

I believe that communication occurs at both rational and nonrational levels, and that the human brain generally gives priority to nonrational processing. Therefore, if what I say verbally (for example, "It's okay for you to disagree with me") is incongruent with the nonverbal message ("I will be upset with you if you disagree with me"), my clients will believe the latter. For this reason, I assume that my statements must come congruently from my words, actions, and emotional responses. I cannot convince clients that it's okay for them to disagree with me *unless it really is okay with me*—not just at an intellectual level, but also at an emotional level. If I consciously encourage clients to develop their own voices, but my anxiety goes up each time their views diverge from mine, my clients will continue to feel vulnerable and at risk. Thus, I believe that my conscious intention to be noncontrolling in therapy, while important, is not enough (Atkinson, 1992; Atkinson & Heath, 1990a, b). My conscious efforts must be congruent with my basic emotional reactions.

I assume that my influence is most appropriate when I focus on clarifying my own process while encouraging clients to focus on clarifying theirs.

In past years, I have attempted to be less hierarchical by trying to decentralize my voice in therapy. Rather than telling clients what I thought, I tried to help them discover what *they* thought; rather than telling them what I felt, I tried to help clients discover what *they* felt. In effect, I tried to lower the importance of my opinions and raise the significance clients attributed to their own opinions. Ultimately, however, in spite of my best intentions, I don't think I really succeeded in decentralizing my voice in therapy. When I lowered my voice, clients simply turned up the volume. When I tried to keep the focus off of myself, I felt that my influence "leaked," and I came to feel that covert or unrecognized influence was potentially more inappropriate than direct, honest discussion about my values, beliefs, and opinions.

Further, I sensed that the more I became involved in helping clients sort out their lives, the more they seemed to count on me to do this. I began to feel as if I were critical to their therapeutic process and progress. I sensed that I was meddling where I didn't belong.

I don't think that my clients need my help in figuring out their lives. They can do this for themselves. In the past, by helping clients discover what they believe, I think I have treated them as fragile and helpless. I have patronized them and implicitly encouraged them to believe that they needed a good listener like me.

Those who have been most helpful to me in my life are not people who tried to tell me what I should do, nor are they those who have tried to help me find my path. Rather, they are those who have been willing to give me their honest reactions, allow me to see how they make sense of life, and who believed in my ability to choose my own path.

I have found the same model to be useful for the therapeutic relationship. I feel most respectful when I refrain from being an

expert on others and instead focus on being clear about my own opinions, beliefs, values, expectations, and reactions in therapy. I feel most appropriate when I refrain from telling people what they should do, avoid trying to help them discover what they should do, and instead tell them directly what I think, feel, and believe, always encouraging them to follow their own voice—not mine. I have found that the more clear and direct my voice is in therapy, the more clarity and autonomy I hear in my clients' voices as well.

CONCLUSION

As long as I can remember, I have sensed that the differing levels of risk that my clients and I often experience in the therapeutic relationship puts me in a position of artificially elevated influence. What has changed over the years is how I have tried to deal with this situation. I have moved from the assumption that I should try to minimize my influence to the assumption that the extent of my influence often depends on factors I cannot control. My ideas about what it means to be respectful have changed. Previously, I thought that respect meant keeping the focus off myself, facilitating the unfolding of my clients' process. Now I think that respect means refraining from meddling in my clients' process. I feel most respectful when I encourage clients to work on their own process (rather than *help* them), while I maintain a focus on clarifying my own process. I have found that the more I get clear, honest, and direct about my own process (my thoughts, feelings, reactions, beliefs, values, assumptions), the more my clients are able to clarify their own process.

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