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How might power and conflict have a place in Psychotherapy? You can use clinical examples to illustrate your points.

Introduction

The perception of the role of power and conflict in psychotherapy has evolved greatly in the last few *decades,* and will likely continue to do so. The Oxford English dictionary defines power as the *"ability to act or affect something strongly"*[1] or *"control or authority over others"*[1] and conflict as *"the clashing or variance of opposed principles, statements, arguments"*[2]. These are very broad terms, so I have chosen to focus on a few specific aspects of their role in psychotherapy, informed by my own clinical experiences. As a medical student, I have mostly seen people when they attend hospital and are experiencing extreme distress, often due mental health problems contributed to by abusive power dynamics and extreme conflict within their families. Similarly, during my neuroscience placements I have met many patients in whom internal conflicts had led them to develop functional disorders that were very disabling, in whom we were proposing psychotherapies as a means to reduce their internal conflict and thus their symptoms. These experiences led me to develop quite a negative view of power and conflict, seeing them as enemies which cause deteriorations in people's mental and physical health, that we can target through psychotherapies to reduce the distress they cause and help improve people's quality of life. However, due to my interest in psychiatry and psychotherapy, I have also tried to gain more diverse experiences in mental health outside of the hospital environment, in which, I am aware there is a bias towards seeing things at their most extreme. Seeing mental health and psychotherapies in different contexts led me to reflect on the views I had formed through my clinical attachments, and begin to see power and conflict through a different lens, one in which power and conflict each exist on a spectrum and can become our allies in helping people grow and heal from trauma and improve mental wellbeing. For example, when talking to patients on inpatient psychiatric wards, I heard many accounts of how harmful conflicts in their early life, often in the form of abuse from figures of power such as parents, had contributed to the development and perpetuation of their mental health conditions and complex emotional needs. Consequently, when I attended a therapeutic community for individuals with personality disorders, I had expected conflict and power to be viewed as the enemy. However, I was surprised to see how within the therapeutic community power and conflict were not avoided, but rather the psychotherapies offered emphasised the importance of a flattened hierarchy and encouragement of 'healthy' conflict within the group to help

individuals confront some deep rooted emotional issues and develop skills to cope with their past traumas and ultimately to live happier lives. Additionally, by gaining experiences in mental health and psychotherapy outside of the hospital environment, and speaking with therapists from a variety of different backgrounds at conferences and a professional open afternoon, I began to reflect upon the nature of the power dynamic that exists between doctors and patients, therapists and clients, and start to consider how this might impact the effectiveness of psychotherapies. In this essay, I will go through each of the ideas mentioned above and try to provide an integrated discussion including key areas of the relevant literature and reflections on my own clinical experiences, in order to try to address a few of the most important roles of power and conflict in psychotherapy.

Power and conflict within families and family psychotherapy

As touched on above, when people present to hospital due to mental health issues it is often when their mental health has deteriorated so much that they have reached a crisis point and there will often be a threat to the individual's physical health requiring needing immediate physical interventions (such as electrolyte monitoring and replacement in severe anorexia nervosa, or intubation and ICU in deliberate overdose). Then, once patients are physically stabilised, typically the liaison psychiatry team is called and the patient's mental health becomes the focus. As a medical student, I have observed and even conducted many of these psychiatric assessments. It would be a lie to pretend some of the stories these patients tell you is anything other than heart-breaking, as they recount their early life experiences that are often full of abuse and mistreatment by other family members and partners. But it can be challenging to know how best to help these individuals when they have reached such a low point.

Talking with patients who have come through the other side of these experiences and reached a place of relative stability, it seems that one of the most effective ways we can help improve their mental health when it has been negatively affected by harmful family dynamics, is via family psychotherapy. These individual accounts are also supported by evidence, for example, one study showed structural-strategic family therapy reduced the amount of internalising and externalising problems that adolescents with mental health problems experienced, as well as improving family cohesion and increasing healthier parental practices[3]. This study specifically focussed on structural-strategic family therapy, but there are also many other forms of relational therapy that may help.

In addition to the more obvious role of power and conflict in the development of the mental health problems that people come to family psychotherapy seeking help for, one approach to considering the role of power and conflict within the relational therapies themselves (of which there are many forms) would be to try and formulate a set of principles underlying all relational therapies and then consider the role of power and therapy within those common principles. This overarching approach seems especially valuable given that the majority of therapists use an integrative approach combining many therapeutic techniques[4]. There have been many attempts to formulate a set of principles underlying all relational therapies, with one influential example being Bowen's Family Systems Theory[5]. Within this model, it is

proposed that much of the anxiety that occurs within families is the result of perceived excessive closeness or distance within relationships, and therefore family psychotherapy can reduce this anxiety by encouraging awareness of emotions and 'differentiation of self', such that the individual can be empowered to make self-directed choices whilst still maintaining an emotional connection with family members[6]. Therefore, within this framework a key role of conflict in family psychotherapy would be in encouraging individuals to make self-directed choices without excessive anxiety about the conflicts these may cause, and by helping individuals to still maintain an emotional connection despite these conflicts.

The role of power within family psychotherapy has been subject to a lot of debate, likely due to the very nature of the power itself. Within many societies there is a perception of a classical power dynamic, in which parents have power over their children and can utilise this to protect children and help them develop as individuals. However, real life is infinitely more complex than this simple static one-way system, and this power balance can become disrupted, resulting in chaotic relationships, conflict within families and even the potential for abuse, sometimes contributing to the crises I discussed above. It might therefore seem obvious that family therapy should seek to explore the power dynamics that exist within a family, with an aim to restore a more harmonious distribution of power. However, Bateson argued for an alternative viewpoint, one in which an individual cannot hold unilateral power over another and that it can be toxic to view the world through the lens of power, thus encouraging a censorship of power in family therapy[7,8]. Many issues around this have been raised, especially by therapists working in areas of child abuse and domestic violence, in which the dangerous effects of power are difficult to ignore. Furthermore, in addition to debates around whether power should be censored or explored within relational therapies, there are also debates around how therapists should respond in cases of abusive power dynamics, with proponents such as Willback and McGregor arguing against the more classic neutral stance that a therapist might hold and instead arguing that this neutrality can be damaging by reinforcing the tendencies of abusers to deny and rationalise their actions and those experiencing the abuse to blame themselves[8,9,10]. Personally, based on my clinical experiences with children and women who have suffered physical and sexual abuse and continue to experience mental health difficulties as a result, I am forced to agree with the latter viewpoint, in which the role of power in relational psychotherapies is as a force to be openly explored in psychotherapies and if necessary redistributed to ensure the safety of all family members. But it should also be noted that the toxic power dynamic can exist between any members of a family, as although the abuse experienced by children from their parents and women from their partners is more common, I have also witnessed a lot of psychological harm resulting from abuse between siblings or from children to their parents.

The interplay between conflict, power and psychotherapy in the context of functional neurological disorders

Functional neurological disorders (FND), previously called conversion disorder, can present with a wide array of symptoms including weakness/paralysis, blindness, seizures and loss of

sensation, but often do not respond to medical treatments. Because of the lack of medical treatment options, many individuals experience persistent disability, with 82% of adults with FND stopping work as a result of their symptoms[11].

I have mostly encountered FND patients in inpatient settings on neurology wards, when they were often very distressed and frustrated by the futility of many medical interventions at improving their symptoms, and the stigmatising way in which these conditions can be presented by some medical professionals. I remember one patient in particular who presented to A&E and was very concerned as he had suddenly become unable to move his legs. I followed his case over the next few days, seeing a variety of alarming diagnoses with poor prognoses being added to the differentials, but as the investigations returned they were eventually all ruled out and the patient was diagnosed with FND. As is the case for many people with functional disorders, this diagnosis was not well communicated with the patient, and he felt he still did not understand what was causing his symptoms even at the point of discharge. At the time I was at a relatively early stage of my training, so I also did not fully understand the diagnosis and so decided to research the disease further with some colleagues, in order to present it at our Grand Round.

I learnt that FND was originally described by Freud as the result of psychological conflicts which were converted into physical symptoms[11]. Many other theories have been proposed in the meantime, but a psychological component is still thought to be prominent[12,13]. Viewing it through this psychological lens, it is unsurprising that most medical investigations yield no positive results and medical interventions are unsuccessful. Having mostly seen these patients when they are in hospital feeling hopeless due to the futility of many medical interventions at improving their symptoms, it was wonderful to attend a conference at which Dr Niels Detert (neuropsychologist) highlighted some promising research papers showing the effectiveness of mindfulness based therapies for improving symptoms in these patients[14,15]. When we reflect on the postulated psychological origins of FND, it is unsurprising that psychotherapies, which can help us to better manage conflicts, might help improve FND symptoms by reducing these internal conflicts. This is not to say that conflict is always the adversary in FND and should be avoided at all costs, but rather that by exploring conflict and relearning strategies of conflict resolution through psychotherapy we are able to better manage conflict and reduce the mental and physical symptoms that might result (as in the case of FND). This idea that conflict resolution strategies may mediate the effectiveness of psychotherapies in FND gains some further support from studies which show that mindfulness (shown to be effective in FND) is associated with particular conflict resolution styles[16].

Power and conflict within therapeutic communities

As discussed earlier, extremes of conflict and power, especially in early life, can be harmful to an individual's wellbeing and result in the development of a variety of mental health conditions. Personality disorders (PD) are no exception, there have been many studies looking at the role of early life conflict in the development of PD, with one study showing children who experienced verbal abuse from mother’s during childhood were three times as likely to develop PD[17], and the association with trauma is so strong there is even an ongoing debate on whether EUPD/BPD should be considered a part of a PTSD spectrum[18]. It is

essential that we develop a good understanding and effective therapies for these individuals with PD both from an altruistic perspective to improve their quality of life, but also financially, as due to the nature of the condition they are associated with high resource use and the cost of care is estimated to reach £12.3 billion by 2026[19].

Earlier I discussed the negative view of power and conflict that I developed when seeing people with mental health problems, with histories of abuse, present to hospitals in crisis, a lot of these patients had EUPD. But here I would like to highlight how, after attending a therapeutic community (TC), in which the majority of patients (hereafter referred to as Members, in keeping with TC principles) met the criteria for EUPD and a few also showed traits of avoidant PD and OCPD, completely changed my outlook on the role of power and conflict in psychotherapy, morphing them from enemies to overcome to potential allies in the therapeutic process.

Even before I arrived at the TC, there were signs that the power dynamic would be different to the one I was used to in the hospital, namely that my application to observe the TC was reviewed by Members rather than just staff and I was told to wear casual clothes with no lanyard, and that I would be greeted at the start of the day by 2 Members who would be in charge of hosting me. This flattened power hierarchy is a reflection of democratisation and communalism, 2 of the important principles that all TCs are founded upon[20]. When I arrived at the TC the altered power dynamic was very striking, my host greeted me and showed me around the building, they talked me through the structure of the day and provided refreshments. Moreover, when group psychotherapy began, I was aware there would be staff members present, but as they were also in casual clothing and had no name badges or lanyards etc., I could not distinguish for at least the first hour or so who was a Member and who was staff, as everyone present was given equal time to speak and everyone offered advice when people started to talk about the difficulties they were experiencing. As the day continued, I was eventually able to identify staff as they were the only individuals whose advice did not include reflections on their own experiences of the difficulties associated with PD, whereas most Members reflected upon their experiences and what had worked for them when supporting other Members. But otherwise much of the advice offered was very similar, and Members and staff were truly acting as ‘co-therapists’.

Holding this essay question in mind, I spent time with a variety of Members and asked them their views on the power dynamic within the TC. One Member of the TC shared some really valuable insight into the patient perspective of the implications of power dynamics in psychotherapy and mental health care. This Member met the criteria for EUPD, had experienced childhood and sexual abuse and multiple crises, and, as a consequence, had lots of experience of mental health services. She explained explained how, in her experience, when presenting acutely in crisis, the considerable power imbalance between patients and clinicians meant she was told what she should be doing, which she contrasted to her experience of the TC, in which she felt the flattened hierarchy encouraged to set her own goals and reflect on what mattered to her, which resulted in her being far more engaged with psychotherapy and motivated to achieve her goals as they reflected her own values and outcomes that felt meaningful to her. This was a really powerful insight into the value of resetting the power dynamic in psychotherapy, which I hope to be able to apply in my career going forward.

I spoke with many of the Members individually to ask about the different psychotherapies they had tried and what they felt had been the strengths/weaknesses of these approaches for them. Between them they had extensive experience of psychotherapies including one-to-one approaches and group therapies, using a variety of therapeutic modalities such CBT, DBT and counselling. One Member explained how she previously enjoyed that in individual psychotherapy you were able to choose what issues you talked about in your therapy session and the session would entirely focus on *your* problems, and was therefore hesitant about starting TC due to its group nature and concerns about voicing her own difficulties in front of lots of people. However, she then went on to explain that since joining TC her views had shifted, as she now felt a key strength of group therapy was that by hearing other Members share issues that you might also have experienced but that you would not have chosen to bring to therapy, you are forced to confront more uncomfortable emotions and behaviours you might otherwise suppress, thus bring about positive change.

Many members of the TC also felt that group therapy had helped them to build connections and a sense of camaraderie based on shared problems, and I was able to observe that by acting as 'co-therapists' for the other members it improved their own sense self-worth and skills such as empathy, communication and ability to mentalise. I share in the belief held by many of the Members and staff, that this unique therapeutic benefit is only possible due to the democratisation and flattened hierarchy in TCs, which helps members feel empowered to help themselves and others. It also allowed them to share helpful techniques such as strategies for managing anxiety and addictions. Members also shared excitement about the potential to engage in local programmes that allowed them to share their experiences with professionals to aid their training and to evaluate other TCs (such as TCs in prisons and for young people). One Member reflected upon why she wished to evaluate other TCs, "I want to see the kids and the prisons, to understand how people go from one to the other", this enthusiasm shows how programmes such as this can empower individuals to learn more about how mental health problems can develop and affect people, whilst also improving their sense of self worth and own mental health.

When I attended the Members were all helping to support each other quite harmoniously, and I was able to see democratisation at its best, observing Members divide the jobs for the next meeting amongst themselves including cooking, shopping and cleaning and supporting each other in group therapies. This was an important learning curve for me, as based on my experience in inpatient settings and A&E seeing PD patients in crisis, I had thought there would be more tension and arguments. I shared this point of personal learning with the group and reflected upon how pleasant my time there had been, which led to some very interesting ideas being shared by Members and Staff. They explained to me that although there had not been many arguments when I was there, arguments amongst the group should not be avoided and they were actually viewed as an important therapeutic tool, as due to their previous experiences of trauma many of them were very avoidant of conflict, but by experiencing conflict in the safe environment of the TC, they were able to re-learn how to express their discomfort to others to bring about positive change, and reduce some of their fears around conflict. Staff also highlighted the importance of staff not intervening in conflicts between Members unless absolutely necessary, so that Members could learn/practice conflict resolution skills. The Members linked this to the idea discussed above, wherein the group environment may force them to share experiences they find uncomfortable to discuss and therefore cause some conflict within the group, but that this ultimately helps them

confront important issues they may otherwise try to avoid and thus enhances their healing process. In this way conflict has a unique potential in group psychotherapy to allow individuals to access deeper issues they may otherwise avoid. For example, during psychodrama psychotherapy one Member explored some issues around housework at home that were troubling her at present, this resonated with another Member who was experiencing a similar situation but had not brought this to the group and made her distressed. A few days after the psychodrama, the second Member discussed with us how uncomfortable she had found the psychodrama as it resonated so much with an issue she had been trying to avoid in her own life, but that this uncomfortable experience ultimately motivated her to stop avoiding the issue at home and face the inevitable conflict with her family in order to resolve the issue.

Overall, the use of a flattened hierarchy in which Members are considered 'co-therapists' and encouraged to help each other with their problems and work through conflicts together under the watchful eye of staff, reminded me of a family dynamic. In this way the Members act like siblings, undergoing conflicts together but ultimately forming a valuable support network in which they can voice their opinions and grow as individuals, improving both their mental health and social functioning[21]. This was also reflected in some of the terms used by the group, such as referring to Members as being younger/older based on the amount of time they had spent in the TC rather than biological age, as this influenced the group dynamics and the proportion of time they would spend helping others with their problems vs receiving help with their own. In this way, conflict and flattened power dynamics are important tools that enables psychotherapies used by the TC to foster skills that many of us develop in our early years in supportive families, an opportunity many people with PD are robbed of due to their adverse early life experiences and family trauma, reflected by studies showing a strong association between EUPD and maladaptive parenting[22].

Conflict and power within the therapeutic alliance

I have mentioned several times in my essay my experiences of how power dynamics between doctors and patients, therapists and clients, seemed to influence mental health outcomes for the individuals involved. But here I am going to consider the role of this power dynamic on the therapeutic alliance in a more detailed way and discuss some of the literature in this area.

Due to the nature of psychotherapy there is an inherent power imbalance between the therapist and client (the client places their trust and confidence in the therapist to help them with their problems). This imbalance is often further enhanced by societal power dynamics such as when the patient is a member of a discriminated-against group and the therapist is not, for example when gender, racial, class, economic and sexual orientation differ between the therapist and client. When we fail to acknowledge this power dynamic, it can blind us to the contribution of the societal power dynamics to psychological distress, potentially leading to over-evaluation of the contribution of personal issues alone and devaluation of the client's experiences, thus contributing to alienation of the client and impairing the therapeutic process[23].

Focussing on the example of the influence of gender related power dynamics on the therapeutic alliance, a study of 600 adolescent substance users found that gender matching of the therapist and client resulted in higher alliances and patients were more likely to complete treatment[24], indicating that by reducing the power imbalance conferred by gender in the therapeutic alliance we can improve retention and potentially outcomes. However, the evidence for the importance of matching gender of therapist and client in adults is less clear[25], with one recent study of 122 clients receiving psychotherapy in Germany showing that although female to female relationships have better outcomes in terms of symptom reduction and quality of life, this effect varied by therapeutic modality and was present in psychodynamic therapy but less convincing in CBT. This might reflect the greater importance of the interpersonal relationship in non-CBT therapeutic modalities vs CBT[26]. Having learnt about hypnosis and psychedelic therapies at a conference, it strikes me that due to the even steeper power balance in these modalities (heightened by the fact that the client has to enter a very vulnerable state in order to receive the benefits of these therapies), the importance of reducing other influences on the power balance may be even more important. This idea of cumulative influences on a power dynamic could also account for the relatively stronger evidence for an effect of gender matching in adolescents vs adults, as it might be that when age differences are already imposing a significant power imbalance, a gender difference can push it over the edge such that it affects therapeutic outcomes.

In summary, within psychotherapies the therapist holds power over the client, although this varies somewhat by therapeutic modality. Sometimes this imbalance can be enhanced further by societal factors and based on a combination of reading the literature in this area and talking with patients about the impact these power dynamics have had on their experiences, I believe more work needs to be done to see whether educating therapists further on the impact of these dynamics, or matching therapists and clients more closely, can help to improve mental health outcomes for people who undergo psychotherapy.

Conclusion

To conclude, from seeing people in A&E experiencing mental health crises and talking to people in considerable distress due to FND, I began to view power and conflict as adversaries that could be overcome through psychotherapy. But, having gained more experience of psychotherapy outside of the hospital environment, I now believe that power and conflict each exist on a spectrum, in which both abusive power dynamics and extreme conflicts can be harmful to mental health and thus reduced by psychotherapies, but that psychotherapies can also use power dynamics and conflicts as a tool for accessing emotional issues and improving mental wellbeing, and that by further studying the nature of the power dynamics and conflicts that are present in psychotherapy, we can ultimately improve their effectiveness.

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