

Clients enter treatment for a variety of reasons, with one common goal: to effect some sort of change in their lives, typically to “grow.” While they may aim for growth, however, they will inevitably resist it operationally, attempting to comfort themselves along the way (both in and out of sessions). A non-therapy specific factor, this growth-comfort balancing is something both they and their therapists need to manage, even if implicitly. Conflicts around meaning are particularly likely to flourish in this domain, around what is an acceptable level of comfort and what can be considered comfort. The potential for *theoretical abuse*, a therapist’s imposing his or her views and/or failing to explore the client’s thus arises.

Accordingly, I will proceed by beginning with a general discussion of growth-comfort balancing, providing both examples and venues in which it is most evident. Then I discuss the notion of theoretical abuse in some detail and conclude with psychological consequences for the client.

### **GROWTH COMFORT BALANCING**

Although individuals enter treatment to effect a change in their lives, whether this might mean creating a new self-definition, learning to master anxiety-producing situations, or gaining a greater capacity for openness, they must also integrate the breakthroughs, the new choices and types of awareness, and the transitions in experience. In addition, as therapy unfolds, they and their therapists must inevitably perceive sessions not only as a forum for renegotiating seemingly intractable behaviors, assumptions, and feelings, but also as an ongoing activity, with a sense of continuity, regularity, and order. And since attempting to and successfully unearthing tacit assumptions or trying out new behaviors is unsettling, clients typically demonstrate some ambivalence toward self-confrontation, even when they understand the necessity of so doing. Accordingly, the therapist must chart a course that directs treatment forward, through the rough spots, and yet allows clients to maintain some sense of control over and comfort with this process.

In general, therapists try to distinguish between the tendency for clients to run from and avoid self-confrontation as a non-productive, automatic avoidance behavior (out of the natural ambivalence of dealing with disquieting issues), and the legitimate need for clients to regroup, consolidate, or gather resources before moving on to the next issue. In the one case, clients use comfort to simply avoid the necessary therapeutic work, while in the other, the use comfort to put themselves in a better position to do that work.

Such sensitivity to client state and appropriate meaning-making is non-trivial: for example, some therapists tend to lump all client signals to pull back as signs of resistance or as indicating a lack of therapeutic impact. NLP founders Bandler and Grinder point out, what therapists term resistance might only reflect their failure to produce an effective intervention/. Other therapists look for any opportunity to nurture clients, running the risk of colluding with them in avoiding change behaviors.

When clients bring forward material to a session that reveals issues they need to address at some point, therapists can engage them in self-confrontation in a variety of ways, depending on their background. Rogerians will reflect back as a way of moving clients to

greater awareness of and responsibility for their feelings. Psychoanalysts will listen in a neutrally empathic manner, encouraging clients to freely associate. Gestalt therapists may give directives and behaviorists may provide strategies for real-life encounters. Ericksonian therapists will hypnotize clients or rely on paradoxical intention. General counselors will attempt to engage clients in a dialogue where they reflect together on the meaning of these concerns.

In certain instances, therapists will deem it appropriate to refrain from a direct confrontation with sensitive issues. Instead, they may provide information, support, or reassurance: they may share an incident from their own lives pertinent to the situation; or they may direct clients away from the pain, asking them to do something that provides comfort. In such cases, they effectively provide resources *before* attempting to engage in therapeutic work.

In these cases, therapists are managing the growth-comfort balance by not routinely pushing for growth. Often, however, their response tends to be something like: “We need to address this issue; this is what you’re here for” – even when couched in very diplomatic terms. A tension between therapist and client inevitably results when the therapist automatically invokes this “go for growth now” position: the client often goes along, even when sensing a need for comfort/additional resources; or the client may openly disagree. Meaning-making conflicts result when what is construed by one party as necessary comfort is not so construed by the other.

#### *Venues for Meaning-Making Conflict around Growth-Comfort Balancing*

Therapists deal with the tension between client growth and comfort in a variety of contexts. Three venues that serve as the source of potentially significant meaning-making conflict are: client non-routine requests, client acute discomfort, and client conflict with therapists. In all these venues, therapist interventions may be designed to directly engage the client in therapeutic work or they may be designed to increase the client’s comfort level. In one instance, the therapist judges the client’s readiness and context to be sufficient for self-confrontation, while in the other, the therapist judges the client’s current state to be insufficient. In the latter case, the therapist gives something to the client, some form of “comfort,” to move him or her into a position of adequate readiness.

A typical meaning-making conflict arises when a therapist judges the client to be ready to move forward and the client feels it necessary to garner more support. This may be termed the *default conflict*. The question we want to consider is how the initial discord is dealt with: in particular, is there a knowledge producing (for both sides) dialogue or is there a struggle, in which each party holds to his or her original position with one ultimately prevailing? To examine this in greater detail, let us focus on the three venues highlighted here for such potential conflict.

#### Client Requests

Periodically, clients make extraordinary requests of their therapists; in particular, they may express concerns about and ask for changes in the conditions of treatment.

Therapists can then regard these concerns as symbolic or as real: that is, they can respond by probing for a latent meaning or they can take action, granting them or rejecting them. In the first instance, they use the request to focus the client inward and to engage in therapeutic work; in the second, they grant the request, if appropriate, as a way of increasing the client's comfort level.

For example, a client asked her therapist to meet with her on the grounds of a psychiatric clinic rather than in her office. She was so stigmatized by merely being in therapy that she found it intolerable and stifling to walk into the waiting room of the clinic. Obviously, the client had issues she needed to confront, but in this instance, the therapist deemed it more helpful to defer the self-confrontation and simply grant the request. Ultimately, the client was able to take a look at her needs and fears of being seen as a "sick person," working through the issue of being a "problem child" in a family with two alcoholic parents.

With hindsight, it is easy to comment that had the therapist insisted on standard protocol and tried to impose her meaning-making on the client ("you're avoiding dealing with this"; "this is part of your contract with the clinic"; "I sympathize, but I'm not permitted (nor do I choose) to meet you outside"), a conflict could either have escalated or ended with a poor outcome (client leaves therapy; client stays, but is so tense that issues cannot be addressed; client stays, but loses trust for the therapist). It is easy to imagine the therapist handling this as a routine matter with routine responses, rather than using it as an opportunity to develop a meaningful dialogue, with new ways of addressing the issues.

### Client Acute Pain

When present circumstances put the client in severe emotional distress, therapists must decide whether to capitalize on the situation as an opportunity to work through deeply troubling issues or to view the situation as too incendiary and overwhelming to deal with in its present form. Again, in the first instance, they seek to engage the client in therapeutic work, while in the second, they raise the comfort level, hopefully to enhance such work at a later time.

Steve Lankton a therapist who practices neurolinguistic programming, tells of a client who called him in a hysterical state, stating that she had been raped. Lankton gave her various directives that allowed her to calm down and feel more centered. Later, she was able to explore some of her feelings and explain the nuances of the event. The specific techniques involved rerouting her subjective experience from a primarily kinesthetic frame to a visual one: her feelings had been initially so overwhelming that she needed to back off and see what had happened.

Whereas the directives given here could easily be construed as part of the therapeutic work, the point we make is that the therapist took the position that the client needed something from him in the form of support and a different perspective on what had happened. In this case, the client's tacit meaning-making was that "this is all too much for me to handle." The therapist responded by agreeing with that, but in effect adding, "yet it's not too much for you to see."

### Client-Therapist Conflicts

When conflicts arise in treatment, therapists can always direct clients to examine their feelings, behaviors, and demands (“what does this mean to you?”) regardless of whether there is any present basis to them. Ultimately, of course, clients must learn to take responsibility for their participation in such conflicts even if they feel fully justified – if, for example, therapists have made errors. However, in some instances, it would help for therapists to provide some operating comfort in the form of acknowledging their own issues and sharing some of the responsibility for any interactional difficulty.

For example, a psychologist precipitously referred a client to a psychiatrist for medication, e.g., an anti-depressant, at a point when the client had just begun to experience deep feelings of sadness. The client interpreted this shift in his therapist’s approach as a sign of abandonment and at the same time became very angry with him, stating that “he ripped off my feelings just when I/we was/were really getting somewhere.” The psychologist stood firm for a while, but eventually prevented a rupture in the relationship by acknowledging his own issues instead of simply pressing the client to examine his reaction to the idea of medication. In fact, the client had strong feelings about being seen as depressed since his own mother had been hospitalized several times for such episodes. But it required the psychologist’s accepting and communicating having misjudged the situation and owning up to being somewhat overwhelmed by the client’s sadness before the client made the connection to his mother’s illness.

### **THEORETICAL ABUSE**

Basseches’ conception of theoretical abuse focuses on conflicts between meaning-making schemes – how therapists and clients interpret, evaluate, and explain various events which occur within therapeutic dialogue. On the one hand, such conflicts are seen as representing developmental opportunities for the client as well as the therapist. Yet these conflicts may also be threatening to the therapist, insofar as they imply challenges or limitations to the adequacy of his or her meaning-making. When the therapist removes both the threat and the possibility of new knowledge by curtailing the full expression or exploration of conflicts, this serves to protect him or her from challenge at the expense of limiting the value of the relationship to the client. This constitutes *theoretical abuse*.

For example, as indicated earlier, any request for more assistance or for a different kind of interaction with the therapist can always be framed as reflective of the client’s psychopathology, as a default attribution.

(The argument, “you’re avoiding by asking me for X/by focusing on Y” vs. “I need X/to focus on Y to move forward toward my issues” is inherently open-ended. In any given situation, with any client and any therapist, either side could be “right.” In fact, there is no “right” without considering the context of their relationship, the client’s history in and out of treatment, and the client’s state at that moment – as well as the therapist’s. The true resolution lies in the dialogic process between therapist and client. This is why theoretical abuse is said to occur when that process is short-circuited: to avoid abuse, the therapist must structure the conversation so that it goes in unexpected places, producing a

continuing set of experiments and refinements to meaning-making for both therapist and client.)

Theoretical abuse can be passive or active. It is passive when it involves failure to acknowledge expressions of clients' experience which pose challenges to the therapist's understanding. It is active when a therapist forcefully advocates different meaning-making schemes from the client's, ostensibly for his or her benefit without attempting to synthesize such schemes with the client's own meaning-making. For example, if a client expresses the thought that more frequent meetings would be helpful, a therapist ignoring or dismissing it (or even empathizing without ever intending to act on it) would represent passive abuse.

Theoretical abuse takes place in its active form when the therapist tries to impose his or her own view, e.g., "you're avoiding," particularly when it is an automatic pattern of response. That is, disagreeing and even forcefully advocating for a point of view does not necessarily represent theoretical abuse; it is rather when such advocacy is a knee jerk reaction, grounded in the therapist's own avoidance (having his or her perspective threatened), that we can call the advocacy abusive.

### **Client vulnerability to continued theoretical abuse: Outcomes**

Clients fail to progress in treatment for a variety of reasons. Some are truly unable to commit to a full engagement with their issues, no matter how much support and direction they receive from a caring and trusted therapist. But theoretical abuse undermines the treatment of many others. When theoretical abuse takes place, the results are typically poor because clients are unable to fully explore the "error" of their ways – for example, in working through maladaptive meaning-making schemes, originating in unresolved childhood conflicts. The therapist might have his or her own meaning-making needs regarding clients' emotional distress, and may act out by imposing these views on them, e.g. through premature direction and interpretation. This would constitute theoretical abuse and triggered by substantive issues.

Far more often, theoretical abuse derives from the process of treatment. And the issue of growth-comfort balancing has high potential to induce it. Clients naturally balk, at least temporarily, when they near a confrontation with their childhood based emotional distress. Should they need/ask for additional support/resources, especially as they begin to deal with core issues, some therapists automatically assume that such clients are avoiding the necessary self-confrontation, i.e. resisting. By so doing, they are acting out their own interpretation of this client behavior and at high risk to commit theoretical abuse.

Revisiting the three venues most relevant to growth-comfort balancing, (1) client non-routine request, (2) client acute need, and (3) client conflict with therapist, all have high potential to threaten therapists. They represent challenges to the rules therapists use, the feelings therapists have, and the interpersonal distance between therapist and client. The construct of growth-comfort balancing represents a significant challenge to both parties' meaning-making.

### *Continued abuse*

In general, a vicious cycle ensues: therapists who have (often unwittingly) been theoretically abusive contribute to client failure to progress; this failure to progress constitutes further threat to the therapist, resulting in an increased tendency to impose meaning-making on clients, hence to be theoretically abusive all over again. This is particularly evident when the issue is growth-comfort balancing – in that case, a therapist stuck in the default position creates a self-fulfilling prophecy. Even when clients agree with the therapist, should they need comfort in the form of resources or support and not receive it, their progress will be slowed, inducing the therapist to push harder, leading to continued treatment failure. When clients do contest the therapist's position, they have a better chance at getting what they need, as some earlier examples demonstrated. But few will be able to maintain their position.

First, clients have no reason to attribute any “impure” motives to therapists who inadvertently commit this kind of abuse. Most clients enter treatment with a relatively high trust level for the therapist and little trust for themselves. They certainly do not have a way of conceptualizing the truncation of their meaning-making process; and if they do sense that it is not getting a full review, would not necessarily impugn the therapist. In fact, the therapist can explain away the lack of client progress as (1) part of the treatment terrain and if it continues to (2) an imperfect process of which she or he is a casualty within statistically acceptable limits. That is, the therapist has self-sealing rationales and these may continue to operate at the client's expense.

Second, protecting the therapist are three features of therapist-client interactions: (1) the therapist has “mental” power over the client, in that the client tends to assume that the therapist knows more than he or she, is at a higher level of interpersonal and intrapsychic development, and even knows where the client needs to go -- more than the client does!; (2) every interactional situation is locally ambiguous in that each party, therapist and client, can attribute instrumental/political or experiential motives to the self and to the other (e.g., he/she is saying this to get me to respond; he/she is saying this because he/she really cares); and (3) clients are locally ambivalent in that at a given moment in treatment, they may prefer to move away from growth and toward comfort.

These features make clients vulnerable to self-doubt and likely to endorse therapist tacit or explicit meaning-making -- particularly when therapist feelings (which they may be acting out) and underlying beliefs (which may speak to a universalistic rather than a dialectical stage of thinking) are effectively concealed. The (hopefully rare) therapist who yells at his or her client in anger can at least be perceived as out of control and unprofessional, in part because the anger is revealed but most acting out can be smoothly carried out and can be outside the therapist's awareness as well.

### *Inherent ambiguity rationalized*

The problem is that in most instances, any therapist behaviors can be explained away -- at least locally, i.e. for a given client at a given time. Thus, even if clients sense that something may be up, e.g. the therapist is pressuring them to move forward, they are no

match for the therapist's professional demeanor and ability to provide alternative explanations (often those that put the onus of conflict squarely on the client). Client self-doubts flare quickly in the fuel of therapist self-protection. Even those who are less vulnerable may know that they do not trust their therapist, but then blame themselves for not having the capacity to trust! Clients will generally not take their interpersonal sense as a marker to move away from the therapist, but rather to despair about themselves.

In general, clients' perception of the therapist as "better than" (he/she must be right when we disagree because he/she has achieved more, knows more, and has dealt with more -- or else he/she wouldn't be in this position in the first place), leads them to defer to the therapist's interpretations. So if outcomes are deemed unsatisfactory, the fault must lie within the client, since it can't be the therapist and since the therapist has indicated that it is the client's. And if therapists conceal well, they tend to "pass on" their unacknowledged and unexperienced affect to their clients who then literally absorb it from them. This includes therapist self-doubt as well. Clients then experience an amplification of their own issues, the origins of which are invisible to them.

Overwhelmed with all of this, unable to put it in context, clients are vulnerable to learned helplessness, i.e. attributing all their failures to inherent aspects of the self and projecting continued failures into the future. They see themselves as doomed and fall into secondary affect sinking into despair. Meanwhile, those therapists invested in acting out often mistake their secondary affect for primary affect, failing to understand why progress eludes them. They may rationalize: this course of treatment takes time, this is a detour, this client is particularly troublesome, this client incorporates the therapy process into his or her neurosis, and so on.

For example, a therapist who seemed to have the capacity for appreciating these issues advised his client early on in therapy that he, the therapist, was open and confrontable. Priding himself on his clinical creativity, this therapist gave the appearance of being self-aware and at a high developmental stage. When the client took exception to certain of his behaviors and tentatively approached him, the therapist listened diligently, indicating he would reflect on the client's remarks and report back. In the next session, he came armed with clever arguments piercing the client's views, all apparently well-intentioned for the client's benefit. In effect, he had done a great job of lawyering, finding a new synthesis from his original meaning-making and the client's, but doing so in a self-indulgent manner, at the client's expense. The result was that the client felt at fault, reluctantly seeing the wisdom in the therapist's position.

When clients do have the ability to sense that there is a conflict going on for which they are not entirely responsible and the therapist holds to an initial meaning-making position, the minimum damage is a highly unpleasant experience with a significant waste of their time, money, and effort. When clients lose this ability or have never had it, the maximum damage may include suicide. In general should clients be even moderately vulnerable and prone to self-doubt, their psychological well-being will be powerfully and negatively affected by theoretical abuse from a "well-insulated" therapist.

## **CONCLUSION**

The notion of theoretical abuse is itself a provocative and loaded term. Therapists can get a preview of their internal and external tendencies by tuning in to their response to this concept as well as to some of the scenarios illustrating it. This article focused mainly on theoretical abuse in growth-comfort balancing when the client is perceived as avoiding therapeutic work by seeking out comfort. The potential also exists for therapists to collude with “avoiding clients” by not challenging them, and by accepting – rather than exploring – their meaning making. The therapist who needs to be liked can act out theoretical abuse in this manner. This provides another direction for us to pursue – and for therapists to consider.