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Power in the Counseling Relationship: The Role of Ignorance

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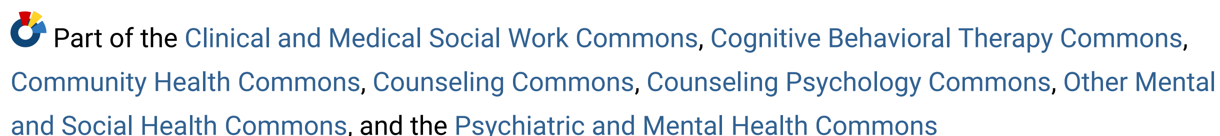
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Abstract

This article explores the role of therapist self-disclosure in clinical settings. Distinctions are made between the enmeshed concepts of privacy, secrecy, and confidentiality to elucidate the role of ignorance in maintaining the power dynamics in therapeutic relationships. While some measure of privacy is essential to counseling practice, secretive behavior (in which the counselor divulges too little about themselves) can have a negative impact on the therapeutic relationship and the client's therapeutic outcomes. There is, therefore, an under-appreciated and delicate balancing act between withholding information to protect the client and the counselor and revealing enough personal details to empower the client's recovery. While it is difficult, if not impossible, to establish hard-and-fast rules for when and what personal details counselors should disclose, understanding the negative effects of secrecy and the nature of ignorance it engenders provides counselors with the tools to identify beneficial self-disclosure and detrimental withholding.

Key words: ignorance, power, harm, confidentiality, secrecy, privacy

Power in the Counseling Relationship: The Role of Ignorance

In a counseling relationship, clients typically know very little about their therapists' lives. The therapist, on the other hand, may learn information or formulate views about their clients that remain unsaid, hidden, or otherwise unknown to those clients (Regan & Hill, 1992). Practitioners have a wide latitude in deciding how openly they want to share information about themselves or their client in therapy (Zur, 2018a). Decision about disclosing thoughts and feelings in therapy is informed, in large part, by the counselor's views about privacy, secrecy, and confidentiality (Goldstein, 1997). Additionally, power differentials between the counselor and their client can influence the therapeutic relationship. The counselor's choice to withhold or share information can have ethical implications for the client and potentially cause the client harm (Barnett, 2011). Selectively withholding information, then, is essential to therapy and is required for upholding the ethical codes and standards of the profession (Jungers & Gregoire, 2013).

In this analysis, we explore the power dynamics that characterize the counseling relationship. First, disclosure and its associated concepts will be examined. In order to sort beneficial from detrimental withholding of personal information, distinctions between privacy, secrecy, and confidentiality, unpacking the roles they play in the therapeutic context are described. Next, an overview is provided regarding how power dynamics are enacted and maintained in the counseling relationship through the creation and management of ignorance. The article concludes with a discussion that suggests ways counselors can approach self-disclosure with their clients' therapeutic outcomes in mind.

Privacy, Secrecy, and Confidentiality

There is a host of ethical and professional considerations that might influence a practitioner's judgment regarding the kinds of information that should be revealed in therapy. Issues surrounding therapeutic intimacy, boundary-setting, reciprocity, authenticity, and genuineness all factor into the decision (Pope & Keith-Spiegel, 2008). The counselor might also need to consider interpersonal variables, such as the norms of the practice setting, the individual characteristics of clients, and the counselor's own cultural identity and theoretical orientation. All of these conscious and unconscious considerations are further informed by the practitioner's attitudes toward privacy, secrecy, and confidentiality (Farber, 2006; Henretty & Levitt, 2010; Waehler & Grandy, 2016).

Privacy

There is no widespread agreement among professionals about the kinds of information that should be disclosed during therapy or how much certain disclosures might affect their clinical practice (Reamer, 2001). At the core of these considerations is the issue of privacy, which Amis (2017) defines as "a right to lack of intrusion into one's personal life" (p. 77). However, while privacy is deemed an important value in clinical practice, there is no consensus on where privacy lies on the continuum between total confidentiality at one extreme and full disclosure at the other (Petronio, 2002).

The right to privacy has been legally codified within our constitution (DeNicola, 2017) and in the HIPAA Privacy Rule, a US Federal law that requires medical practitioners to inform their clients of their rights to confidentiality and access to their records (Corey, Corey, Corey, & Callanan, 2015;Wheeler & Bertram, 2015). Clients and therapists have the same right to privacy, but they exercise that right in different ways. If a client subjects a therapist to unwanted inquiries, the therapist can enact their right to privacy by withholding information and refusing to

comment. Some counselors may deflect requests to disclose personal information by telling the client, "I'm sorry, but I have a strict policy of not answering personal questions from clients" (Waehler & Grandy, 2016, p. 280). The client, however, cannot claim their right to privacy in the same way. If the client is seen as withholding information, it may be used against them. They may be deemed uncooperative, in denial, unmotivated, resistant to change, hostile, and so forth (Silverstein, 1993).

Secrecy

Exercising the right to privacy involves a certain degree of secrecy. In some respects, therapy is the place where secrets are supposed to be shared, at least by the client to the therapist when the client trusts the therapist and feels safe, comfortable, and believes that withholding information would prevent progress (Baumann & Hill, 2016; Kelly, 1998). However, therapy is also a place where secrecy is maintained. Through informed consent, clients are notified prior to treatment that the treating staff do not intend to reveal information about the client to others (Warren & Laslett, 1977). Similarly, the counselor is not obligated to reveal personal information about themselves outside of their professional role as a counselor, nor would be considered withholding or concealing personal information that is already in the public domain (e.g., educational background, years spent with the practice). Smithson (2008) notes that "Privacy is… identified with intimacy" and privacy is then used as a means of controlling intimacy (p. 217). It limits the other's ability to pry into matters we may wish to keep secret, allowing us to remain secluded and providing us with a sense of dignity and decency (Amis, 2017).

Confidentiality

When secrets are shared in a therapeutic context, the therapist has an obligation to maintain the client's confidentiality. Confidentiality is a legal and ethical concept that formally

restricts the sharing of private information (DeNicola, 2017). Counselors are expected to know how confidentiality works and its limitations (Zur, 2018a). Violation of confidentiality is blameworthy, inexcusable, and would be considered culpable ignorance (Rescher, 2009). Clients, however, do not hold that same obligation to maintain their counselors' confidentiality. In adhering to confidentiality laws, counselors cannot divulge a client's personal information to third parties without that client's explicit permission (BrintzenhofeSzoc & Gilbert, 2017). There are, however, special or extreme circumstances in which the duty of confidentiality is trumped by the public interest. For instance, a counselor might be required to break confidentiality to report the abuse of a child or a dependent adult (Jenkins, 2005). In general, however, when counselors adopt confidentiality practices, others are kept ignorant about a client's status. The widely accepted ethical practice of confidentiality protects clients by keeping counselors from airing their clients' secrets.

Self-Disclosure

According to Smithson (2008), "Privacy involves a consensual and essentially cooperative ignorance arrangement, whereas secrecy is unilaterally imposed" (p. 221). Because clients are not formally obligated to respect their therapists' privacy, therapists may be hesitant to share more intimate statements about themselves to their clients (Warren & Laslett, 1977). This is especially the case where the disclosure involves a greater personal risk (e.g., the therapist informing the client that they have the same psychiatric disorder, as opposed to a lower risk disclosure like stating where one was born and raised) (Farber, 2006).

The proposition that therapists have a right to privacy and should not feel obliged to disclose personal information to clients has ethical implications that can possibly contribute to harm (Taleff, 2010). Further, that proposition raises the question of whether counselors can show

empathy for their clients while at the same time limiting their willingness to give up their privacy. Clients are expected to accept that they will learn very few positive or negative details about their therapist; a sense of ignorance imbuing a semblance of neutrality that can lend to clients' functional improvement (Levitt et al., 2016). To the contrary, such ignorance about the therapist may also have a negative impact on clients in their treatment.

Disclosure can be unpleasant for both the therapist and the client, and it can sometimes have negative consequences for the therapy (Pinto-Coelho et al., 2018). However, when a therapist withholds crucial information, such as feelings towards the therapeutic relationship, treatment or the client, the therapist may miss an opportunity to improve how the client perceives them, enhance treatment effects, and help the client make symptomatic change (Ziv-Beiman, Keinan, Livneh, Malone, & Shahar, 2017). This will often outweigh the possible harmful effects of self-disclosure by the therapist. Moreover, certain types of information withholding could be a violation of the counselor's professional ethics and responsibility (Proctor, 2014). For instance, if a therapist chooses not to tell their client that they have a terminal illness, the abrupt termination of the counseling relationship due to the sudden and unexpected death of the therapist can be construed as a form of clinical abandonment. Ethical breaches are, therefore, possible when counselors guard their own privacy and secrecy too closely.

The Role of Ignorance

It is common practice for therapists to maintain their clients' ignorance about certain types of information. Since ignorance can be nurtured deliberately and used to positive ends (such as protecting the client's privacy or ensuring better therapeutic outcomes), it will be helpful to think of ignorance not simply as being void of intellect (and thereby needing correction) but through the concept of agnotology, coined by R. Proctor (2008). Agnotology studies socially constructed and self-imposed ignorance, supporting the notion that ignorance might be a good or

even virtuous state of mind. Ignorance can be conceived as good insofar as it spurs further inquiry, leading to new discoveries and greater knowledge (Gross & McGoey, 2015). For therapeutic practitioners, however, ignorance may be good even if it does not result in greater knowledge (Smithson, 2008). For example, refusing to pry into a client's medical records, Google search for innuendo or listen to gossip about them are virtuous forms of ignorance that do not lead to greater knowledge but do conform with the ethical and moral standards of counseling practice and can be regarded as virtuous acts (Cohen & Cohen, 1999).

As revealed in the previous section, varying degrees of ignorance underpin notions of privacy, secrecy, and confidentiality, and ignorance can be imposed on others without violating trust or causing harm (DeNicola, 2017). Trust, in fact, implies a perceived vulnerability or risk to the person who places their trust in another. The person giving their trust must be somewhat ignorant of the person in who that trust is placed. Although trust does not depend on concealing information, relationships of trust (like that between a client and counselor) do entail a measure of privacy. After all, if a counselor feels their client is watching them too closely, or if the client insists on being given background information, the counselor may infer that the client does not trust them (Smithson, 2008). Thus, counseling is a relationship that requires tolerance of ignorance or trust.

Williams (2018) for instance, elaborates on various modes of deception therapist may enact, at times guided by various respectable norms including professionalism and risk management, to reveal how truth is a negotiated concept in therapeutic dealings—for better or for worse. Farber (2006) notes, therapists seek to construct professional, competent, and expert identities by keeping aspects of themselves anonymous and not revealing certain information to ensure clients remain in a state of ignorance. For example, counselors who limit their disclosure and avoid negative disclosure (i.e., avoid revealing personal weaknesses, disruptive experiences,

etc.), may influence client perceptions and, consequently, be rated higher on expertise (Hare-Mustin & Marecek, 1986). Since counselors strive to control the amount of information revealed, for both therapeutic and non-therapeutic reasons, they do not always deal in the truth, the whole truth, and nothing but the truth (Williams, 2018). This enables counselors to, among other things, deny, distort or suppress information that poses a threat to the professional image they have constructed (Grus & Kaslow, 2014). Ignorance can then be considered both a "legitimating influence" and used (among other things) to justify therapeutic practices (Smithson, 2008, p. 223).

The active maintenance of ignorance is both an essential feature of clinical practices and beneficial to the client the counselor is serving. Mismanaging that ignorance, however, can have negative repercussions. Muddling important distinctions between privacy, secrecy, and confidentiality — practices intended to preserve ignorance — results in unnecessarily withholding intimacy and authentic emotional connection with the client and can unwittingly cause confusion and misunderstanding the client (Heyward, 1993). When cultivating ignorance, therapists would question whether they are using it correctly. Some counselors will, for instance, unnecessarily withhold non-controversial personal information on the grounds of a right to privacy, even when such overprotectiveness is more a matter of secrecy than a method of strengthening rapport and the therapeutic alliance. This may result in the development of a personal and professional hierarchy, a sense of distance between the therapist and client, and an emotional separation or deprivation of intimacy (Greenspan, 1993).

Intimacy, within the context of professional counseling, is not meant in the sense of over-identification with, becoming friends with, or having a relationship with the client outside of therapy (Greenspan, 1993). Rather, it involves adopting a professional posture that requires the counselor to authentically be themselves which can translate into being more effective in their

therapeutic role. In so doing, the therapist may disclose insight and feelings that can then meet the emotional needs and feelings of the client (Pinto-Coelho, Hill, & Kivlighan, 2016), where these needs would be neglected as a result of, for example, excessive professional distancing supported by fear and anxiety over dual relationships (Zur, 2018b). Some therapists may feel that self-disclosure enables them to form a more satisfactory relationship with their clients. As Weiner (1978) says, the therapist may find that revealing more of themselves makes for a more natural relationship:

> …the therapist is entitled to meet some of his own needs in psychotherapeutic sessions… [without] necessarily compromis[ing] his patient. A therapist can allow himself the gratification of recognition as a person by his patient, but he must not insist upon it…In allowing himself the gratification of being real with his patients, the therapist may be indirectly helpful by demonstrating that all persons have emotional needs and that the patient is not the empty, sucking parasite he feels himself to be. (p. 67).

For example, some therapists may self-disclose personal information (e.g., psychiatric disorder) to satisfy their personal need to be real (sincere, human, flawed, truthful) and attempt to flatten the perceived counselor-client power differential, which can yield therapeutic effects on client functioning (Levitt et al., 2016). In this way, the therapist communicates as an actual person, validating sentiment, trust and respect for the client from one person to another. The therapist fosters an alliance built on genuine intimacy—a felt sense of relational mutuality to cooperate and willingness to be understood (e.g., Somers, Pomerantz, Meeks, & Pawlow, 2014). In taking this stance, the therapist actually comes to know who someone is in terms of their similarities across values, beliefs, and shared issues as a person. (Audet, 2011; Audet & Everall, 2003; Simon, 1990).

Power Dynamics: Soft and Hard

Power, as we will define it here, is largely confined to the context of publicly-funded mental health and substance use disorder treatment agencies, in which "the system is designed and run by professionals as part of the structure and method of work" (Hugman, 1991, p. 118). It is within this system that power is legitimated and endowed to counselors by virtue of group membership, title, status, or position within the agency (see Table 1). It is a form of hard power (or formal power), meaning that it is embedded within the structure of an agency, is static and unidirectional, and exists independently of the therapist (Kelman, 1972). It is an ever-present resource that the therapist can draw upon in order to elicit action and compliance from the client (Brown, 1994; DeVaris, 1994; Gadpaille, 1972).

Hard power also emanates from and is legitimatized by state or federal laws, and is then further authorized by the professional qualifications or licensing laws that regulate the therapist's position (Zur, 2017). Proscriptive and prescriptive policies and procedures, as well as normative rules within the agency, all can act as sources of power (Hillman, 1995), as they grant counselors the authority to favor their own interests in certain decisions over the interests of clients (Bayles, 1986; Garrow & Hasenfeld, 2016). These powers act as additional resources or institutional leverage, "conceived in terms of coercion in fact or by intent" (Schimel, 1972, p. 14). The stipulations and pressures imposed on the client by the referring agency, institution, or third-party authority decrease the client's ability to exercise their autonomy and power. The power difference minimizes the client's preferred outcomes by favoring the supposition that the service provider (e.g., probation office) or counselor knows what is best for the client. The power structure effectively controls, limits, restricts, contains, sways, or otherwise influences the client's actions and behavior (G. Proctor, 2008).

Table 1. *Dynamics of Hard Power*

Elements	Formulations	Manifestations
Power to assess and determine diagnosis (Brown, 1994), and ultimately define the client's problem (G. Proctor, 2008).	Power to testify in court, and generate(progress/compliance) reports that influence third-parties and affect clients.	Pressure clients into a state of duress to take medication or undergo psychiatric treatment under therapeutic pretext and pretense and auspice of treatment (Zur, 2017).
Power to confront and challenge clients under the guise of treatment counseling (Heller, 1985).	Power to choose what gets interpreted and named in therapy (Heller, 1985).	Power to determine what constitutes resistance, (counter)-transference, difficult or problematic behavior (Heller, 1985).
Legitimate coercion equals threat or expectation of punishment for failure to conform (Gadpaille, 1972; French & Raven, 1962).	Power to report child and adult abuse to the authorities (i.e., "duty to report") (Zur, 2017).	Power to leverage agency resources to usurp client autonomy by galvanizing the collective power of the agency to define the client as good or bad, manipulative,noncompliant, unmotivated (Hugman, 1991).
Power to alert police or other institutions or people if clients pose danger to self or others (i.e., "duty to warn") (Zur, 2017).	Power to detain clients against their will (i.e., initiate civil commitment) (Zur, 2017).	Power to change fees and dictate other transactions (Brown, 1994; Heller, 1985; Zur, 2017).
Power to choose what to reinforce and reward, what to incentivize or punish (Heller, 1985)	Power to make referrals, mostly without having to justify their status, knowledge, or expertise (Hugman, 1991, p. 114).	Power to place the client on a contract (Carroll,2005) and bind clients to structure of treatment as defined by the counselor, especially for court-referred clients (Horner, 1989).
Power to make formal recommendations.	Power to define what thoughts are maladaptive (Heller, 1985).	"Power to define who and what client/patient is and should be" (Hugman, 1991, p. 113).

For example, with the institution's backing, counselors can ultimately impose their will by arbitrarily terminating the delivery of treatment services (i.e., administrative discharge) against the will, wish, or desire of the client (Williams, 2016; Williams & Taleff, 2015). Hard power represents power derived from agency statutes, official rules and regulations (Greenblatt, 1986)

and, the "unequal distribution of power [that] first gives origin to hierarchy" (Arieti, 1972, p. 22), in terms of overt or implied roles accorded to counselor and client (Ryder, 1972, p. 36). This external power system is central to soft power.

Because of power's symbolic, intersubjective, and interpersonal nature (Brown, 1994; Gadpaille, 1972), power in another sense, can have "weight and influence in interpersonal affairs" (Schimel, 1972, p. 14)— that is, power can be soft or informal (see Table 2). Unlike the hard power granted by institutions, soft power is a more multidimensional, bidirectional, dynamic form of power (Gelb, 1972). The extent of the client's "cooperation" ultimately determines whether the counselor is "powerless in their joint venture" (Cantor, 1972, p. 199). The client can also exercise and derive a sense of soft power via "subversive power" or "coercive power" by deliberately frustrating the therapeutic actions of the counselor and thereby undermining their sense of competency and efficacy as a helper (Cantor, 1972, p. 199; Gadpaille, 1972).

Clients also have the right to lodge a formal complaint or report their grievance with the state credentialing or licensing board, by virtue of the rights assigned to those classified as clients, if they believe that the therapist has behaved unethically, operated below the standard of care, if they wish to take revenge, or for any other reason (Gallagher & Haworth, 2005; Gunther, 2016; Lazarus, 1994; Zur, 2017). Hence, power is not exclusively the domain of the counselor, as the balance of power can tilt in favor of the client, depending on counseling processes (Zur, 2008). Despite this potential for what might be perceived as subversion by some counselors, soft power is still generally lopsided in favor of the counselor (Gannon, 1982). For example, a client may present in treatment as needing help of some sort and expose private fears, feelings, and fantasies, but the counselor is not expected to engage in such vulnerable and revealing exercises

(Kelly, 1998). This imbalance sets the stage for the emergence of power issues in the relationship (Horner, 1989).

Soft power is not only influenced by the hard power bestowed by institutions; it is also maintained and reinforced by the confluence of mutually reinforcing interaction between society, third parties, and stakeholders (among others). It typecasts the relational roles designated in the counselor-client dyad, ultimately serving to distribute more symbolic power - "cognitive authority" and credence - to the therapist (DeVaris, 1994, p. 590; Veldhuis, 2001; Addelson, 1993). As Hugman (1991) notes, the ways in which individuals become and continue to be clients form part of "the definition and maintenance of professional boundaries" (pp. 113-114). Institutional personnel ascribe client status to the person, conveying the role as a "socially constructed object of professional power" within the network of relationships and interactions (Hugman, 1991, pp. 113-114).

Soft power stems from the client's perception and degree of acceptance of the therapist's leadership, trustworthiness, expertise, or illusory power (Haley, 1969). The degree of soft power the therapist can exert depends on the extent of the client's meekness, vulnerability, fragility, and dependency, all of which "sets the stage for power dynamics … as concomitant with the illness state or psychological difficulty" (Heller, 1985, p. 93; see also Gadpaille, 1972; Goldin, Perry, Margolin & Stotsky, 1972). Soft power can, therefore, be enhanced or diminished based on the structure of the therapist-client dyad, its progressive unfolding, and its multifaceted developments (Haley, 1969). For example, a vulnerable, depressed client, in submitting to help from the therapist, bestows therapeutic authority upon the therapist to treat or heal, thereby augmenting the therapist's soft power. To that point, Zur (2017) notes:

> While therapists may not pay direct attention to issues of power, they often indirectly and unconsciously enhance their aura and power in numerous subtle ways. These may be part of the therapeutic-professional rituals, customs and habits, or may involve meta-communications. They may involve: the way therapists organize the office seating arrangements, furnish the room, put a tissue box by a patient's chair, take notes, talk with an authoritative tone, touch in a patronizing way, use professional jargon, monopolize the conversation with long sermons, etc. (para 215).

Soft power is also predicated on the relational exchanges and dynamics of the counseling relationship between counselor and client (Adler, 1972). Zur (2017) writes:

> What it comes down to is personal power, which derives from a wide array of sources, including a person's position, education, personality, physical strength, physical attractiveness, sex appeal, charm, charisma, force of personality, and ability to manipulate or elicit guilt or gratification, to reward or threaten… the measure of power is ultimately a person's capacity for direct, indirect, or subliminal persuasion — the ability to bring about change in one's environment, impose his/her will on others; to bring about change and to control or influence others (para 217).

In therapeutic contexts, power falls on a continuum of social influence – from not enough power (“my therapist can’t help me”) and just the right amount of power (“my therapist appears qualified and competent”) to holding too much power (omnipotence or magical thinking). When combined, hard and soft power provide the therapist with an intensified or amplified aura of power and authority. Together, these forms of power constitute a type of institutional privilege. We will be referring to this institutional privilege as professional power.

Table 2. *Dynamics of Soft Power*

Elements	Formulations	Manifestations
Proving suggestions, advice, recommendations that intone the sentiment of: "I know what's best for you" or "You'll get better if you just listen to me and do what I say."	Therapist appears against the background of books, certifications, degrees, and other items adorning (the walls of) the counseling office— symbolic associations with wisdom and intelligence (Heller, 1985).	Determining when and how to end session (Brown, 1994): "It's time to conclude for today," "See you next Thursday," "We have to stop" (Heller, 1985, p. 119).
"Not just power as a function to illuminate, to interpret, to help, but actually as a controlling of which the patient is afraid" (Arieti, 1972, p. 27).	"The professional is a priori deemed emotionally sound; The client is a priori deemed emotionally impaired (Why else submit oneself to professional authority)" (Greenspan, 1993, p. 197).	Reward power via positive benefits and acceptance in return for conformity (Gadpaille, 1972, p. 175; French & Raven, 1962).
Maintaining anonymity (Zur, 2017).	Power exemplified by "authority of the therapist is justified by the principle of beneficence or paternalism" (G. Proctor, 2008, p. 240).	Set schedules and designate the place where treatment takes place (Brown, 1994; Heller, 1985).

Power Dynamics, Ignorance, and Harm

Keeping in mind the key distinctions between secrecy, privacy, and confidentiality, we can now see how the imbalance of power and information in the therapeutic context be harmful to the therapeutic relationship and the client's progress. Counselors can manage their disclosure of information while using their soft power (backed by hard power) to elicit information from the client. This process gives even more power to the therapist and could exacerbate the inequalities built into the counseling relationship (Salzman, 1972), inflate the counselor's sense of aggrandizement, and disempower the client (Mack, 1994).

Awareness of key distinctions between secrecy, privacy, and confidentiality can influence the disparity in information sharing. Counselors can openly encourage questions and the sharing

of concerns, so content becomes shared knowledge between counselor and client. Counselors may dissemble, keep secrets, and stay hidden, while the client is exposed to interpretations and assumptions by revealing the most vulnerable aspects of themselves to the counselor. This process unfolds within the norms of therapy and, in turn, serves as therapeutic ballast (Marks, Hill, & Kivlighan, 2019).

Abuse of Power

Duffy (2007) writes, “When the counselor’s or therapist’s needs and interest prevail—that is, come before the client’s needs, interests, and overall welfare—abuse of power and boundary violations are classic indicators of such a conflict” (p. 127). Abuse of power takes place along a continuum, ranging from the sexual involvement with clients, to keeping clients in therapy longer than necessary and requiring unnecessary appointments when the goals of treatment have already been met in order to keep generating income. Although not all such behaviors are considered predatory or abusive to clients, taking advantage of a client’s vulnerability for the sake of one’s own self-interest are abusers of power (Kuyken, 1999). Duffy (2007) contends that by being aware or mindful of power differentials in therapy, counselors or therapists can practice an ethic of care for themselves and their clients, and thereby reduce the risk of boundary violations resulting from abuse of their power.

Imbalance of Knowledge

Farber (2006) points out, disclosure is “a recursive process; that is, disclosures are a function of previous disclosures, building on them, affected by the reactions (in oneself and others) that these disclosures have elicited” (p. 206). Hinshelwood (1997) also notes that therapists communicate their disclosures from “a loaded framework of words and concepts derived from [their] social position” (p. 165). A so-called Laingian “knot” is one in which the

therapist knows (or thinks she knows) a great deal (Laing, 1972), but also knows that the client does not know much (Hinshelwood, 1997). This occurs, for instance, when the therapist categorically refuses to answer certain questions from the client. Wachtel (2011) contends that an imbalanced distribution of knowing within a therapeutic setting can create an unstated power struggle and confrontational relationship between therapist and client, especially when the therapist is seen by the client as cold, remote, and unwilling to make oneself knowable.

A balance of power between counselor and client can more easily occur when there is a sense of equity in the relationship (Amis, 2017). The client's share of speaking will undoubtedly be disproportionate, since their background, anxieties, and concerns are discussed during sessions. This increases the imbalance of knowledge between the therapist and client, giving the therapist another power advantage (Zur, 2008). Clients expose their emotional, cognitive, and interpersonal needs and difficulties during counseling. This places them in a position of reduced power and greater vulnerability with respect to the counselor (Duffy, 2007, p. 126). Thus, disclosure on the part of the counselor is clearly beneficial for its potential to strengthen the bond with the client. Greater intimacy follows the therapist's disclosure, and there is an understanding that the client will feel more comfortable in making deeper disclosures (Farber, 2006). The therapist's own limited revelations can help to equalize the balance of power by creating a sense of equal knowledge and connection encouraged by (Farber, 2006).

Clients are not obligated to keep whatever information is learned about their therapist confidential. A therapist's willingness to disclose will, in part, depend on the client's response to earlier ones (Levitt et al., 2016). For example, a therapist's disclosure may lead to misinterpretation, regret, or negative emotions, in which case further disclosures are unlikely. On the other hand, therapist disclosures may bring about closeness and an increased sense of trust

and rapport in the therapeutic relationship. Of course, there is always the risk that the client "outs" the therapist. In light of this, professionals are likely to hold a double-standard by withholding information in counseling, calling it non-disclosure. Asymmetrical or imbalanced disclosure, then, is not always a problem, so long as it is motivated by a respect for privacy and an understanding of how much information is too much or inappropriate. As Amis (2017) notes, "one of the central tenets of a successful counselling relationship being that of recognized equality between counsellor and client" (p. 26).

The therapeutic relationship can be a powerful one for the counselor as well as the client, and counselors who have their own unmet emotional and relational needs are at greater risk of using the therapeutic relationship to benefit themselves more than their clients. Hence, therapists might be reluctant to respond to their client's direct vitiations, allowing the client to project their insecurities and inadequacies onto the counselor (Edelstein & Waehler, 2011; Waehler & Grandy, 2016). The relationship between counselor and client is formalized through the treating agency and institutionalized by a service contract, emphasizing the needs of the client, not those of the therapist. The contract specifies the role of the counselor as helping the client address their problems and supports a predominantly unidirectional flow of personal and emotional disclosures. As such, counseling is not a reciprocal relationship like a friendship, in which emotional disclosures and feelings are freely exchanged in a relatively uncensored way by both parties. Although psychotherapy and friendship share features, such as trust, openness, support and positive regard, therapy is not friendship and friendship is not its purpose. Rather, it is designed as a way to produce positive change for the client. The therapist may coincidentally benefit from the relationship, but that is not the purpose of therapy (Sussman, 1992, 1995).

Therapeutic Posturing

Counselors may be concerned about the tension between satisfying the client's desire to know them better and their own wish to stay hidden and somewhat anonymous (Farber, 2006). Therapy entails counselors to safeguard their image as a competent helper, which invites repressing their own personal faults and errors by holding tightly to strict interpretations of secrecy and privacy that are geared to promoting the agenda of treatment. For instance, counselors establish and guard boundaries around their clinical practice and approach in order to protect their professional image and reputation. If clients were to see into their therapists' personal lives, however, they might find reasons for doubt and distrust (Sussman, 1992). When the façade is fractured, by virtue of the counselor's presentations in sessions exposing overtime large discrepancies between their client's expectations of the counselor and the realities of the counselor image as a fallible professional, to further attempt disguising shortcomings, kept hidden by policies of non-disclosure, may be more damaging than enhancing to the welfare of clients—referred to as therapeutic posturing (Arons & Siegel, 1995). For instance, the lives of many therapists are far from what clients imagine them to be or what the therapists pretend they are –therapeutic posturing—and misunderstandings and misuse of the notions of privacy, secrecy, and confidentiality are a way for therapists to legitimize their defenses, and yet distant, rigid, and uninvolved therapists have been reported by clients themselves to be detrimental to their therapeutic progress (Zur, 2005, p. 265). When the therapist masks their true emotions and disguises more genuine thoughts, they can cast a cloud of doubt over their competency (Danzer, 2019).

Disempowerment

Healthy therapeutic progress requires a sense of accountability, responsibility, and personal ownership on the part of the client (Dineen, 2001). We define disempowerment as a process of clouding, adulterating, or limiting the client's awareness, usually in order to maintain the status quo. Disempowerment also occurs when the client lacks the ability to control different situations (Becker, 2005). Disempowering a client undermines those traits they require to make healthy therapeutic progress (Charnofsky, 1971). On the other hand, beneficence (i.e., the obligation to maximize the welfare and happiness of others) necessarily confers limits on both the clinician's actions to help clients and the clients' autonomy and freedom of choice (Taleff, 2010). Counselors may, therefore, be justified in disempowering their client to some limited extent, so long as doing so is an act of beneficence. Respecting the client's autonomy, however, means helping the client make their own choices, even if it sometimes means allowing them to act against their best interests at times (Cottone & Tarvydas, 2016). Still, empowering the client is always in large part the role of the counselor, since the client already has little autonomy in counseling settings (p. 162). For example, Hare-Mustin and Marecek (1986) noted:

> No matter how hard a therapist might try to be egalitarian, she or he is still 'in charge.' Even to assert that the client shall ultimately determine the goals of therapy denies the reality that all therapists hold certain normative concepts of health and sickness, growth and stagnation, male and female. It is naïve to claim that the therapist merely evokes what is in the client. (p. 206).

A dominant group usually constructs a false belief system that serves to maintain its superior status and emphasize its distinctness from a subordinate group (Miller, 2008). Such

belief systems can have powerful effects, keeping each group in its assigned role and maintaining the status quo (Miller, 2008). When the professional therapist or counselor "clientizes" the person receiving counseling services (Harrison, 1993), both client and therapist slip into predefined roles. Guilfoyle (2006) says these are roles of "common sense" expectations that "everybody knows," and power is distributed in fixed unequal proportions, based on this knowledge with respect to the power dynamic between therapist and client, the implication is that no one is in control or can prevent this dynamic from happening (Totton, 2006). Moreover, any attempts to shift the balance might be seen to create difficulties within the therapeutic process. That process entails clients to value what therapists are doing in session. In general terms, the therapist wants the client to acknowledge their problems, recognize that the therapist understands those problems, and acknowledge that by working together, the two of them have a chance to resolve the problems (Totton, 2009). On occasions when clients question the therapeutic process, therapists can re-assert their control by referring to the client's psychological "resistance" and "denial." In other words, when the therapist's credibility is challenged, they can appeal to psychodynamics and use it to their benefit (Craciun, 2016).

Conclusion

Professional training may implicitly encourage some counselors to hide behind dictates of privacy, secrecy, confidentiality, and professionalism in an effort to prevent their clients from truly knowing them as a person. The counseling doctrine holds that self-disclosure is appropriate when it is therapeutically beneficial to the client; however, counselors should avoid sharing even mundane personal information so as to keep the therapy session from becoming about the counselor and to ensure the therapeutic relationship does not take on the air of a friendship rather than a paid arrangement between provider and help-seeker (Curtis, 1981). There are some issues

here. First, this line of reasoning assumes a slippery slope – namely, that mundane disclosure will lead to so much sharing that the client will feel as if they have become personal friends with their counselor. Second, it assumes that counselor reticence to reveal themselves in any form or fashion does not have negative effects on therapeutic outcomes, when, in fact, counselors disclosures that are irrelevant to therapy can nonetheless be beneficial to clients and can positively influence therapy (Henretty & Levitt, 2010). Moreover, whether personal disclosure is beneficial to clients is quite subjective and varies according to the particular client (Ziv-Beiman, 2013).

The principal aim of therapy is to enhance the client's existence (Duffy, 2007). Because of the authority assigned to the counselor through the customary and unequal roles of counselor and client, along with the duty of care, the counselor is ethically required to prioritize what is best for the client (Proctor, 2014). This is the agreed upon structure of the therapeutic relationship, in which the client is expected, even obligated, to self-disclose fully and honestly (Dince, 1972). Practitioners are apt to feel threatened, or at least highly uncomfortable, by clients who insist on violating the social norms dictating that clients take a submissive role in the therapeutic relationship—augmenting soft power. Such clients directly question the counselor's authority and know-how, and are likely to ask personal details about the professional's life. These clients speak candidly and are forthright about being treated as a person, not a client. In essence, they challenge counselors to never lose sight of the fact that counseling is supposed to be a relationship between persons working together, with gives-and-takes of soft-power, with the consequent need to build an authentic relational bond (Greenspan, 1993; LeBon, 2001). By promoting a kind of low-quality ignorance, the therapist denies the client personal and professional information in order to maintain a so-called professional detachment from the client. Some counselors, however, may be excessively secretive and unnecessarily withhold information

under a mistaken interpretation of confidentiality mandates or personal privacy expectations. At the heart of this struggle is finding a balance between managing a sense of self-expression and exercising a more authentic representation of oneself as a person who works as a counselor (Sussman, 1992, 1995).

Secrecy and privacy are concepts used to protect mental health professionals and their clients. They are invoked to justify the therapist's refusal to share personal information about their own trials or tribulations. Yet sharing such information might empower the client, reduce stigma, and strengthen the therapeutic bond. Such refusal can be appropriate at times but it is not always clinically advised since it could create an artificial wall between the therapist and client, potentially interfering with therapy and affecting the working alliance (Marks, Hill, & Kivlighan, 2018). Through fear of being labeled unprofessional (or worse pathologized through the psychodynamic framework of countertransference), therapists may yield to fear-driven, pseudo-objective distancing in therapy with their clients or misperceiving similarities with clients (Greenspan, 1986; Pinto-Coelho et al., 2018). However, therapy often benefits from the client sharing an equal role in the change process and investing in their own personal development (Knox & Hill, 2016).

Counselor and client conservations are considered privileged communication. Legal protection under state and federal law prohibit the counselor from divulging information about the client without their permission or consent, barring certain exceptions (Gibson, 2012). However, these laws do not apply reciprocally to the counselor, so what is said in the counseling room is not safe or secure and may carry far-reaching implications for the counselor's reputation if leaked by the client (Nyberg, 1993). Privileged communication is a legal principle covering the counselor-client relationship, which allows a clinician to refuse to divulge sensitive or personal information or records concerning the client in court proceedings. Together with legal statutes

relating to confidentiality, privileged communication is designed to protect clients, not professionals (Corey et al., 2015).

Soft power is usual imbalanced in favor of the therapist, since they are expected to have more knowledge and skill and aid the client in achieving counseling goals and expected outcomes. With respect to this power imbalance in therapy, counselors should consider whether their self-disclosures can lead to tangible outcomes for the client, in terms of positive changes in a client's living situation, improvements in a client's health, better relationships with others, and a client's increased control over psychiatric symptoms (Boehm & Staples, 2002). Soft power can obscure itself when a therapist claims, "my hands are tied," or "the system just isn't fair." Clients sometimes appear to some of this power, but in actuality they have very little of that soft power because the hard power of the institutional structure has already put them in a position of subordination. There are so few successful ways for clients to resort to soft power in sustaining resistance. For instance, when counselors shows certain personal reactions to the client in therapy, the kind of response that the client's behavior induces in the counselor is potentially empowering for some clients. The exercise of soft power is not the same for the therapist as it is for the client due to the hard power backing the therapists. Power may appear to "go both ways," but the consequences of using this power are so radically different. For example, the client might get kicked out of treatment or have a prison sentence executed for violating the terms of parole or probation for noncompliance with treatment, while the counselor is left with a free slot in their schedule.

It is not always clear how well privacy, secrecy, and confidentiality are used or play themselves out in actual counseling practice in relation to soft and hard power dynamics. In addition to power issues as a function of cultural identities (e.g. race, gender, sexual orientation,

class) (Douglas, 1985). Regardless, civility requires that counselors be granted privacy so as to avoid clients' invasive or unwelcome queries into their personal lives, particularly when such information is divulged without counselors having the protection of privileged communication. Counselors can balance this sense of privacy by making themselves feel personally known to their clients, if only marginally, rather than remaining private and unknown. To the extent they are successful in accomplishing this balancing act, counselors "let some aspects of themselves be known completely, others moderately, others slightly, others not at all" (Farber, 2006, p. 200). For the counselor to be known, even in a small way, can more than not push therapy in positive directions (e.g., Henretty, Currier, Berman, & Levitt, 2014; Yeh & Hayes, 2011).

References

Addelson, K. P. (1993). Knowers/doers and their moral problems. In L. Alcoff & E. Potter (Eds.), *Feminist epistemologies* (pp. 265-294). New York, NY: Routledge.

Adler, K. A. (1972). Power in Adlerian theory. In J. H. Masserman (Ed.), The dynamics of power: Science and psychoanalysis (Vol. 20., pp. 53-63). New York, NY: Grune and Stratton

Amis, K. (2017). Boundaries*, Power and ethical responsibility in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Arieti, S. (1972). The origin and effect of power. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. xx, pp. 16-35). New York, NY: Grune and Stratton.

Arons, G., & Siegel, R. D. (1995). Unexpected encounters: The Wizard of Oz exposed. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 125-138). New York, NY: Wiley.

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24*, 85-100. https://doi.org/10.1080/09515070.2011.589602

Audet, C., & Everall, R. D. (2003). Counsellor self-disclosure: Client-informed implications for practice. *Counselling and Psychotherapy Research*, *3*, 223-231. http://dx.doi.org/10.1080/14733140312331384392

Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy*, *48*, 315- 321. http://dx.doi.org/10.1037/a0026056

Baumann, E. C., & Hill, C. E. (2016). Client concealment and disclosure of secrets in outpatient

psychotherapy. *Counselling Psychology Quarterly*, *29*, 53-75. http://dx.doi.org/10.1080/09515070.2015.1023698

Bayles, M .D. (1986). Professional power and self-regulation. *Business and Professional Ethics Journal*, *5*(2), 26-46.

Becker, D. (2005). *The myth of empowerment: Women and the therapeutic culture in America*. NY: New York University Press.

Boehm, A., & Staples, L. H. (2002). The functions of the social worker in empowering: The voices of consumers and professionals. *Social Work*, *47*, 449-460. http://dx.doi.org/10.1093/sw/47.4.449

BrintzenhofeSzoc, K., & Gilbert, C. (2017). Social workers have an obligation to all patients regarding confidentiality… however, for some patients, the obligation is greater. *Social Work In Health Care*, *56*, 779-793. https://doi.org/10.1080/00981389.2017.1371097

Cantor, M. B. (1972). Discussion of papers of Warren J. Gadpaille, M.D., and Lester A. Gelb, M.D. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 197-201). New York, NY: Grune and Stratton.

Carroll, M. (2005). Psychological contracts with and within organizations. In R. Tribe & J. Morrissey (Eds.), *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists* (pp. 33-46). New York, NY: Brunner-Routledge.

Charnofsky, S. (1971). Counseling for power. *Journal of Counseling and Development*, *49*, 351-357. https://doi.org/10.1002/j.2164-4918.1971.tb03645.x

Cohen, E. D., & Cohen, G. S. (1999). *The virtuous therapist*: *Ethical practice of counseling and psychotherapy.* Belmont, CA: Wadsworth.

Corey, G., Corey, M. S., Corey, C., & Callanan, P. (2015). *Issues and ethics in the helping professions* (9th ed.). Stamford, CT: Cengage Learning.

Cottone, R. R., & Tarvydas, V. (2016). *Ethics and decision making in counseling and psychotherapy*. New York, NY: Springer.

Craciun, M. (2016). The cultural work of office charisma: maintaining professional power in psychotherapy. *Theory and Society*, *45*, 361-383. https://doi.org/10.1007/s11186-016-9273-z

Curtis, J. M. (1981). Indications and contraindications in the use of therapist's self-disclosure. *Psychological Reports*, *49*, 499-507. http://dx.doi.org/10.2466/pr0.1981.49.2.499

Danzer, G. (Ed.). (2019). *Therapist self-disclosure: An evidence-based guide for practitioners*. New York, NY: Routledge.

DeNicola, D. R. (2017). *Understanding ignorance: The surprising impact of what we don't know*. Cambridge, MA: MIT Press.

DeVaris, J. (1994). The dynamics of power in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 31, 588-593.

Dince, P. R. (1972). Power and omnipotence. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 64-70). New York, NY: Grune and Stratton.

Dineen, T. (2001). *Manufacturing victims: What the psychotherapy industry is doing to people* (3rd ed.). Montreal, ON, Canada: Robert Davies.

Douglas, M. A. (1985). The role of power in feminist therapy: A reformulation. In L. B. Rosewater & L. E. A. Walker (Eds.), *Handbook of feminist therapy: Women's issues in psychotherapy* (pp. 241-249). New York, NY: Springer.

Duffy, M. (2007). Conflict of interest, boundaries, and the use of power. In L. Sperry (Ed.). *The*

ethical and professional practice of counseling and psychotherapy. (pp. 126-144). Boston, MA: Pearson Education.

Edelstein, L. N., & Waehler, C. A. (2011). *What do I say?: The therapist's guide to answering client questions*. Hoboken, NJ: Wiley.

Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York, NY: Guilford.

French, J. R. P., & Raven, B., Jr. (1962). The bases of social power. In C. Cartwright & A. Zander (Eds.), *Group dynamics* (pp. 607-623). Evanston, IL: Row, Peterson, and Company.

Gadpaille, W. J. (1972). The uses of power: A particular impasse in psychoanalysis. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 173-183). New York, NY: Grune and Stratton.

Gallagher, T., & Haworth, R. (2005). Complaints: professional ethical issues. In R. Tribe & J. Morrissey (Eds.), *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists* (pp. 131-144). New York, NY: Brunner-Routledge.

Gannon, L. (1982). The role of power in psychotherapy. *Women and Therapy*, *1*(2), 3-11.

Garrow, E. E., & Hasenfeld, Y. (2016). When professional power fails: A power relations perspective. *Social Service Review*, *90*, 371-402. https://doi.org/10.1086/688620

Gelb, L. A. (1972). Psychotherapy as a redistribution of power. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 184-195). New York, NY: Grune and Stratton.

Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal*, *40*, 287-296. http://dx.doi.org/10.1007/s10615-012-0391-4

Goldin, G. J., Perry, S. L., Margolin, R. J., & Stotsky, B. A. (1972). *Dependency and its implications for rehabilitation*. Lexington, MA: Lexington Books.

Goldstein, E. G. (1997). To tell or not to tell: The disclosure of events in the therapist's life to the patient. *Clinical Social Work Journal*, *25*, 41-58. https://doi.org/10.1023/A:1025729826627

Greenblatt, M. (1986). The use and abuse of power in the administration of systems. *Psychiatric Annals*, *16*, 650-652.

Greenspan, M. (1986). Should therapists be personal? Self-disclosure and therapeutic distance in feminist therapy. *Women and Therapy*, *5*(2-3), 5-17. http://dx.doi.org/10.1300/J015V05N02_02

Greenspan, M. (1993). On professionalism. In C. Heyward (Ed.), *When boundaries betray us*. (pp.193-205). San Francisco: Harper Collins.

Gross, M., & McGoey, L. (Eds.) (2015). *Routledge international handbook of ignorance studies*. New York, NY: Routledge.

Grus, C. L., & Kaslow, N. J. (2014). Professionalism: Professional attitudes and values in psychology. In W. B. Johnson & N. J. Kaslow (Eds.), *The Oxford handbook of education and training in professional psychology* (pp. 491–509). New York, NY: Oxford University Press.

Guilfoyle, M. (2006). Using power to question the dialogical self and its therapeutic application. *Counselling Psychology Quarterly*, *19*, 89-104. https://doi.org/10.1080/09515070600655189

Gunther, S. V. (2016). Questioning the victim status of complainants in professional ethics Investigations. *Psychotherapy and Politics International*, *14*, 173-186.

https://doi.org/10.1002/ppi.1391

Haley, J. (1969). *The power tactics of Jesus Christ and other essays*. New York, NY: Grossman.

Hare-Mustin, R. T., & Marecek, J. (1986). Autonomy and gender: Some questions for therapists. *Psychotherapy: Theory, Research, Practice, Training*, *23*, 205-212. http://dx.doi.org/10.1037/h0085599

Harrison, B. M. (1993). Response. In C. Heyward (Ed.), *When boundaries betray us*. (pp. 206-211). San Francisco: Harper Collins.

Heller, D. (1985). *Power in psychotherapeutic practice*. New York, NY: Human Sciences Press.

Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology*, *61*, 191-207. http://dx.doi.org/10.1037/a0036189

Henretty, J. R., & Levitt, H. M. (2010). The role of therapist self-disclosure in psychotherapy: A qualitative review. *Clinical Psychology Review*, *30*, 63-77. https://doi.org/10.1016/j.cpr.2009.09.004

Heyward, C. (1993). *When boundaries betray us*. San Francisco, CA: Harper Collins.

Hillman, J. (1995). *Kinds of power: A guide to its intelligent uses*. New York, NY: Currency Doubleday.

Horner, A. J. (1989). *The wish for power and the fear of having it*. Northvale, NJ: Aronson.

Hugman, R. (1991). *Power in caring professions*. Basingstoke, UK: Macmillan.

Jenkins, P. (2005). Client confidentiality and data protection. In R. Tribe & J. Morrissey (Eds.), *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists* (pp. 63-76). New York, NY: Brunner-Routledge.

Jungers, C. M., & Gregoire, J. (2013). *Counseling ethics: Philosophical and professional foundations*. New York, NY: Springer.

Kelly, A. E. (1998). Clients' secret keeping in outpatient therapy. *Journal of Counseling Psychology*, *45*, 50-57. http://dx.doi.org/10.1037/0022-0167.45.1.50

Kelman, H. (1972). Power: The cultural approach of Karen Horney. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 71-82). New York, NY: Grune and Stratton.

Knox, S., & Hill, C. E. (2016). Introduction to a special issue on disclosure and concealment in psychotherapy. *Counselling Psychology Quarterly*, *29*, 1-6. https://doi.org/10.1080/09515070.2015.1095156

Kuyken, W. (1999). Power and clinical psychology: A model for resolving power-related ethical dilemmas. *Ethics and Behavior*, *9*, 21-37. https://*doi*.org/10.1207/s15327019eb0901_2

Laing, R. D. (1972). *Knots*. New York, NY: Vintage.

Lazarus, A.A. (1994). The illusion of the therapist's power and the patient's fragility: My rejoinder. *Ethics and Behavior*, *4*, 299-306.

LeBon, T. (2001). *Wise therapy: Philosophy for counselors*. Thousand Oaks, CA: Sage.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly*, *29*, 7-28. https://doi.org/10.1080/09515070.2015.1090396

Mack, J. E. (1994). Psychotherapy and society: Power, powerlessness, and empowerment in psychotherapy. *Psychiatry*, *57*, 178-198. https://doi.org/10.1080/00332747.1994.11024684

Marks, E. C., Hill, C. E., & Kivlighan, D. M. (2019). Secrets in psychotherapy: For better or worse?. *Journal of Counseling Psychology, 66,* 70-82. http://dx.*doi*.org/*10.1037/cou0000311*

Miller, J. B. (2008). Telling the truth about power. *Women and Therapy*, *31*(2-4), 145-161.

Nyberg, D. (1993). *The varnished truth: Truth telling and deceiving in ordinary life*. IL: University of Chicago Press.

Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure*. Albany: State University of New York Press.

Pinto-Coelho, K. G., Hill, C. E., Kearney, M. S., Sarno, E. L., Sauber, E. S., Baker, S. M., ... Thompson, B. J. (2018). When in doubt, sit quietly: A qualitative investigation of experienced therapists' perceptions of self-disclosure. *Journal of Counseling Psychology*, *65*, 440-452. http://dx.doi.org/10.1037/cou0000288

Pinto-Coelho, K. G., Hill, C. E., & Kivlighan Jr, D. M. (2016). Therapist self-disclosure in psychodynamic psychotherapy: A mixed methods investigation. *Counselling Psychology Quarterly*, *29*, 29-52. https://doi.org/10.1080/09515070.2015.1072496

Pope, K. S., & Keith-Spiegel, P. (2008). A practical approach to boundaries in psychotherapy: Making decisions, bypassing blunders, and mending fences. *Journal of Clinical Psychology*, *64*, 638-652. https://doi.org/10.1002/jclp.20477

Proctor, G. (2008). CBT: The obscuring of power in the name of science. *European Journal of Psychotherapy and Counseling*, *10*, 231-245.

Proctor, G. (2014). *Values and ethics in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Proctor, G. (2017). *The dynamics of power in counselling and psychotherapy: Ethics, politics and practice*. Herefordshire, England: UK: PCCS Books. [not noted in text]

Proctor, R. N. (2008). Agnotology: A missing term to describe the cultural production of ignorance (and its study). In R. N. Proctor & L. Schiebinger (Eds.), *Agnotology: The making and unmaking of ignorance* (pp. 1-33). CA: Stanford University Press.

Reamer, F. G. (2001). *Tangled relationships: Managing boundary issues in the human services*. New York: Columbia University Press.

Regan, A. M., & Hill, C. E. (1992). Investigation of what clients and counselors do not say in brief therapy. *Journal of Counseling Psychology*, *39*, 168-174. http://dx.doi.org/10.1037/0022-0167.39.2.168

Rescher, N. (2009). *Ignorance:(On the wider implications of deficient knowledge)*. PA: University of Pittsburgh Press.

Ryder, R. G. (1972). What is power? Definitional considerations and some research implications. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 36-52). New York, NY: Grune and Stratton.

Salzman, L. (1972). Compulsive drives for power. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 162-172). New York, NY: Grune and Stratton.

Schimel, J. L. (1972). The relevance of power: An introduction. In J. H. Masserman (Ed.), *The dynamics of power: Science and psychoanalysis* (Vol. 20, pp. 14-15). New York, NY: Grune and Stratton.

Silverstein, J. L. (1993). Secrets versus privacy in group psychotherapy. *Group*, *17*, 107-114. https://doi.org/10.1007/BF01427819

Simon, J. C. (1990). Criteria for therapist self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp. 207-225). New York, NY: Plenum.

Smithson, M. J. (2008). Social theories of ignorance. In R. N. Proctor & L. Schiebinger (Eds.), *Agnotology: The making and unmaking of ignorance* (pp. 209-229). CA: Stanford University Press.

Somers, A. D., Pomerantz, A. M., Meeks, J. T., & Pawlow, L. A. (2014). Should psychotherapists disclose their own psychological problems?. *Counselling and Psychotherapy Research*, *14*, 249-255. https://doi.org/10.1080/14733145.2013.860996

Sperry, L. (2007). *The ethical and professional practice of counseling and psychotherapy*. Boston, MA: Pearson Education.

Sussman, M. B. (1992). *A curious calling: Unconscious motivations for practicing psychotherapy*. Northvale, NJ: Aronson.

Sussman, M. B. (1995). Introduction. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice* (pp. 1-12). New York, NY: Wiley.

Taleff, M. J. (2010). *Advanced ethics for addiction professionals*. New York, NY: Springer.

Totton N. (2006). Power in the therapeutic relationship. In N. Totton (Ed.), *The politics of psychotherapy* (83-93). Maidenhead, UK: Open University Press. Therapy Today.

Totton, N. (2009). Power in the therapy room. *Therapy Today*. Retrieved from http://homepages.3-c.coop/erthworks/power.pdf

Wachtel, P. (2011). *Therapeutic communication: Principles and effective practice* (2nd ed.). New York, NY: Guilford Press.

Waehler, C. A., & Grandy, N. M. (2016). Beauty from the beast: Avoiding errors in responding to client questions. *Psychotherapy, 53*, 278-283. http://dx.doi.org/10.1037/pst0000082

Warren C., & Laslett, B. (1977). Privacy and secrecy: A conceptual comparison. *Journal of Social Issues*, *33*, 43-51. https://doi.org/10.1111/j.1540-4560.1977.tb01881.x

Weiner, M. F. (1978). *Therapist disclosure: The use of self in psychotherapy*. Woburn, MA: Butterworth.

Wheeler, N., & Bertram, B. (2015*). The counselor and the law: A guide to legal and ethical practice* (7th ed.). Alexandria, VA: American Counseling Association.

Williams, I. L. (2016). Moving clinical deliberations on administrative discharge in drug addiction treatment beyond moral rhetoric to empirical ethics. *The Journal of Clinical Ethics*, *27*(1), 71-75.

Williams, I. L. (2018). Lies, deception, and denial in the counseling profession: an inconvenient truth*. Journal of Ethics in Mental Health, 10*(1), 1-27.

Williams, I. L., & Taleff, M. J. (2015). Key arguments in unilateral termination from addiction programs: A discourse on ethical issues, clinical reasoning, and moral judgments. *Journal of Ethics in Mental Health, 9*(1), 1-9.

Yeh, Y. J., & Hayes, J. A. (2011). How does disclosing countertransference affect perceptions of the therapist and the session?. *Psychotherapy*, *48*, 322-329. http://dx.doi.org/10.1037/a0023134

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration*, *23*, 59-74. http://dx.*doi*.org/10.1037/a0031783

Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2017). Immediate therapist

self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research*, *27*, 558-570. https://doi.org/10.1080/10503307.2016.1138334

Zur, O. (2005). The dumbing down of psychology: Faulty beliefs about boundary crossings and dual relationships. In R. H. Wright & N. A. Cummings (Eds.), *Destructive trends in mental health: The well-intentioned path to harm* (pp. 253-282). New York, NY: Routledge.

Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations.* Washington, DC: American Psychological Association.

Zur, O. (2008). Re-thinking the "power differential" in psychotherapy: Exploring the myth of therapists' omnipotence and patients' fragility. *Voice: The Art and Science of Psychotherapy*, *44*(3), 32-40.

Zur, O. (2013). *Culture of victims: Reflections on a culture of victims and how psychotherapy fuels the victim industry*. Retrieved from www.zurinstitute.com /victim_psychology.html

Zur, O. (2017). *Power in psychotherapy and counseling*. Retrieved from http://www.zurinstitute.com/power_in_therapy.html

Zur, O. (2018a). *Ethics codes on confidentiality in psychotherapy and counseling*. Retrieved from http://www.zurinstitute.com/ethicsofconfidentiality.html

Zur, O. (2018b). *The truth about the codes of ethics: Dispelling the rumors that dual relationships are unethical*. Retrieved from http://www.zurinstitute.com/dualtruth.html

Veldhuis, C. B. (2001). The trouble with power. *Women and Therapy*, *23*(2), 37-56. https://doi.org/10.1300/J015v23n02_04