

Reflections on a 30-year Journey through the World of Psychotherapy Theory

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INTRODUCTION

In three decades of study in the field of psychotherapy, I have explored a multitude of different perspectives, and found something of value in most of them. I have long been intrigued by the alternative paradigms of psychopathology versus adaptation; treatment versus growth.

This paper explores how I integrate the various theories I draw on in my clinical practice as a somatic psychotherapist and mental health social worker. I describe the impact of evidence from neuroscience and developmental research for mental health, as well as contributions from contemporary intersubjectivity theory. I attempt to integrate a scientifically-grounded, bio-psycho-social view of mental health with a postmodern view of the self, one which is contextually and relationally constructed, yet ultimately fluid.

1980's

The impact of the biological in understanding human functioning has long impressed me. From a phenomenological point of view, the body is "the vehicle of being-in-the-world" and "ours is an embodied consciousness" (Merleau-Ponty in Spinelli, 2001 p82).

My first encounter with psychoanalysis was through the writings of Wilhelm Reich, who took up Freud's libido theory and developed a system of character analysis (Reich, 1933/1972) based on the "functional unity" of body and mind (Reich, 1951/1979 p105).

Reich saw mental health as resulting from the release of pent-up emotions, so the life force can resume its natural flow. He argued society was culpable in causing emotional repression, especially towards the holding and nurturing of infants and the healthy expression of sexuality. His radical views from the 1930's fitted well with the anti-psychiatry and encounter movement which gained popularity in the 1970's.

Another strong influence at that time was Carl Rogers' person-centred psychotherapy (Rogers, 1961), which underpinned and pervaded the new crop of experiential, humanistic therapies. After witnessing some family members' experience of the psychiatric system, I adopted the optimistic view that mental illness could be cured by body-inclusive emotional expression, authentic communication, healthy boundaries and the pursuit of self-

actualisation. As well as Reich, my sources included Eric Berne ((1964), R D Laing (1960), and Virginia Satir (1964/1983).

Undertaking a social work degree extended my view of the person to include their social, economic and cultural context, emphasising the forces at play in individual lives which influence and limit choice. However, the lack of psychological analysis in social work led me back to the milieu of psychotherapy. After five years of experiential and theoretical training, in 1989 I began my private practice as a somatic psychotherapist.

1990's

Encountering a wide range of client presentations, I began to explore the world of psychoanalysis, particularly object relations theorists such as Melanie Klein (1932/1975) and D W Winnicott (1957/1964). The dynamics of unconscious communication, particularly in the therapeutic transference and counter-transference, opened a new dimension in my view of assessment and treatment.

I found the theory fascinating, but did not feel at home with the role of the knowing and interpreting therapist. My doubts about supposed analytic neutrality, and my awareness of the power differential in the analytic relationship, kept me sceptical of this method, which seemed to require a handing over of authority to the therapist during long years of treatment.

I struggled with the contradictions between my developing style of practice and the postulates of psychoanalytic psychotherapy I was learning in courses and supervision. Some clients responded well to transference interpretations but many did not, and my own experience as a client in this kind of psychotherapy confirmed it was not for everyone.

In my practice, I was integrating an approach which included a supportive therapeutic alliance, some use of touch and other body-focused techniques, and an exploration of unconscious relational dynamics, as appropriate for each particular client.

In this period I encountered the Diagnostic and Statistical Manual (American Psychiatric Association 2000), and studied the psychopathology of personality disorders according to post-Kleinian and object relations writers such as Otto Kernberg (1984/1986), Harry Guntrip (1992) and Joyce McDougall (1982/1986). The psychoanalyst I was most influenced by, however, was Donald Winnicott, with his refreshing simplicity towards mothers and babies and the analytic encounter.

In addition, by studying infant observation, I encountered the world of attachment research, particularly that of Bowlby (1969/1999). I began to distinguish evidence about early childhood experience from theoretical conjecture on the unconscious motivations of children and adults alike.

2000's

Becoming dissatisfied with psychoanalytic psychotherapy and the theory that underpins it, I discovered a new approach to the therapeutic relationship in Heinz Kohut's (1971) self psychology. Conceiving of the unmet relational needs of the patient as understandable in the context of their emotional development, Kohut describes how to treat narcissistic and borderline disorders as "disorders of the self", by providing the "self-object experiences" (Lessem, 2005 p90-1) which the patient needs to build internal cohesion and resilience.

I found Kohut's argument, that empathic understanding is what humans need to grow a healthy functional self, quite compatible with my humanistically-oriented approach to body psychotherapy, particularly as it recognised that corrective emotional experience has a place. This seemed especially relevant to the client population I saw most of: individuals with difficulties stemming from trauma, abuse and neglect in their developmental history.

According to Nancy McWilliams, the influence of humanistic, existential, self psychological and intersubjective theorists led to a widespread revision of psychoanalysis in the late 20th century, culminating in a "redefinition of both developmental theory and clinical technique, to reflect the central role of the self" (McWilliams, 1999 p165).

Self psychology privileges understanding the client, through empathic immersion in their subjectivity, over objective forms of assessment. Symptoms and dysfunctional patterns are seen as adaptations in the service of cohering a fragile self-structure; hence, the therapist aims to understand the patient's experience from within, rather than interpret it from outside. This is compatible with Rogers' client-centred psychotherapy, but extends the role of the therapist towards providing specific self-object experiences according to the client's unmet developmental needs.

Reading further on infant research, I explored evidence on the role of attachment in normal human development. Research by Daniel Stern (Stern, 1985) and Beebe and Lachmann (Beebe and Lachmann, 2002) reinforced the impact of caregiver-infant relationships on the developing baby's internal sense of self, other and the world.

The implications of this research for psychotherapy treatment are significant. The importance of attunement is supported by studies on the impact of secure, avoidant, anxious and disorganised attachment patterns (Karen, 1994/1998 p211), and also by Kohut's analysis of the developmental value of meeting a child's or adult's narcissistic needs for mirroring, idealisation and twinship (Lessem, 2005 p9).

I also studied Stanley Greenspan's developmental psychotherapy (Greenspan, 1997), in which he shows how the style of a patient's communication – whether through behaviour, gesture, or language which is concrete, affective or symbolic – can be highly indicative of the level of integration or "differentiation" (Greenspan, 1997 p163) they have attained. This

knowledge can help the therapist meet the child or adult patient with developmentally-appropriate engagement, rather than expecting a maturity they cannot muster.

Working within a supportive-empathic stance, my integration of the various psychodynamic theories and methodologies formed into an approach wherein I noticed the unconscious signs in clients' body language, behaviour and speech, and factored it into my understanding of how they operate and see the world, but offered interpretations only as far as the client seemed secure enough to receive them. My case formulations were based in both humanistic and psychodynamic theories.

NEUROSCIENCE

The 1990's were dubbed 'the decade of the brain' by Allan Schore, a prolific writer on neuroscience and attachment. His research used functional MRIs to document brain development and in particular, the right-brain-to-right-brain non-verbal communication which occurs between mother and baby, and between all humans in relationship (Schore, 2003 p39).

Schore's "Affect Regulation and the Repair of the Self" (2003) had a profound impact on my understanding of how trauma is carried in the mind and body, and how the neural pathways in the brain are laid down via repeated experiences with significant others, particularly caregivers in early childhood. This and other research, such as Bruce Perry's (2007) work on trauma, validated the view of body psychotherapists, who have long held that "the body keeps the score" (van der Kolk, 1996).

Writers such as Daniel Siegel (2000), Bonnie Badenoch (2008), and Fosha et al (2009) have examined the implications of brain research on how best to conduct psychotherapy treatment. They provide evidence for the therapeutic value of a relationship which is supportive, understanding and empathic, as well as providing psycho-education and positive behavioural reinforcement.

One significant piece of scientific research which I believe has implications for assessment and treatment is Jaak Panksepp's "Affective Neuroscience: the Foundations of Human and Animal Emotions" (Panksepp, 1998/2005). This study presents neurobiological evidence on the brain systems which produce emotions in all mammal species, including humans. Panksepp shows how emotions arise, in response to events external and internal to the body, in the lower and middle areas of the brain, after which they flow to the upper or cognitive part of the brain (Panksepp, 1998/2005 p43).

Panksepp argues that the social-constructivist view of emotions, which posits that human emotions arise out of cognitive perceptual processes, is not supported by the biological evidence (Panksepp, 1998/2005 p44-5). He shows that, while there is evidence of a two-way

flow between the cognitive and affective parts of the brain, suggesting that thoughts influence emotions to some extent, the vast majority of neural flow is from the emotion-centre to the neocortex.

I believe this evidence is important in trying to understand how humans operate, being biological creatures with a mind, a body, and particularly, a nervous system and a brain. It implies that treatment needs to involve more than a client's thoughts and beliefs. In my view, the affect system, involving both emotions and moods, is of primary importance if we are to understand and help people to manage their lives better.

Stolorow showed in "Faces in a Cloud" (Stolorow, 1979/1993), that each of us is drawn to theories and treatments which 'speak to our condition', and this is certainly true regarding my view of the primacy of affects. However, psychological theories need to be tested on the available evidence, and I see validation for body-inclusive psychotherapy (and other humanistic approaches) from research in three important areas: infant development, trauma theory and neuroscience.

The implications for practice which I draw from this growing body of contemporary research are: that healthy development depends on appropriate relational attunement from caregivers; that self-cohesion is a result of building the capacity to regulate one's affective experience and integrate it into a meaningful whole; and that this capacity develops by gradually internalising self-regulation in an attuned and understanding relationship.

For me, the role of the psychotherapist becomes clearer in the light of this evidence, and leads to questions about what kind of relationship best facilitates such growth, how long or short the process needs to be, and how the therapist can adapt to different clients, who may present as more or less fragmented, overwhelmed, defended or dissociated.

My approach to assessing and treating clients is strongly influenced by the evidence mentioned above, as well as contemporary self psychology theory. Shane, Shane and Gales' "new self psychology" (Shane, Shane & Gales, 1997 p3) emphasises the new relational experience between therapist and client as a way of reworking the transference, focusing equally on positive new growth as on understanding the dysfunctional patterns of the past.

SUBJECTIVITY

While scientifically-based evidence has gained increasing importance in the field of counselling and psychotherapy, another trend of equal impact is the postmodern turn towards the study of subjectivity.

Postmodernism argues that theories do not describe objective reality, but rather, the subjective viewpoint of those who construct them (Teicholz, 1999/2001 p72). In recognising the co-construction of subjective reality in relational and cultural contexts, postmodernism

has removed the old certainties about truth and meaning, and revolutionised our view of how “self” and “other” come into being.

Atwood and Stolorow’s (1984) intersubjectivity theory and Stephen Mitchell’s (1998) relational psychoanalysis have implications for the role of psychotherapy in both clients’ and therapists’ lives. The mutual influence of both parties upon each other, the co-creation of experience in relationship, and the co-construction of meaning in relationship, are important factors which have influenced my view of both assessment and treatment.

In considering how to apply the insights of postmodernism in practice with clients, I find Donna Orange’s focus on working “as engaged partners in the joint search for meaning” (Orange, 2009 p131) a useful guide. Meaning-making is considered to be one of the inborn tendencies of humans (Spinelli, 1989/2005 p144), and also one of the key functions of psychotherapy, so here again I see biology placing a natural limit on the deconstructivist endeavour.

Nevertheless, the constructivist critique of the influence of theory upon our view of what is observed, has been extremely valuable in questioning the dominance of diagnostic labels in assessing the mentally ill, the disempowered, and social minorities of gender, race and culture (Berman, 2010 p31).

For example, recent formulations of borderline personality disorder as a pattern of fragmentation in response to massive, early trauma, show a more compassionate understanding of this condition, and illustrate the power of theory to colour the way a client is seen and treated (Rosen, 2012). Schizophrenia, too, is being reconsidered as more than simply a biological disorder, with the Hearing Voices movement (The Age, 2012) finding ways to understand and dialogue with the voices patients hear, rather than just quell them with medication.

Postmodernism urges clinicians to hold their theories “lightly” (Orange, 1995 p52), and draws attention to the power relations and cultural forces at play in the therapeutic relationship. It also reminds us that all evidence, however scientifically derived, is embedded in the context in which it arises, and could well be superseded by later understanding.

In “The Suffering Stranger” Orange describes the intersubjective application of the “hermeneutics of trust” (Orange, 2011 p25), exemplified by a compassionate attitude of coming close to the client’s subjectivity and trying to understand, through dialogical engagement, their life experience.

INTEGRATION

Above I have outlined the various writings that have influenced my thinking and practice, and drawn out the implications of these for assessment and treatment. My aim in this paper is to describe how I currently integrate what seems valuable from these various strands of theory and research, into a cohesive view of how to help people manage their lives and find fulfilment.

I place a high importance on assisting clients towards greater self-regulation, a central part of which is regulating their affects. This necessarily involves processing aspects of their thoughts and beliefs, to come to a more harmonious integration of the whole self. It also involves developing their awareness of their emotional experience, and building the skills to manage feelings and resolve the difficulties these present. For many clients it will also involve processing trauma within a safe “relational home” (Stolorow, 2007 p49).

Since registering as a mental health social worker in 2007, I have seen an increasing number of patients under mental health care plans. This work is short-term and necessitates reports to the referring doctor, outlining a succinct treatment plan, in terms of the criteria established by Medicare for evidence-based “approved focused psychological therapies” (Australian Government, 2011). The list of approved therapies may be weighted towards cognitive and behavioural forms of treatment, but it also includes interpersonal therapy, psycho-education, skills training and relaxation strategies (Australian Government, 2011 p5).

“Formulating a case is a subjective, speculative, individualized and comprehensive process” (McWilliams, 1999 p200). For me, the pragmatics of private practice mean I need to be flexible, open and collaborative with clients about the treatment plan we decide on. At the end of the first session with a new client I will sum up for them my thoughts on the main issues they have brought, and how I would approach working with those.

Whether or not a mental health care plan is involved, with all clients I am accountable directly to them for the effectiveness of the treatment. I find that the client’s goals and wishes have a major influence on the direction and duration of the treatment, which reflects the intersubjective nature of the therapeutic process. My treatment plan develops as the sessions unfold, and is modified by what I learn from the client, how they respond to my interventions, and also what ideas and reflections emerge in my supervision.

It is my belief that an attuned psychotherapist can adapt their style of relating to what the client seems to need from the relationship. In particular, the therapist can gauge how much to provide a client with mirroring, space, direction, intimacy, warmth, self-disclosure, following, challenge, humour, flexibility, containment, homework, information and so on.

I also believe the various goals of treatment can be successfully blended in a mix which responds appropriately to the needs of the client. Teaching clients techniques to manage their anxiety or depression can be incorporated with processing of trauma, psycho-

education, reframing negative self-talk, affect regulation, making sense of experience and integrating new meaning. All this can take place within a reliable holding relationship where more unconscious self-object needs are addressed, such as offering reflections in a manner which empathically mirrors the client's self-statements back to them.

Experience has taught me that different clients require and respond better to different therapeutic orientations, so being flexible in applying different paradigms is an important skill. Many theories are built around a certain type of presentation or client sub-group, for example Freud's treatment of oedipal problems or Kohut's approach to narcissism. What is helpful for fragile or sensitive personalities will not be appropriate for more robust, defended individuals.

Clients with a resilient, functional self may seek counselling after one traumatic experience, and be able to recover their trust in life within a short number of sessions. Others find they need months or even years of psychotherapy to rebuild a highly damaged inner self. I think most practitioners would agree that the deeper and earlier the trauma, the longer and more relational the therapy will need to be.

My current approach to psychotherapy may be summed up as one which aims to help the client integrate their feelings and thoughts into a self-regulating and flexible self-structure, incorporating self-awareness, trauma resolution, meaning-making and self-care practices in an appropriate blend which fits the individual person and their stage of development.

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