

# psychotherapy: paradoxes, pitfalls & potential

Michael Soth

We do not resolve our conflicts. We lose interest in them as we grow out of them. The polarisation of opposites which we suffer is not resolved, removed or even transcended, but it does not necessarily have to continue to dominate our experience, if we can enter, sustain and rest in the underlying paradox freely re-formulated after Jung:

*External pressure and internal conflict are inherent in the therapeutic position*

The professions of counselling and psychotherapy are under pressure and in conflict. Externally, we are under pressure through constant challenges by the media and by other helping professions. Along with the trend towards professionalisation, there are calls for scientific validation, and demands for a coherent, unified model, especially one that is consistent (or at least comparable) with the 'medical model'. Internally, we are in conflict, fragmented into a multitude of competing schools and approaches, with continuing rifts and splits which have characterised the field from the beginning.

My assumption in writing this article is that external pressure and internal conflict are inherent in the therapeutic position. And my suggestion is that

we will find it difficult to respond to the conflicting demands which we necessarily attract both in society and in the consulting room, unless we ourselves embrace the essential paradoxes underlying our profession. We cannot contain the client unless we can rest in the paradoxical nature of the therapeutic endeavor. We are trying to do an impossible job which is inherently paradoxical.

It seems to me that only by entering (rather than trying to overcome or resolve) the underlying paradoxes *experientially* (rather than only philosophically), do we stand a chance of responding therapeutically to the polarisations we are being invited into - individually by each particular client and collectively by the public at large.

## **Client - therapist rship = rship between public - therapeutic professions**

I am thinking here about our position as a profession in relation to the public as analogous to my position in relation to a client. I see a parallel between working with collective transference in relation to us as a profession and working with individual transference in the consulting room: both are characterised by external pressure (in the transference) and internal conflictedness (in the countertransference). And I am suggesting that we work this parallel both ways: that we apply learning from our practice to the public domain and vice versa.

Having followed public criticisms of counselling and psychotherapy over the years in some detail, I am convinced that they are largely based on major and fundamental misconceptions of our work - and of the '*psyche*' of *psychotherapy*.

In responding to public demands for a coherent, safe, predictably and quantifiably effective, unified therapeutic profession we are in a tricky position - it's quite similar to being with a client who demands drugs to cope with their pain: do we collude and just give in to the demand? Or do we think about it within *our own* frame of reference, i.e. psychologically and therapeutically?

How is such a client best served, and what is our role and task? And how do we fulfil this role and task when we take into account that more often than not the client is caught in major and fundamental misconceptions of our role and task and the therapeutic process in general ?

If this client could understand and relate to their issue the way I, as the therapist, understand and relate to it, they wouldn't be experiencing it as a problem in the same way (by 'understanding' I obviously mean much more in this context than 'intellectual understanding').

**'The field of psychotherapy is as fragmented and conflicted as the psyche of its patients - and practitioners. And maybe that's alright. Maybe we do not have to deny paradox, conflict, unpredictability, pathology and diversity in order to make ourselves publicly acceptable.'**

The dilemma for the therapist is not only that the client brings their pain and how to respond to it. What complicates therapy is that this client is presenting their pain in a conflicted and ambiguous fashion, refracted through the lens of their own distorted 'mapping' of it and exacerbated by their own defensive relationship to it. Generally speaking, as therapists we are lovers and allies of a psyche which only comes to us as mediated through an ego which has a very ambiguous and conflicted relationship with psyche.

It is significant that in response to the external pressure through the client's pain and demands, we are immediately full of polarised questions: do I go along with the client's demands, or is there a way in which these demands themselves are an expression of the

problem, rather than 'the solution' which the client apparently has already concluded it is?

'As counsellors and psychotherapists we are trying to do an impossible job which is inherently paradoxical. We cannot contain the client - individually or collectively - unless we ourselves can rest in the paradoxical nature of the therapeutic position.'

This is a simple illustration of the external pressure and internal conflict inherent in the therapeutic position. In order to extend this into a formulation of the paradoxical nature of therapy, I first need to focus on how therapists and therapy models may avoid, minimise or try to overcome this pervasive sense of conflictedness.

#### **How does a therapist deal with / minimise / override this internal conflict?**

There are a variety of ways in which we are tempted to minimise the intensity of our internal conflict as therapists.

#### **Therapist focussed on client's conscious personality only**

As long as we see the client as equivalent with their - let's call it - conscious personality (which they identify with and which apparently is making the demands); as long as we have no doubt that the client *is* what they are

saying and demanding, there is no reason at all to hesitate about annihilating that pain, in whatever way possible. It's an unnecessary, meaningless experience which the client would obviously rather be without, and there is no loss in anaesthetising it.

Problems arise for the therapist out of the recognition that the client is not just their conscious personality, but that - psychologically, albeit unconsciously - a whole lot more may be going on. On the receiving end of the client's communication we may, for example, get the distinct and significant impression that the client is *also* identified *with* the very pain which consciously they are identified *against*. That creates a conundrum: we realise that there is a fairly intense war going on, that there are two polarities which are experienced as irreconcilable by the client, but that *both* polarities are invested with and carry an important part of the client's being: the pain *and* the urge to get rid of the pain. Whilst on the one hand we empathise with the impulse to get rid of the pain, *empathically* we *also* understand that a part of the client lives in that pain and is identified with it. Therefore, we do not want to lose sight of the possibility that this same pain is essential to their experience of self, that as part of the process it therefore needs to be felt, that it even heralds (and contains already) the urge towards transformation - thus we are inclined to hold out against any attempt to numb or suppress it.

Any approach which attends to the client's conscious *and* unconscious aspects immediately operates within the territory of internal conflict. If the therapist empathises with the client's whole being, there is usually no way around empathising with two

conflicting and apparently mutually exclusive polarities at the same time.

Some therapists might try to muddle through the specific dilemma in my example by maintaining a position which apparently does sufficient justice to both 'de-sensitisation' as well as embracing the pain. Generally speaking, they may oscillate between doing a bit of relating and a bit of treatment, a bit of empathic listening and a bit of directive structuring. And this may in fact be all that we can do in practice. However, for the purposes of therapy (rather than the therapist's survival) the point is that the client has entered an internal war zone: they are in territory where they *do* experience two conflicted and mutually exclusive polarities. To the client it *does* feel like either - or, all or nothing. To do 'a bit of both' often boils down to the therapist clinging to a defensive position which avoids entering the intensity of that conflict.

### **Therapist overrides conflict through reverting to approach**

So how do we deal with this conflictedness in the countertransference?

The two main questions through which the conflict tends to manifest in the therapist's mind concern intervention and understanding: what should I do ? what is going on ?

In trying to answer these questions, there is usually an implicit assumption that there is a 'right' (i.e. therapeutic) thing to think or do. The point, however, is that the therapist is in conflict precisely because there appear to be at least *two* conflicting 'right' things to think or do.

In response to the mounting pressure of these conflicting demands, sooner

or later the therapist is liable to 'crack' and revert to their own habitual stance in response to stress, doubt or uncertainty. There come a point where the therapist takes refuge in their therapeutic 'credo', i.e. their own basic belief as to what should happen in therapy: a Reichian may require the client to feel and discharge the pain through primal catharsis, an analyst may coax the patient into 'making sense of it symbolically' by interpreting it as 'acting out', a Jungian may persuade the client to 'actively imagine' it, a Gestalt therapist may get the client to enact it, an NLP therapist might try and extend the pain into other 'representational channels', etc, etc.

Whatever the 'truth' and the appropriateness of any such intervention, it is - at the very least - bound to be *perceived* by the client as 'taking sides' in the client's internal war, even if the therapist is not explicitly biased towards one of the client's polarities over and against the other. However valid and therapeutic the therapist's application of their theory and technique may be, we do not want that to incline us towards ignoring the simultaneous counter-therapeutic implication: in becoming associated with one of the sides in the client's internal conflict, any intervention is liable to be experienced as a betrayal of the other polarity. An important part of the client's being will necessarily feel betrayed by *any* perceived bias on the therapist's part, whether intended or not.

This betrayal constitutes a re-enactment of an habitual relational pattern which the client suffers both externally and internally. The more the therapist contribution comes out of their own habitual stance, the more likely it is

that the therapist remains unaware of the counter-therapeutic effect of their 'therapeutic' interventions.

**Three parallel relationship patterns: original, internal(ised), re-externalised**

It may be useful at this point to spell out some of my implicit assumptions when talking about the client's habitual internal conflict. These can be formulated succinctly in terms of the basic object relations insight that there is a parallel between an original relationship scenario and the way it becomes internalised as a pattern by which the client now relates to themselves internally, and that this is in turn paralleled by the re-externalisation of that pattern in the transference to the therapist.

From this perspective, therapy is already set up to be the repetition of a relational pattern which is the origin rather than the solution of the problem. And no therapeutic model or concept, and no therapeutic tool or technique is immune against becoming a vehicle for this re-enactment.

To illustrate this abstract, theoretical principle through the example of the client demanding drugs: for the therapist to just give in, without a sense of internally feeling conflicted about it, inevitably carries a sense of something being missed: the crucial point is that the client is making these demands *of the therapist*. What is being conveyed in the transference is disappointment and a continuing lack of faith in the 'other', feelings which the client may well be unaware of.

**THREE PARALLEL RELATIONSHIPS**

1) ORIGINAL RELATIONSHIP	PRIMARY SCENARIO: the forces in the childhood psychological landscape	past relationship(s)
becomes internalised as ...		
2) THE WAY I RELATE TO MYSELF (internal conflict)	CHARACTER (FROZEN LIFE HISTORY): habitual ways of relating	internal and internalised relationship(s) - object relations
is manifest/becomes re-externalised in ...		
3) THERAPEUTIC RELATIONSHIP	TRANSFERENCE (as well as other relationships)	here and now relationship(s)

Maybe the client comes from a family where substance use and/or abuse was the dominant model for coping with pain. Maybe they never had an experience of being contained by another, have never felt their pain being transformed through contact. Without such an experience as a reference point, the best they can then hope for may indeed be chemical numbing. I am not at all suggesting that the therapist steadfastly refuses the client's demands on the basis of a general policy or ideological position. On the contrary: the therapist may well conclude that it is not the point now to change the habit of a lifetime. I am not concerned here with what the therapist ends up doing or not doing. I am concerned with what has already happened prior to the therapist doing anything: in demanding that the therapist subdue their pain, the client is already subduing a part of themselves in the same way in which - we assume according to the object relations formulation above - they felt subdued originally and from then on throughout life.

In some cases the client will experience the therapist's collusion with their demand as a weak and over-anxious lack of faith, repeating a relationship pattern of lacking containment in a way which the client is probably only too familiar with, both internally and externally. And the opposite is equally likely: in other cases (or at some other time) the client will experience the therapist's holding out *against* the fantasised 'soothing' through the drug as a re-traumatising withholding of empathy and mirroring, thereby re-enacting a harsh and unresponsive 'other'. This - again - may well repeat a basic

feature of the client's internal and external relationship experience throughout their life history.

This illustration takes us back to the point stated earlier that any intervention can fuel, or at the very least, *be unconsciously perceived* by the client to fuel a re-enactment of one of the wounds which bring them to therapy in the first place.

### **Re-enactment not only unavoidable, but necessary**

In a previous article in S&S (Vol. 27 No. 1) I have referred to re-enactment as the foundation of an integrative model and how we can link this to an understanding of the therapeutic position as rooted in conflict.

Above I have now sketched some ways in which we are tempted to override that internal sense of conflict inherent in the therapeutic position.

The function of the therapist reverting to their own habitual stance, their 'credo', is precisely to minimise internal conflictedness and avoid awareness of the inevitability of the re-enactment. However, there is going to be re-enactment *whichever* polarity I take sides with, deliberately or by default. And here we begin to catch the first flavour of paradox: the more I try to avoid re-enactment, the more I contribute to it happening, albeit surreptitiously and unconsciously.

So far I have talked about re-enactment as possible, likely, even unavoidable.

However, when we take one further step, when we embrace our internal conflict and re-enactment as *necessary* to the therapeutic process, a crucial point becomes apparent: the re-

enactment carries information about the client's most basic and pressing habitual patterns. Because the re-enactment, according to the diagram above, is a parallel process to the original and internal(ised) relationship pattern, it takes us right into the heart of where it hurts and matters

The client - at least unconsciously - *needs* the therapist to be conflicted between polarised feelings, impulses, thoughts. *That* is the avenue by which the client's conflicted internal reality communicates itself to the therapist and re-appears in the countertransference as contradictory therapeutic impulses. That is the 'royal road' taking us into the essential wounds which tear the client apart and bring them to psychotherapy. In order for these wounds to be addressed, their impact needs to be felt fully (i.e. in detail and across all the levels physical, emotional and mental) by the therapist.

### **Entering internal conflict = getting drawn into polarisation and re-enactment**

This could be summarised in fairly general terms: the therapist's commitment to psyche implies being and remaining available to being constructed as an object by the client's unconscious. This is equivalent to being 'contaminated' by and drawn into the client's conflicts and unconscious inner world (via projective identification) to the point of recognising how the client's wounds are re-enacted in and through and by the therapist, their therapeutic interventions and therapy *per se*.

It is the communication of the client's unconscious reality of conflict, pain and potential which manifests in the

countertransference as contradictory and irreconcilable therapeutic impulses. To formulate it in very condensed jargon terms: our therapeutic impulses are basically parallel process enactments of the client's (original and internal) object relations.

The therapeutic process, therefore, *necessarily* entails that the therapist spends considerable time feeling conflicted and subjected to an internal sense of polarisation.

One basic recognition which follows from this: no therapeutic theory, model or concept, and no therapeutic technique, exercise, strategy, structure or tool, can be *in and of itself* therapeutic. If each and every 'therapeutically intended' thought and action is liable to have implicit counter-therapeutic effects, we need to conclude that 'therapy' does not inhere in therapeutic theory and technique, but in something else *beyond* theory and technique. We might be tempted to call this amorphously the 'quality of the relationship' - as the crucial therapeutic factor underlying both theory and technique. But to leave it at that means we do not phenomenologically enter the internal experience, the therapist's internal process. As described above, the therapeutic process necessarily pulls the therapist into all kinds of internal polarisations - a minefield of internal conflict - which the therapist needs to contain moment-to-moment in order to sustain and 'provide' that so-called 'quality of the relationship'.

### **The territory of paradox : embracing the paradoxical nature of psychotherapy**

When we attend to the pervasive presence of the counter-therapeutic in all our therapeutic efforts and

intentions, we begin to push through to the territory of paradox.

The client's internal splits and associated 'fixed ideas' will necessarily touch and exacerbate the therapist's splits and associated 'fixed ideas'. When this happens, the therapist ideally needs to be not only available to be 'constructed as an object by the client's unconscious', but in the inevitable second step also to be 'de-constructed' - which is even less palatable or predictable. It involves de-construction of the therapist's established way of being in the relationship, i.e. de-construction both of the therapist's role *and* person. The therapist's identity, both professional and personal, is then on the line, and the therapist's clinging to their 'credo', certain theories, techniques, ways of working may get in the way of the continuing process. To do justice to the process, the therapist then probably needs to enter the territory of paradox.

Jung's 'theory of opposites' and his idea of 'entantiodromia' formulate the swinging between polarities, where at its furthest peak of development one polarity turns into its opposite, as an essential feature of the individuation process. A therapist who is too identified with a particular 'credo', with a particular view of health and therapy, will find it difficult to hold the space for the underlying paradoxical nature of the process when it swings from one extreme to the other. In order to contain the process of polarisation we need to be rooted in the possibility of paradox underlying the two polarities. This is what I understand John Rowan to be referring to when he speaks of 'dialectics as a felt experience ...: that is, going through and beyond our conventional splits into

a kind of wholeness'. That wholeness is paradoxical rather than 'perfect'.

Paradox can be experienced as maddening when our ego wants to overcome it or get rid of it; it can be experienced as containing when we can rest within it.

For example: from a 'medical model' perspective the task of the practitioner is to remain neutral and objective, the assumption being that we can *only* be helpful as long as we remain 'outside' of the client's pathological experience. From this perspective the question how one could possibly allow oneself to be 'contaminated' whilst remaining therapeutic, how to be merged and be separate at the same time, appears every bit as impossibly paradoxical as the physicists' conundrum at the beginning of the 20th century whether light is a wave or a particle. There is no way the dualistic ego can imagine this, and the idea of it being *both* would not occur, let alone the notion that they depend on each other.

The essence, however, of my argument above is that I can *only* be therapeutic if I get 'contaminated' to the point of re-enactment, that I can *only* contain *through* feeling conflicted, that my congruence and authenticity as a therapist are *only* therapeutic to the degree to which I can embrace their opposite, i.e. conflict, incongruence and fragmentation.

Many of my supervisees work with an implicit notion of re-enactment, but initially - once they understand it - they usually take it upon themselves to try and stop it happening. They correctly intuit the danger inherent in it. They tend to formulate their therapeutic responsibility as having to do everything in their power to try and avert it. However, as mentioned



above: the only effect of fighting against re-enactment, is to bring it about all the more strongly, but unconsciously - this makes it next to impossible to contain it when it does happen.

To the ego this is an entirely inconceivable paradox: for the client to re-experience in therapy and at the hands of their therapist the very pain they want to overcome through therapy, must be a 'bad thing' which the therapist must avoid at all costs. However, from a perspective which embraces the paradox we can say: we can only have a therapeutic position, if we can lose it. The working alliance is only as strong as our capacity to survive its breaking, and it needs to break in order for it to exist.

### **Paradox as necessary for working at the edges of ego**

As long as client and therapist are content to work within the territory established by the cooperation of their two egos, there is no need for paradox. There is a paradigm of change which is syntonic with the ego: it relies on the ego's strengths: goal-orientation, vision, determination, focus, power-over - Wilber might call this kind of change 'translation within the egoic sphere', and that is an important process which only anti-egoic anti-heroes would want to exclude from the therapeutic endeavor.

However, there is another paradigm of change which - happily following Wilber's terminology - we can call 'transformation': for us in the post-modern West this boils down to engaging with the conflict between ego and everything outside its territory (which is the bulk of existence). This paradigm of change may also involve pushing and vision

and will, but beyond a certain point opens out to the spontaneous emergence and re-organisation that occurs when a 'holon' (in Wilber's terms) transforms to another level of complexity. This process involves an experience of self-regulation and self-organisation *beyond* the confines of the ego, a surrender to a larger force and container. In the Reichian tradition we tend to recognise this spontaneous process most readily as coming through the vegetative, physical levels; the Jungian and transpersonal tradition is more sensitive to its manifestation on the level of image, symbol and imagination.

Such transformation inevitably puts the therapist into a paradoxical position: being available to the endless dichotomies of egoic experience without our own ego fully believing them, i.e. being drawn into the emotionally intense experiences of polarisation, but *not* to take sides, to participate in the inherent agony without aborting it. Transformation requires holding of polarities until re-organisation occurs *spontaneously* - in its own good time.

### **Psychotherapy IS paradoxical because psyche IS paradoxical**

When we are working at the edges of ego, and have sufficient experience of surviving intense polarisation and sustaining paradox, we are beginning to look at therapy through the eyes of the psyche rather than the ego. This article would not be complete without acknowledging that this is territory in which James Hillman has been vociferous for the last 30 years. He claims that 90% of psychology (and he includes psychoanalysis and psychotherapy in this broad use of the term) is in the service of ego.

He outlines a variety of ego fallacies which make it hard for us to apprehend and relate to psyche. We therefore need, he says, a therapy of our ego-restricted therapeutic ideas.

From the perspective of ego one of the worst things is that psyche is not linear, categorisable. Psyche disappears from view when approached with neat sets of one-to-one categorisations, however accurate or useful they are. Psyche is associated with Hermes, the trickster, with the ambiguous twilight of the moon, rather than the solar dualism of light and shadow.

Psyche is distinct from body, mind, and spirit, and therefore does not obey the laws of biology or logic or transcendence. More often than not, our therapeutic ideas of progress, growth, development, integration, even individuation are tools and objectives of the ego.

Psyche has affinity with pathology and suggests other ways of relating to wounds than DSM IV. Psyche is polytheistic and lives in multiple meanings. Psyche escapes integration attempts aimed at unification. Psyche plays with our reductionist interpretations and reveals them for what they are: fantasies. Fantasies are what psyche thrives on.

To an ego depending on its own version of reality this is all paradoxical from start to finish. Psyche, however, breathes and lives on paradox like plants on sunlight. When psychotherapy as a profession tries too hard to deny paradox, to avoid ambiguity and uncertainty, to minimise conflict and tension, or to reduce diversity, plurality and unpredictability, we may be getting rid of essential qualities of the very psyche which psychotherapy is supposed to attend to.

## **Is there enough room for paradox in the profession?**

Let me, therefore, return to the parallel between the consulting room and society: what are some of the implications for containing our countertransferential response as a profession in relation to the public ?

### **(Mis)-perceptions of our role**

Engaging with the public's widespread misconceptions of our role cannot simply be a question of education and giving information. Transference projections cannot be 'explained' to the client when it suits the therapist - it's a question of ripeness in the process and even then it's not a matter of 'explanation'.

Publicly we *will be* misperceived and required to fit the more familiar role descriptions and paradigms, such as doctor, teacher, advisor, social worker. As long as the culture misperceives and struggles against psyche, we cannot expect to be understood and appreciated on our own terms as psychotherapists. Whether we like it or not, if we set ourselves up as therapists to individuals, we will acquire a therapeutic function within the body politic. As a profession we are necessarily engaged in a therapeutic process with the wider public.

Other professions make their useful contribution to society each within their paradigm. If we want to do our job, we ourselves need to be anchored in ours - I am suggesting that our paradigm necessarily include paradox. Our role is not to be too clearly defined into a role, but to hold the tension between - for example - doctor and therapist, or priest and counsellor sufficiently, so that the client's unconscious can define *us*.

### Sustain internal conflict: plurality

If, as I have suggested, internal conflict in the countertransference is inherent in the therapeutic position, the equivalent is true for us as a profession. If we want to be psychotherapists to and within a body politic, we need to sustain internal conflict *psychologically*. We can then see the lamented fragmentation of our profession also as a strength and necessity: different approaches cater for different territories of the psyche, whether we distinguish these territories in terms of Wilber's four quadrants and/or different stages of development or - a lá Hillman - in terms of Greek gods and goddesses (who get jealous when one of them is being worshipped exclusively).

This is not to deny that the field's history of parochial imperialism has been detrimental. To varying degrees all of us have been on a 'trip' and have used our approach as a defensive crutch to bolster our ego and identity, addictively clinging to it with insular dogmatism. But, beyond this, we can see each approach as a fantasy, not in the sense of it being 'unreal', but in archetypal psychology's sense as the ground of all ...

Each school is - initially through the subjective perspective and pathology of its founder - sensitised to certain 'truths' and attracts - both for the 'right' and the 'wrong' reasons - a group of followers who resonate with this perspective. This inevitably implies certain shadow aspects and insensitivities which get structured into the 'culture' of each particular approach - like a patient, each approach has its areas of differentiated awareness, expertise and competence, and its internal contradictions, idiosyncrasies, hypocrisies, its own 'unconscious'.

'I take this to be generally valid, although not acknowledged by all theoretical schools: as therapists, we inevitably feel conflicted and torn - the therapeutic position necessarily inclines us towards contradictory impulses and responses.'

When we see our commitment to psyche and the process of psyche as preceding and prior to any identification with a particular therapeutic school or approach, we not only appreciate the other schools and approaches, but more than that: we paradoxically *need* the plurality, diversity and internal conflictedness of the field. Paradox cannot be explored, let alone 'resolved' by abstract discussion. It needs experiential and therapeutic rather than philosophical or theoretical work. Paradox can be experientially entered into, physically, emotionally, mentally, if we can sustain an attitude of 'not knowing'.

*Michael Soth is a psychotherapist, trainer and supervisor, and a Training Director at the Chiron Centre in London. As an Integrative Body Psychotherapist, inheriting concepts, values and ways of working from both humanistic and psychoanalytic traditions, he is interested in the therapeutic relationship as a body/mind process between two people who are both wounded and whole. A fuller, more detailed version of this article is available on his website. During the spring term 2003, he will be running a series of Wednesday evenings in Oxford on the theme: 'psychotherapy: paradoxes, pitfalls & potential', open to the interested public and practitioners - for further details call: 01865 725 205, email michael@soth.co.uk, or visit www.soth.co.uk*