Blog Entry 2 – June 27th 2013

In an impossible profession, the therapist *needs* to fail

In the last entry, I suggested that psychotherapy's depth, impact and effectiveness would increase dramatically, if we took the notion of the 'impossible profession' not as a quip, but as an essential reality – as the paradoxical foundation of our work. Today – without yet delving into any deeper reasons or explanations - I will state the same point from the therapist's perspective, by focusing on that interesting moment when the impossibility emerges as a crisis in the therapist's professional identity which they bring to supervision …

You may ask: if the impossibility of the impossible profession is so obvious to me, why is it not known or generally accepted or obvious to everybody? Well, it is known – as a quip. Like a joke, the quip both reveals and occludes, at the same time. The quip keeps things ambivalent. As Freud pointed out, a joke is funny because it reveals a deeper truth – precisely a truth that we have sort of known, but which has been hitherto kept unconscious by denial.
Yes, I think on the whole, it's not only the general public that is in denial about therapy. Worse than that: we, as a profession, are in denial about ourselves as a profession and some of its essential inherent features.

There is a well-known and insightful quote[1] regarding our profession from Dr Ian Suttie, an early Scottish psychoanalyst whose influence on the development of psychoanalysis in the UK is underestimated[2]. He said: "There is only one kind of person attracted to this work [he meant psychoanalysis, but it's true for all therapy], and that is somebody in pain. Once they have been attracted to it and trained in it, there are two kinds: those that deal with it and those that don't."

Pain: those that deal with it and those that don't

We might say that over the last 100-odd years of our relatively young profession we have not quite managed to "deal with it". As we know from our clients, and from ourselves as clients, when it comes to 'dealing with it', we have an ambivalent response to pain: one response where we are capable of being interested, compassionate and reflective; and another response where we fight it and just want to get rid of it, overcome it, zap it.
Explore versus deny, engage versus control.
We can read the history of our field in terms of this ambivalent response: across the multitude of therapeutic models and approaches, how much of our theorising and practicing is inspired by our capacity for enquiry and thinking from *within* the pain? And how much is based upon 'finding a solution', *fixing* it by overcoming, transcending or plain getting rid of the pain?

As therapists, we understand better than the rest of the population that both in relation to physical pain, but much more so in relation to emotional pain, a simple knee-jerk reaction towards getting rid of it by resorting to a 'pain-killer' can be dangerously misleading. It helps the person ignore and deny the pain, which then gets driven underground, festers and eventually creates much bigger problems. This is not meant as some kind of rigid anti-position, where I am categorically opposed to taking painkillers. Precisely not: neuroscience, especially in relation to traumatic pain, has established the central importance of 'regulation'. That means: regulating the pain both 'up' and 'down', within the window of tolerance. It means as a therapist being *equally* open to soothing the pain as well as to intensifying it. And at the extreme ends of the window of tolerance, and from within the traumatised state, that translates into: 'killing' it versus 'making it happen'.

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1 I have used this quote before, when I was interviewed by Therapy Today Journal about my personal journey and why I became a therapist – you can read the full interview here: http://www.therapytoday.net/article/show/2237/

2 Cassullo, Gabriele (2010) Back to the Roots: The Influence of Ian D. Suttie on British Psychoanalysis. American Imago, Vol. 67, No. 1, 5–22. The Johns Hopkins University Press

So I am not arguing against painkillers, nor the painkilling reaction which underpins it. I am not polarising against symptom-reduction or 'fixing' or 'making better' which are necessary elements of what therapy does and does need to be seen to deliver.

What I am trying to do is to clarify the *psychology* of pain which helps us understand the addictive pain-avoidance which has become taken-for-granted as a norm in our culture. Therapy cannot escape the public misconception that – as doctors for the feelings – the supposed aim of our work is symptom-reduction and the killing of emotional pain. Half the time, that's what clients think they pay us for: good therapy equals making things better which gets equated with reducing the pain. From our side we understand, of course, that it's more complicated than that. We understand that not all pain is bad: that psychological growth and maturation occur through confronting and embracing pain – 'dealing with it'.

Psychotherapy's ambivalent response to pain

But how we go about that, and are capable of going about that, is deeply conditioned, framed and limited by the history of our profession. In clarifying the psychology of pain, I am also trying to acknowledge, for myself and all of us, that we are not beyond and above that same ambivalence towards pain which possesses the culture and our clients. The same ambivalence has pervaded our profession and its historical development, across the modalities and approaches. Whatever training and therapeutic orientation we have pursued, at best we inherit a profoundly ambivalent toolbox of models and techniques.

As those of us remember who trained in the 1980's, traditionally, the field of psychotherapy was fragmented into diverse, dogmatically fundamentalist tribes, competing with each other for the 'best' or 'true' solution.
Becoming attracted to a particular tribe and its inherent subcultural norms and theoretical edifice, was inseparable from idealising the 'solution' it promised. As students, we – at best: semi-consciously - selected and then got trained into a particular one-dimensional approach and modality because it seemed to provide *the* fix for conquering our own pain and that of the world.
In the process, we also acquired many precious experiences and insights that helped us to connect with, explore, reflect upon and eventually understand our pain. Most of us are grateful for the growth and psychological maturation which thus became possible and which now allows us the capacity to embrace pain, to surrender to it, to follow it and continue learning from it.


Klaus Elle (1988/89): Große Gefühlsgestalten 017
www.klauselleart.viewbook.com

So, on balance, we have ended up with an ambivalent capacity: to both inhabit the pain and think from *within* it, as well as an abundance of tendencies to provide the answer and overcome and kill the pain (which is the unfortunate thread that our therapeutic identity and reputation hangs on).

So whilst in degrees the training helped us "deal with it", in large measure our attraction to our chosen approach was fuelled by an idealisation of the symptom-reduction and painkilling it seemed to promise. It is inevitable that when we are about to commit ourselves to a psychotherapy training, and are about to hand over years of our life and thousands of pounds, we are inspired to the investment by some idealisation. Without that, not enough people would sign up to therapy training, nor to therapy for that matter. We cannot legislate against that even if we wanted to (and thus do ourselves out of business), and we cannot deal with it by up-front customer information.

The need and the impulse towards idealisation are not amenable to rational discussion or information. Depending on your viewpoint, this has unfortunate or fortunate implications: it does mean that eventually the process (our own and the work with our clients) will eventually drag us toward the moment of disappointment, when the promise breaks, the idealisation crumbles and the underlying impossibility of the profession finally has some space and time to dawn.

When supervisees realise that the inside experience of the therapist at work is not at all so sunny and straightforward as they had expected or wanted to - and were led to - believe in training; when they become despondent about their lack of impact on clients; when they lose their faith in therapy; when they hit that shocking brick wall, I take that as an indication that the impossibility of the profession is knocking on the doors of perception and awareness:

“My clients resist and avoid, or obediently comply - which is equally problematic. They push themselves when they shouldn’t, they leave before they’re ready. They control the session and they complain, and I struggle. I come to supervision and I *feel* like I am failing – failing my clients, myself, the profession, you as my supervisor, some ideal of what should be possible …”

At this point, my supervisee is all wrapped up in the feeling of failure – both overwhelmed by it and struggling against it - and they tend to take the experience very personally.
From my perspective, the struggle goes beyond the personal: I see them becoming immersed in the impossibility of the profession, whilst simultaneously resisting it, believing that it *should* be possible, that the textbooks *should* make it easier, that it *should* be a linear process, that some other therapist *would* know how to do it better. I see my supervisee as caught in fighting against the impossibility, fighting their disappointment, the loss of their therapeutic identity, the deconstruction of their cherished assumptions and idealising notions. At this point, my supervisee has no idea that it might be possible to *inhabit* that impossibility – to work from *within* it, rather than *against* it; to surrender and inhabit it, rather than trying to deny or overcome it.

As the supervisor, I can at this point see a variety of avenues that offer themselves for exploration. Because the supervisee takes it very personally, anyway, the first productive avenue would be to reflect on these feelings of failure as the therapist’s own wounding or pathology (i.e. as their own shame or defeat), and I often do. Next, I could explore it as what I call ‘habitual countertransference’[3], and I often do. And I will definitely enquire into it as countertransference to the particular client who evokes these feelings, and I usually do.

On top of all that, it comes with the territory that I myself feel implicated in the atmosphere of failure, as if it is me who is failing my supervisee. When they find their job impossible, is it not me as their supervisor who is responsible for protecting them and sufficiently containing them, making sure they are “fit for purpose”, as one of my clients calls it? When I feel that I am failing my supervisory task, I can then comprehend this as parallel process, and I usually would.

But often – it seems to me - all of this will still not quite do justice to my supervisee’s struggle. They may then react by imploring me to help them re-double their efforts: to advise them on further CPD training, to give them more book references, to explain some key principle to them again – there must be *something* they can do to make the grand project of therapy work the way it was supposed to.

Anything to keep the idealised frame of therapy intact and the show on the road.

This is the point where, as the supervisor, I may be inclined to say something to the effect of:

[3] the therapist’s assumptions, scripts, beliefs about therapy and what makes it work – their own unconscious construction of the therapeutic space, rooted in their own life story and character style

"Therapy IS impossible. It's not just a *feeling*, not just *your* feeling. Your feeling is not a *mistake*, and not *your* mistake. It does not just *feel* impossible – it is true that it *is* impossible. If and when therapy works, it does so *in spite* of its fundamental impossibility, not *because* it's possible, as you have been taught to believe. It works *in spite* of your efforts to make it work, not *because* of them. To think that this is just your individual shortcoming, character flaw, stupidity or incompetence adds insult to injury and is undermining, damaging and uncontaining: to yourself, to the client, and to the process."

The supervisee will often reply in disbelief: "But you are just saying that. *You* would know what the right intervention is, and *you* would be able to do it."
So I say: "Regardless of your feeling of failure, the point at this particular juncture in the process is that *you* are irreplaceable - this impossibility is unique to the relationship between the two of you, and there is no *right* intervention. There is no *right* thing for you to do. Typically, there are *two wrong things* for you to do at this point. For the sake of the process, you - as the therapist - *have* to fail."

"I don't understand why I have to fail. I feel I *am* failing, but I don't like it - that's not what I had in mind when I became a therapist."

"Well, from where I am sitting it was you who - maybe not knowingly, but for some intuitive, ingenious reasons of your own – signed up for an impossible profession."

Both my supervisee and I will recognise at this point that I have not yet spelled out what *actually* it is that makes therapy impossible. I haven't given any theoretical reasons or explanations for *why* ours is an impossible profession. I have simply stated it as a fact – with both disturbing and reassuring implications[4]. My supervisee is supposedly failing their client, and I am supposedly failing my supervisee – with the little difference between us being that I *know* that this failure is inevitable and potentially productive, whereas my supervisee still imagines that there is and should be a way around it.

As long as we are compelled to seek ways around and out of the inherent impossibility, we perpetuate the ambivalence which has characterised the field of psychotherapy over the last century - and continues to do so. But denying the inherent impossibility, psychotherapy fails to grasp the paradox at the heart of its own endeavour and denies the essence of what makes therapy work.

The question is whether it is possible to find a position beyond that ambivalence. In future blog entries I will want to come round to more of an explication why our profession is – and needs to be – impossible, drawing on a selection of ideas mined from research amongst colleagues.
But for now, let's keep it nicely amorphous and mysterious, so we do not rush prematurely to conclusions before we have grasped the full extent of the issue, which I intend to pursue over the coming months in this blog.

… to be continued …

[4] when I address this point in training, it is not uncommon for the group to respond in both ways: some feel predominantly thrown, disempowered and disturbed; and others feel relieved, like a huge burden is lifted off their shoulders: "I came away from the workshop feeling so much more able to give myself permission for my struggles as a therapist. For years, I felt like a fraud and a charlatan, because it seemed I was sneakily getting away with appearing professional in spite of my inner struggles which I was hiding from my colleagues and supervisors, because I was indeed assuming that these struggles were due to my own lack of competence and understanding. I suddenly feel more able to inhabit the therapeutic position, with all of its uncertainties and feelings of failure, because I begin to understand that these are – as you said – a necessary part of the job."