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Is psychotherapy a vector for isolation and anomie?

MARK FURLONG

A key traditional question the client learns in the conventional psychotherapies is ‘Am I getting what I want?’. But can this question incite a mindset that does not align with the ‘give and take’ essence of sustainable everyday relations? Is it possible that the psychotherapies—if these practices can be bundled together—might teach clients to become more self-centred and relationally illiterate? MARK FURLONG suggests that well-intentioned practitioners can inadvertently de-empathise, ignore or even disrupt their clients’ intimate networks. Findings from his research support the proposition that the action of the mainstream therapies tends to undermine the service users’ prospects for sustainable personal relationships. Exceptions were found in the specialist settings of paediatric and aged care, and in narrative and family therapy practice.

It has been a blessing to be involved with the psychotherapies over several decades. Working with many committed and talented colleagues has pressed me to learn much that is both vivacious and disciplined. The opportunity to work with individuals and families, often over extended periods, has been its own reward. The roles of therapist, trainer, consultant and researcher have been personally enriching, accompanied by complex and rare privileges, delights and satisfactions, as well as travails.

With that said, it is troubling to think that there is an active possibility that the psychotherapies—if these practices are bundled together—might teach clients to become more self-centred and relationally illiterate. This is not to say that this is the deliberate intent of therapists, as most practitioners are well-meaning, professionally committed, learned and client-centred. Nor is it suggested that clients are not feeling helped. Rather, while the outcome may be that the client feels somewhat better, they may also have been taught inadvertently to become more assertive and entitled, self-knowing and ‘in charge’, self-accepting and less guilty. This secondary outcome is not likely to enhance the client’s prospects to sustain a robust and intimate sociality.

Good personal relationships have to be learned and earned. As much as they are wonderful and joyous, our contacts with others can also be irritating and compromised. A key traditional question the client learns in the conventional psychotherapies is ‘Am I getting what I want?’. But can this question incite a mindset that does not align with the ‘give and take’ essence of sustainable everyday relations? Might the conventional therapies, such as cognitive behavioural therapy, have the effect of pulling the relational rug out from under the client’s feet?

This is not a minor concern given that psychotherapy has become a mass practice. According to Hugh MacKay (2002), perhaps the highest profile social researcher in Australia, in 2002 around 5% of the population (approximately 1 million people) consults some kind of counsellor or therapist at least once a week. It is likely that this figure has increased since the recent introduction of Commonwealth government rebates for accredited mental health professionals delivering psychotherapeutic services. If the psychotherapies are designed to ameliorate or resolve presenting problems, how is it then that they might re-socialize clients in a way that erodes, or even disrupts, the prospects for personal relationships?

Nikolas Rose (1999), an historian of the psychotherapies and unofficial biographer of the Tavistock Centre, proposes the following starting point to understand how clients are influenced in psychotherapy:

“The psychotherapies, the languages of the psychotherapies, their explanations, their types of judgment, their categories of pathology and normality, actually shape, have a proactive role in shaping, the subjectivity of those who would be their consumers. I think in those circumstances it’s not surprising that people will understand themselves in analogous kinds of ways when they go into the psychotherapies and will often find a certain kind of hope and comfort (in this story)” (p. 42).
Rose is suggesting that participation in the therapeutic process has several levels of action. The most obvious level is the matter of symptomatic relief, which presumably is all that is sought by the customer. Yet Rose highlights a larger effect—the reforming of the client’s subjectivity. He argues that this partial ‘turning of the self’ reflects the therapist’s specific model. To a demonstrable extent, this becomes the revised template for the client. While, in general, there can be symptomatic improvement, clients may also experience significant internal reorganization and resocialization—even if they did not sign up explicitly for this secondary outcome.

For example, consider the situation with ‘Kevin’, a man in his mid-forties who consulted a well-qualified CBT practitioner on the advice of his general practitioner. The referral took place after his GP told him “you have a mild to moderate depressive condition”. Although not thrilled by this announcement, the diagnosis did not surprise him as he was aware he had been feeling frustrated at work, distant at home, and dissatisfied (‘snakey’) with himself and his life to an unusual degree over several years. Kevin told his GP he had a ‘high powered job’ that earned him ‘a serious income’ in terms of salary, perks and bonuses, and that he also had a ‘stable marriage and home life’.

In his initial discussions with Mya, his therapist, Kevin found himself intrigued by the idea that he was experiencing ‘cognitive distortions’ and ‘irrational beliefs’. In his own mind, he had long seen himself as a hard-headed pragmatist, albeit a person of clear values, and found himself curious, even fascinated, by the prospect that he might be able to release himself from the habits of mind, patterns he had learnt early in life, that were preventing him from being ‘personally effective’ and his ‘own boss’.

Coached by Mya, Kevin began to feel re-energized over their eight contracted sessions. During this time he clarified, and established a plan to implement, a number of goals, several of which he decided he would not discuss with his wife, colleagues, friends or family. Most private of these goals was his decision to recruit a mistress: “I deserve the sex life I have missed out on all my life. I’ve always worked really hard and now I can afford this little bon-bon, this luxury. No one has to know about it and it won’t hurt my family, my wife or my kids if I take up this option—as long as I can execute this goal with precision. I’ll tell no one except, maybe, my older brother. With what he’s been through he’ll be on the same page and understand I’m entitled to get something for me. Shit, he might even be a bit jealous.” Mya had not discussed this goal explicitly with Kevin but, even if they had done so, she would not have thought its ethics to be her concern.

At the conclusion of their final session, Mya considered her practice

Illustration: © Savina Hopkins.
with Kevin a clear success. Kevin had been a model client, had followed the program she had mapped out and had even expressed his appreciation clearly, if not expansively. Mya might have been surprised if she had known that there was one idea that stood out for Kevin from everything that had happened in their work together. “Yes,” he said to himself, “the structured program was good and having someone who was absolutely in my corner was great. But the thing that got me really thinking, the thing that has got me starting to feel free, was when I heard her say ‘guilt is your single most useless emotion. It never does anyone any good. You feeling guilty is just an old racket, one that is stopping you from moving on.’ That was a revelation to me. She said something similar a few times—but it was hearing this the first time that got me round the corner.”

Is it really possible that clients might receive a specific re-socializing effect from their participation in the psychotherapies—an effect that inclines them towards what is interpersonally inept? Given that ‘the psychotherapies’ include diverse schools of thought often antagonistic to each other, in principle as well as tradition, can such a generic claim be made? This is a large question, one that necessarily involves an extensive conceptual and empirical investigation.

What conceptually unites disparate psychotherapeutic approaches—whether cognitive behavioural or psychodynamic, experiential or ‘new age’—is that each have the client put themselves at the centre of the picture. In terms of the particular kind of reform that therapists and counsellors propagate, Bauman (2003) suggests it is to:

‘...advise more self-appreciation, self-concern and self-care, more attention to their client’s inner ability for pleasure and satisfaction—as well as less ‘dependence’ on others and less attention to others’ demands for attention and care. Clients who diligently learned the lessons and followed the advice faithfully should from now on ask themselves more often the question ‘what’s in it for me?’’ (p. 58).

Roseneil (2007) concluded that the effect of such a pattern of ‘I-centred’ thinking is the creation of a life of ‘intense individualization’ (p. 126), a condition that creates isolation and loneliness.

Yet, how could this possibility be tested empirically? This presents a considerable challenge—even if a common axis can be identified that unites diverse psychotherapeutic traditions on the basis of implicit outcomes and theoretical focus on the interests of the individual, and this axis aligns therapeutic practice away from the importance of the client’s interdependence with their significant others.

To explore this question further a small scale empirical project with a sample of twenty-two private psychotherapists and mental health case managers was undertaken by the author (Furlong, 2007, 2008).

This project did not seek to measure outcomes, nor did it involve observing practice or meeting with clients. What was undertaken was a semi-structured interview process with a multi-disciplinary set of practitioners. These interviews focused on a specific research question:

‘To what extent, and in what manner (if at all), are affectionate relationships deemed to be relevant with respect to the matter of how practitioners understood ‘the self’, and with how these practitioners construct health and pathology, well-being and dysfunction?’

Analysis of the data generated a clear pattern: interviewees rarely presented clients as embedded, relational entities. On the contrary, clients tended to be viewed, often exclusively, as autonomous beings whose capacity to be in charge of their life was more or less flawed. (This finding held for both the private psychotherapists and for the mental health workers.)

Although this report offers slim empirical support for the contention that psychotherapy does not promote the client’s capacity for interpersonal sustainable personal relationships. In the main, the psychotherapies tended to ignore, disparage or even disrupt the importance of, and the skills and attitudes helpful for practicing accountable and sustaining personal relationships.

Exceptions were found in the specialist settings of paediatric and aged care, and in narrative and family therapy practice. While the study did not seek to explicate what was at play in these instances, it seems likely that in settings where the focus is on early or late life it is literally the case that significant-other linkages often have to be given a centre stage status, albeit to a mediated degree. In relation to the second exception, it seems obvious that the systems thinking end of the theory base of family therapy emphasises interdependence and that the narrative tradition privileges personal accountability, including with respect to the conduct of relationships. In case these comments seem to be ‘playing favourites’, it ought to be acknowledged that the majority of those trained in family therapy rarely now see family ensembles, and those working with narrative as their flag do not tend to actively convene sessions with couples or families preferring to see only those who offer to attend.

What brings the findings of this project into sharper relief is that there is now excellent public health research that validates the intuitive idea that ‘supportive relationships’ are good for a person’s health and well-being. Recent research on social networks, social capital, social exclusion and social epidemiology has concluded that a person’s well-being, quality of
life, mental health, even resistance to, and capacity to recover from, a range of physical diseases is indexed to the quality of that person's interpersonal life. Isolated people, for example, are many times more likely to suffer an early death compared to those with strong interpersonal connections: the evidence is that supportive relationships radically decrease the chance of having heart attacks, respiratory problems and cancer, whilst 'loneliness' (is) on the list of risk factors for ill-health and early death alongside smoking, obesity and lack of exercise. (Cacioppo & Patrick, 2008; see also Berkman & Glass, 2000 and Ryff & Singer, 2001). In this focus on personal relationships it is important to note that these webs of relationships comprise linkages that are intimate, at the same time as they may also be more or less traditional.

In light of this research on the importance of personal connections what do we know about the current health of personal relationships? We know that the 'single person household' is the fastest growing housing demographic across the western world; and there are mixed reports about whether the kinds of internet mediated relationships many people now have—for example, Facebook, email and multi-player gaming—are sufficiently robust to offer the secure attachments within which humans thrive.

In this context, it is important to consider the possibility that the psychotherapies—assumed to be key tools for promoting well-being—might be implicated in the patchy performance of modern relationships. Would it not be a real concern if the rhizome of 'what's in it for me' thinking is being propagated by a process of amoral thought reform humming at the centre of the conventional psychotherapies? Perhaps, the psychotherapies are becoming a vector for a disease that, as yet, has no medical name.

A brief vignette, albeit one that is apocryphal, might draw this short paper to a clear conclusion. Imagine a middle-aged man who comes to see a therapist giving the impression he is dissatisfied with his work, his relationships and, in a general way, his life. He does not appear to be either particularly depressed or distressed; rather, he reports feelings and thoughts consistent with a picture of anhedonia and listlessness. In the absence of any distinct pathology, in the first instance the psychotherapeutic formulation developed by the practitioner will depend on their chosen practice ideology. One school of thought would frame his presentation in terms of 'cognitive distortions', or 'the wounded child within', 'disowned depression', 'the mid-life crisis', 'a non-authentic false self', 'an underdeveloped feminine side', 'a disabling self narrative', 'ordinary psychosis', 'a case of non-clinical autism', and so forth. Alternatively, the therapist might re-define the man's presentation as the result of 'infantile attachment difficulties', another of 'an absence of positive goal setting'; another of 'emotional illiteracy'—there are many conceptual possibilities.

Later, as therapeutic work progresses, and again depending on the conceptual vocabulary preferred by the therapist, it follows that the client will be (more or less explicitly) coached towards becoming practiced in using well-researched techniques for the management of the self; more emotionally sensitive and expressive; aided to have his observing ego identify his projections; to author his own preferred story; or, to learn to be less shy and more entitled.

However sensible these approaches can be in particular circumstances, there remains the possibility that they are variations on the same theme: teaching a dog to chase its tail. If there is an absence of affiliation, if there is a quality of asymmetrical or even exploitative relatedness, that is the context to this man's dissatisfaction it will be counter-productive for the therapist to prescribe greater self absorption, the expectation he should get more of what he wants, or that he should more effectively mine his environment. It is from a critique of the pursuit of autonomy as an ascendant goal and value, together with the acceptance of the associated sub-values of self-actualisation (Maslow, 1954) and self-determination (Davidson & Rees-Mogg, 1997) that the concern with the workings of psychotherapy aligns.

References


AUTHOR NOTES

MARK FURLONG Ph. D. teaches Social Work at La Trobe University. Previously, Mark practiced in therapeutic and mental health settings for 20 years. He has published in Arena, Dissent and Overland magazines, as well in a diverse range of professional journals.

Comments: m.furlong@latrobe.edu.au

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*HoNOS Data—Years 2002 to 2009