

Beyond words – the role of psychoanalysis

Patrick Casement with the third of our special opinion pieces on 'improving access to psychological therapies'

My aim in this article is to consider some of the ways in which problem-focused therapies such as cognitive-behaviour therapy (CBT) may be attractive, but also some of the ways in which these therapies may in the long term fail to provide the relief that is most deeply being looked for. Patients frequently need time to achieve an enduring resolution to their inner conflicts. They must discover solutions within themselves rather than, as in some cases, having superficial solutions imposed upon them by someone who is aiming for quick results in order to satisfy those who are funding the therapy.

CBT as an attractive therapy

It can indeed be very appealing to think that here is a form of therapy that can be both brief and effective, and in some cases I believe it may be. When compared to psychodynamic therapies, CBT may seem to be much cheaper, so it will of course be attractive to a provider. It may also be closer to what many people believe they are looking for, in being given practical advice and being taught strategies for managing difficult situations. It may appeal to common sense more readily than do the mysterious theories and practice of psychoanalytic therapy. And it may seem to produce results that are more amenable to being measured than are the results from psychoanalysis or psychotherapy.

But what about when people have to

come back for more treatment? In the long term, CBT may not always be cheaper when consideration is given to those patients who find that the coping strategies provided for them have not adequately resolved their underlying conflicts.

From the position of any psychoanalytic practice we are bound to wonder about the effectiveness of a therapy that seems to suppress or change symptoms rather than to understand them. We are also concerned that there may be more trouble later from what is being suppressed or changed, and from what may remain unconscious, as symptoms are often an expression of unconscious conflict that is seeking resolution. So what may happen when the unconscious communication in symptoms is pushed aside in favour of some more immediate relief?

Unconscious communication

Some communication is not deliberate, and is beyond one's own awareness. It

may however convey some unrecognised intention, as in forgetting an important appointment with someone who is disliked. Similarly it may signal the presence of conflict that one may not be aware of, as in a slip of the tongue that indicates a hostile wish one may consciously want to conceal. Much unconscious communication is nonverbal, as in behaviour indicating unmet needs; for instance behaviour that conveys the need for someone to engage with difficult feelings or with a state of mind that has come to be regarded as unmanageable by others.

For monitoring the psychotherapy process, I have relied a lot on a clinical discipline I call *internal supervision* (Casement, 1985). This is how I have come to monitor my own work and the clinical work of those who present to me in supervision or in clinical seminars.

An important part of this internal supervision is 'trial identifying' with the patient. This means putting myself in the position of the patient in order to monitor

my own part in the clinical process, considering how they may be experiencing my input into a session. Another part of internal supervision is to look for unconscious prompts from the patient that can help me to recognise when a patient is being affected

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by me in ways that I had not meant, and had not anticipated.

For example, patients quite often give unconscious criticism of the therapist. Someone else may be spoken of as not understanding, or as avoiding something difficult, perhaps indicating that this is how the therapist is being perceived. Or a patient may speak of someone else who really addresses something difficult, as if to say to the therapist 'and why don't you?'

Staying with what is difficult or by-passing it

I have frequently noticed that patients show more than one level of response to what is being presented to them. Perhaps the easiest example of this is when we fall into giving some form of reassurance to a patient in distress.

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We might, for instance, be wanting to help a patient to see that things will get better even though at the moment they may seem very close to impossible. At one level a patient might show signs of gratitude that we seem to be helping them to get beyond their current sense of hopelessness. But, at another level, it often becomes apparent that a patient sees the therapist as backing off from what is most difficult for the patient.

A simple example of that may be before a break from therapy, as for a therapist's holiday. A patient may seem to manage, but they often show signs – if we can let ourselves notice them – that this coping has been at a cost. A patient may speak of no one recognising their state of distress, which could include the therapist. Patients also monitor to see if the therapist is willing to remain close to their inner states of mind.

I have often found that patients feel better held through a break when they sense that the therapist is willing to remain in touch with how shaky they are actually feeling. If patients are encouraged to step aside from their inner insecurities in order to appear to be coping while the therapist is away, they are left very much alone with their deeper fears.

Some particular states that may not be helped by CBT

CBT therapists are often giving their clients strategies for coping, which may be helpful to some, but there are many patients who need something much more than this.

An example comes to mind (see chapter 9 in Casement, 1985) of when I was seeing a patient with bulimia. She had already received 'a belly full' of advice from all those with whom she had close personal dealings with regard to her compulsive eating. She had received frequent diet advice, drug therapy (antidepressants and appetite suppressants) and behaviour therapy. Eventually she had been made to have her teeth wired. All of this had failed. What, in the end, had the most potent therapeutic effect upon this patient was her realisation that I had never tried to guide her or to tell her what to do, or what not to do. This had been the first time in her life that she had been in a relationship of this kind, a freedom being preserved for her in which she could begin to discover 'her own version of herself'. This phrase became a mantra that she frequently referred to, and it was

this in particular that she took away with her after seeing me for about 15 months.

This patient called on me 10 years later. She wanted me to hear and see how she had thrived since she had stopped coming to see me. She was clear that she had found in the analysis something that had been uniquely different from all other kinds of help that had previously been thrust upon her. Only in her analysis had she found a freedom to become herself.



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be able to bring all that has been most dreaded in themselves into an ongoing, present-day relationship, as with an analyst or therapist. They then need to be able to discover that this therapeutic Other is able to survive, without collapse or retaliation, all that had previously seemed to be dangerous, even lethal, if it wasn't kept away from a significant Other. Only then, and very gradually, may they begin to realise that they can allow themselves to be more fully alive, more free to engage others intimately, not having to remain fearful of their anger or their hate, their dependence upon others or their own aliveness (Winnicott, 1971).

This kind of work cannot, in my opinion, be engaged with in CBT, especially when a premium is being set on the length of therapy. Also, if we monitor a patient's responses to the therapist's style of working, we are likely to

find that patients are having their deepest fears seemingly confirmed, that this person too seems to be avoiding the worst in their mind. Even though that 'worst' in them may come to be better concealed as a result of CBT, it is not going to be detoxified. The unconsciously assumed qualities of all that is being avoided will then seem to have been too much for the therapist to manage.

Much takes place in therapy that lies beyond any matter of learning strategies for coping. There is much also that lies beyond words: beyond what a patient is able to speak about, and beyond what a therapist is addressing with their own words. If we are not going to fail our patients we often need to tune into the deeper significance of this – in symptoms, in behaviour, in avoidance, in tone of voice, in body language and manner. We need to monitor each party in the therapeutic relationship for the communication that lies beyond words. For it is here that we can discover how extensively some patients are affected by what they perceive in their therapists, whether the therapist is willing and able to stay with the deepest distress in their minds or whether the therapist is behaving in ways that are seen as an avoidance of that.

Another kind of patient who will not be helped by CBT is the kind that has come to be known as 'false-self' (Winnicott, 1955). These have come to feel that they have to satisfy significant Others in their lives by being good, by being compliant, by not being themselves. These patients, unlike the patient above, may seem to thrive upon being given advice, being offered strategies for coping. But all of this may only add to their problems about being real, in not daring to confront others, not daring to be as they feel.

A final group that may not be helped by CBT are some traumatised patients for whom the principal trauma has been internal. This can happen when a breakdown in relationship has been associated with a sense that a significant Other has not been able to bear the intensity of a patient's feelings and/or neediness, or indeed their own aliveness, most particularly during early childhood. (cf. Bion, 1967). As a result, patients may feel that they have to protect any significant Other from whatever is now thought to be too much for anyone.

These patients, if they are to get beyond this compulsion to protect their significant Others from all that is most alive in themselves, need eventually to