What is the mysterious process that determines how many clients we can ‘hold’ in our practice, and what factors affect our emotional space and capacity? Across a four-part series of articles, Michael Soth explores some of the fundamental factors.

There is a basic conflict structured into therapy – especially in private practice – between ‘love’ versus ‘business’, which none of us is immune to or can escape. It’s important to face this issue squarely, and not shrink from it. However, the simplistic polarisation between ‘love’ and ‘business’ easily becomes a trap, dreaded by therapists, epitomised by the common client question: ‘You’re only nice to me because I pay you. Would you continue seeing me [ie loving me] if I wasn’t paying your fee?’

This is a real question and it deserves a solid therapeutic answer. What may be is not straightforward or even possible to figure out if we take the question at face value only. What helps us avoid falling into the trap is the recognition that the question contains an even deeper polarisation which is inherently in our intersubjective practice.

In this series of articles I will attempt to clarify these notions. For example, there is a basic conflict structured into therapy – especially in private practice – between ‘love’ versus ‘business’, which none of us is immune to or can escape. It’s important to face this issue squarely, and not shrink from it. However, the simplistic polarisation between ‘love’ and ‘business’ easily becomes a trap, dreaded by therapists, epitomised by the common client question: ‘You’re only nice to me because I pay you. Would you continue seeing me [ie loving me] if I wasn’t paying your fee?’

There are many practical and emotional reasons why these things occur, and so many intangibles involved that we may well feel unable to make any conclusive assertions. However, applying a particular ‘psycho-logic’ suggested decades ago by David Malan, I have come to hypothesise a correlation between certain fundamental issues central to the therapist’s self-regulation as a practitioner, and how large, manageable and sustainable their practice can become. These issues only become fully evident when I get actively involved in the supervisee’s personal and professional development, and actually care about them thriving as a practitioner. Without that engagement on my part, manifest in how I handle the inherent parallel processes, I can’t expect much impact. I have clustered these fundamental issues into three topics:

• The therapist’s capacity to digest and compost the emotional impact of the therapeutic relationship as a bodymind process.
• The therapist’s capacity to embrace/inhabit ‘enactment’ as the central paradox of therapy.
• How entrenched or flexible the therapist can be in their ‘habitual position’, or their own unconscious relational ‘construction of the therapeutic space’.

In this series of articles I will attempt to clarify these notions and ideas, and how they impact on our practice, specifically on how thriving and sustainable it can become, for our clients, ourselves and the whole endeavour of private therapeutic practice as a business proposition (which some of us want and need to make a living from). Over the years, I have run several CPD workshops on this topic, with various cross-modality groups of therapists, giving me some insight into how the typical practitioner thinks about these issues and processes them, and more generally where our discipline is at in terms of the sustainability of practice.

Investment in marketing shows diminishing returns

Over recent years, many therapists have got their act together in terms of the business and marketing mechanics of running a private practice. The internet has given easy access to increasingly sophisticated tools and services, which make those tasks manageable. Businesses specialising in supporting self-employed therapists, as well as online directories and referral networks, have raised the professionalism to a fairly ubiquitous level, meaning that on this level there now remain only diminishing returns for establishing or expanding one’s practice.

Many workshops available for practitioners on the topic of making a living focus on the business skills needed. Other workshops focus on the therapist’s own ambivalence and personal issues around money, linking their struggles about charging money with underlying psychological issues of self-worth. This is a valid link to make and explore, as becomes apparent in supervision in situations where clients mess us around in terms of payment — our own issues are readily hooked then. However, many of these workshops — quite apart from their dubious narcissistic overtones — are based on the simplistic ‘go-getting’ assumptions, values and attitudes (‘You can create abundance’, ‘You deserve everything you want’ and I wonder whom they serve. They certainly don’t address the underlying tensions and vicissitudes that are necessarily inherent in our subjective practice.

A blank cheque for exploiting human suffering?

There is a basic conflict structured into therapy – especially in private practice – between ‘love’ versus ‘business’, which none of us is immune to or can escape. It’s important to face this issue squarely, and not shrink from it. However, the simplistic polarisation between ‘love’ and ‘business’ easily becomes a trap, dreaded by therapists, epitomised by the common client question: ‘You’re only nice to me because I pay you. Would you continue seeing me [ie loving me] if I wasn’t paying your fee?’
This is underpinned by our capacity for balancing our emotional spaciousness between work and home, between taking care of ourselves in the role of therapist and as a person, which is our whole life. In order to get some reflective leverage on how we actually do this balancing act in practice, and before I dive into this, let me lay out the three underlying issues across the subsequent articles, we need to establish some important and under theorised elements of the therapeutic position, the fragmented nature of the self-other boundary that forms our individual identity - and its undoing.

We need to understand our subjectivities from a depth-psychological perspective, the more we can understand how our object-relating is shaping and enabling how we negotiate the ‘deal of therapy with each client. Our early years – the client’s and the therapist’s – and how as infants and children we were used as an object, and how we were allowed to use the other as an object, are of huge significance in the therapeutic contract we make, whom they serve and how sustainable they are.

These are contested interpersonal territories, and the inherent struggle to make collective power struggles - cut across all the levels of the being, from the most personal to the familial, sociocultural and political economic. We want to be acutely aware of how we may be falling into neo-liberal stereotypes of late-capitalist relating, and how our practices extract and utilise these processes - identified by Menz - which turns natural and human resources into commodities to be bought and sold. And, in therapy, we are thinking specifically in terms of suffering and the need for attachment and love. Rather than trying to overcome these implicit struggles with pat recipes for individual prosperity, I am to get to the bottom of these emotional salient and unacknowledged attitudes inherent in therapeutic practice, respecting the mutual human attachment and always forms the foundation of our work.

Fully qualified! Ready to practise as independent therapists

The main assumption throughout the field seems to be that once we have qualified and our certificate is hanging on our consulting room wall, we are sufficiently prepared to translate what we have learned into running a successful therapeutic business and all that entails. Steadily maintaining our practice week in, week out, managing a substantial number of clients, they will be good for profit, with supple knowledge of supervision, taking responsibility for our own professional development and requirements as independent practitioners, running a self-employed business and competing in the marketplace.

I don’t think this assumption is born out in practice; even after 450 or more sessions of placements, the jump into the rigours of running a private practice (especially with anything resembling the kind of caseload that one can manage on a self-employed basis) is emotionally stressful and dilemmas, which many therapists are not prepared for. It’s one of the undertheorised aspects of the therapeutic movement that a plethora of therapeutic options necessarily contain for the client, who may experience the therapist as trying to be all things to all people, yet never taking a firm position that one can stand against. Importantly for our topic here, neither is an integrative approach containing for therapists - in most cases we do not actually feel very integrated, but more eclectically confused, oscillating between different therapeutic impulses, theories and approaches.

As we will see, the stress of the therapeutic position, which makes practice difficult to sustain, arises significantly out of uncontaminated, sublimated, dissociated and un-thought or unformulated processes in the relationship. Therefore, the very notion of ‘containing’, deriving a significant therapeutic principle from psychoanalytic clear that the range of clients and the problems they bring are much greater than our trainings have prepared us for.

Several decades ago, therapists also had to contend with the additional difficulty that they had been trained, within an atmosphere of tribal dogmatism between the approaches, into a somewhat blinkered and one-dimensional therapeutic position. This made it more difficult to cater for a wide variety of clients and their diverse needs, and made sustainable practice difficult to achieve. This tendency has lessened with the rise of the integrative movement over the last 25 years, and therapists to tailor their approach to the needs, values and belief systems of their clients. Therapists can now be responsive to the whole of the theories and theories and that are good things in the working alliance.

However, as precarious as this, the integrative movement has not made our practice more sustainable, contrary to what I would have expected 20 years ago, and I have been looking to find explanations for this. The best reason that I can offer is that the integrative impulse is quite validly pointing us towards some future possibilities of coherence as a profession, which we are not manifesting yet. As long as the outer integrative impulse itself is not matched by a corresponding integration within and between the therapist (specifically in terms of expertise and theoretical), we cannot expect ourselves to manifest a more self-sustaining and sustainable practice.

What we might mean by inner integration is a complex question, beyond the scope of this article, but let me include three points relevant to the current topic. As in any evolving system, one of our main challenges is to find a therapeutic stance that is both responsive and stable, flexible and containing - for our clients; and also contains us. So integration, driven originally by the impulse towards greater flexibility for the sake of our clients, must be an ongoing, dynamic process, which operates in dialectical tension between the integrative principle, which can be effectively described by integrating and psychodynamic orientations. Traditionally, openness and evolving flexibility have been championed by the humanistic approaches, in pursuit of human potential and diversity of the self-other boundary, and the psychodynamic tradition has emphasised stability and containment, some would argue to the point of rigidity and ossification. In order to transcend this polarization, what we need, also, is humanistic stability and psychodynamic flexibility, which are so inexorably connected, and are absolutely necessary in order to go even further and subjugate our needs to theirs. How we feel kinship with and our elders, our theories, our supervision, our community and peers, in the role of therapist and as a person with a life.

The hidden conflictedness of the therapeutic position

A key source of unprocessed bodymind stress for therapists is the conflict between the two parameters, important as they are. We typically do this by avoiding or minimising transferential and countertransference, in order to access vital information in the therapeutic relationship, the way we actively or covertly collude with the client’s working alliance, making it more difficult to anticipate and contain relational ruptures, which in turn increases the pressure in the system further.

One of the main problems affecting the sustainability of our practice is that we can position ourselves in the role of therapist and as a person with a life.

Rather than trying to overcome these implicit struggles with pat recipes for individual prosperity, I am to get to the bottom of these emotional salient and unacknowledged attitudes inherent in therapeutic practice, respecting the mutual human attachment and always forms the foundation of our work.

Therapeutic models and assumptions

Traditionally, therapeutic approaches used to be characterised and differentiated, compared and contrasted, by their theory postulates - the conventional and early psychoanalytical. However, in those days the therapeutic endeavour was exclusively conceived of as ‘treatment’, and the therapeutic position was almost exclusively conceived of as static, in terms of the paradigm. Remnants of such 19th century assumptions and paradigms can still be felt throughout the field, and influence our ideas of boundaries, accountability, pathology, therapeutic action and many other factors. As a result, we can still be stuck with dualistic medical model assumptions, imported from our professional from the natural sciences, even more so about themselves and their own bodymind functioning than about the client’s. In what follows, my argument has been that recognition that such linear quasi-medical principles are irremovable and alien to the essence of our work if used as exclusive or dominant explanatory frameworks, but necessary and helpful if taken as one concept expressed among others (neither falling into nor categorically refuting dualistic perspectives).

Lingering medical model assumptions

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My Perspective

failed to recognise at the time was that my thoroughly reparative stance and assumptions about therapy were already predicated on the conviction that there was a ‘wound’, a ‘deficit’ – a problem that needed ‘fixing’ and that would thus justify my existence and role as a therapist. The inescapable implication that my fixed perception of the urgent need for repair required a diagnostic stance on my part, was not reconcilable with my philosophical assumptions about life as I was fancying myself without diagnosis, and intuitively beyond theory and technique. It was operating on a prereflexive level within me – as my implicit, underlying relational stance.

Our underlying relational stance

The more we have come to see therapy not just as a treatment, but also as a first-person encounter, the more we recognise that our own contribution to the relationship co-creates that encounter. We, therefore, need to take into account our own relational stance and attitude (conscious and unconscious), which can no longer be assumed to be objective and neutral to the supposed ‘treatment’, but intrinsic to the intersubjective field. It is the shape of this field, including ourselves as wounded healers within it, which – for better or worse – is decisive to the eventual shape of the therapeutic process will take.

These statements are now well-established assumptions among the majority of therapists, with the medical model now comprehensively deconstructed as the dominant paradigm for psychotherapy. A simple way of phrasing this would be as a distinction between the 19th century assumptions of modernity and the 20th century assumptions of the postmodernists, who comprehensively critiqued the dualistic, positivist and reductionist beliefs of earlier generations (to their parents and grandparents, including their therapeutic forefathers).

In the modernist paradigm, the doctor examines the patient much like a scientific observer/researcher would, establishes a diagnosis which correlates the findings of the investigation with generally known theories and principles, and then prescribes and administers the most appropriate treatment indicated, according to that diagnosis. This paradigm assumes that objective truth is ‘out there’, irrespective of the therapist’s own subjectivity, and that healing arises through the ‘correct’ treatment. In the postmodernist paradigm, the client is not an inanimate object, but another human, whose subjective reality I can only hope to meet and engage with through my own subjective humanity. Whatever perceptions, understandings and interventions I come up with, they are considered as always already embedded and constructed by my own history and context, which is why the postmodernists say that ‘there is no truth ‘out there’, only perspective’. This paradigm assumes that reality is perceived, constructed and interpreted via the therapist’s own subjectivity, and that there always is an underlying, implicit relational stance, whether or not the therapist is aware of it and acknowledges it. There is no ‘pure’ or ‘objective’ theory and technique, uncontaminated by the therapist’s subjectivity. If possible at all, healing here is seen as arising through intersubjective dialogue, through the meeting between two vulnerable humans, their mutual exploration. If we do not want to reduce our conception of the relationship to something less than the sum of our personalities, we need to include what, following Watzlawick, we might classify in the widest sense as both pre- and transpersonal modes of being and communicating. There are many precious and satisfying experiences – including those of suffering – that do not depend on specialization, professional identity, or the power-over paradigm inherent in the medical model, and the work, which our empathy has necessarily opened us up to.

I summarise the contrast between the classical, positivist, one-person psychology assumption and the modern, relational, intersubjective, systemic, two-person psychology assumption in the following graphic:

19th-century one-person psychology

postmodernist, objectivist ‘medical model assumption

Taken for granted a third-person ‘I-It’ stance:

My own attitude and relational stance make no difference to objective ‘reality’ assumed to be ‘out there’. No reflexive stance or questioning of assumptions. All perceptions, understandings and interventions are considered as already embedded and constructed by my own history and context. This paradigm assumes that reality is perceived, constructed and interpreted via the therapist’s own subjectivity. This paradigm assumes that there is no ‘pure’ or ‘objective’ theory and technique, uncontaminated by the therapist’s subjectivity. If possible at all, healing here is seen as arising through intersubjective dialogue, through the meeting between two vulnerable humans, their mutual exploration.

The ‘Implicit relational stance’ underlying theory and technique

- My subjective being/beingness co-creates our relationship
- How I ‘see’ and ‘construct’ the world

My underlying, implicit relational stance

How I relate to the world, others and myself.

Polarisation between ‘medical model’ versus ‘antimedical model’

The distinction between these two contrasting philosophical underpinnings will become even more relevant, when we reflect upon which assumptions support us as therapists in noticing and then processing the impact of our involvement in the therapeutic encounter, on ourselves and our own bodymind, and what kind of assumptions get in the way and serve to keep us oblivious of our own vulnerability and susceptibility to mirroring, ‘spooning’, or the traumas and conflicts inherent in the work, which our empathy has necessarily opened us up to.

However, for our purposes here, we need to go beyond that simple binary historical distinction between the origins of therapy in 19th century medical model assumptions on the one hand, and the mid-20th century postmodern insistence on two-person psychology on the other. While the deconstruction of one-person psychology was entirely necessary, we can wonder whether we haven’t jumped from the frying pan into the fire – or at least from one extreme to another – by postulating an exclusive two-person psychology paradigm.

I have suggested elsewhere that the various perspectives that oppose the classical ‘one-person psychology’ paradigm – humanistic, existential, intersubjective and relational – are caught to some extent in an equally dogmatic antimedical model stance. By validly critiquing the medical model for its underlying objectifying stance, many of us have created an equal and opposite oversimplification, which reduces therapy to nothing but an authentic, dialogical, I-Thou encounter between existentially equals – a meeting which surprisingly, became therapeutic only through the mutual recognition of each other’s subjectivities.

This anti-position, as valid as it is in many ways, has a tendency to shrink our conception of how complex these subjectivities actually are, by falling into the wide open trap of Cartesian dualism, it usually ends up equating subjects with their reflexive, cognitive capacities, reducing them to ‘flatland’ personalities, without depth, passion or bodies, sometimes to the point of not even recognising the existence of unconscious processes.5

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very origins of our woundedness in contexts of early development that are characterised by intense helplessness and subjectifying, between treatment and human encounter, between ‘allowing myself to be used as an object’ and mutual recognition.

In formulating it like that, I immediately experience more spaciousness for the lived reality of my work, and feel a more compassionate embrace of our role as the ‘impossible profession’ and my place in it. How can it be possible to be comfortable in the therapeutic position as long as I am ignoring, minimising or skating over that inherent impossibility? This third, paradoxical position, ever torn between ‘one-person’ and ‘two-person’ paradigms, transcending and including both, never being able to simply exclude either, and reducible to neither, could graphically represent like this:7

(See diagram below)

One of our main challenges is to find a therapeutic stance that is both responsive and stable, flexible and containing - for our clients as well as ourselves.

The essential relational conflict inherent in the therapeutic position

The paradoxical integration of conflicting stances and paradigms

The sustainability of my practice, I contend, is proportional to the degree to which I can embrace and rest in that dynamic tension, inherent in that pervasive and ongoing paradigm clash. My practice is unsustainable to the extent that I am caught between-1 it and -1 relating, between objectifying and subjectifying, between treatment and human encounter, between ‘allowing myself to be used as an object’ and mutual recognition.

The therapist is situated in dynamic tension between these equally valid modes of relating (or kinds of relatedness): ‘I-It’ object-relating (which can be both deeply healing and deeply wounding), on the one hand and diadic ‘1-I’ subject-relating (which can be both deeply healing and deeply wounding) on the other. The therapist is caught on the seams between these opposing pulls, frequently torn between conflicting impulses (the client’s conflict becomes the therapist’s conflict), partly in response to transferenceal pressures and partly in response to the urge/fighting for mutual recognition.

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A third position transcending the paradigm clash

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