

# Embracing the paradigm clash between the 'medical model' and 'counselling' (2)

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# Overview



1. **The confusion** within the field of counselling and therapy



2. **The dualism within** the 'medical model'

3. **The dualism between** the 'medical model' and counselling

4. **The polarisation within** the counselling field

5. **The polarities within** our own practice

6. **Embracing the polarities** as ...

a) **psychological** (rather than ideological *only*),

b) **inherent** in the helping relationship and

c) **a possible avenue** into the depth of the process

# The dualism between the 'medical model' and counselling

- the paradigm clash between 'medical model' and counselling is implicit in everything which the hierarchical dualism of the 'medical model' rejects or labels inferior
- starting with its origins in Freud, our profession has emerged from within that paradigm clash, constituting and identifying with the neglected, inferior side

# Counselling as the art of 'mothering' ?

- **Emmy van Deurzen-Smith (1997) "The Future of Psychotherapy":**
  - what was traditionally the intuitive art of mothering, in our modern culture has become the profession of counselling; as a profession it needs the rigour of scientific validation

## Further Reading:

- **Soth, M. (1998) "Collective Mothering and the Medical Model", AChP Newsletter 1998**
- **Soth, M. (1997) "Collective Mothering and the Medical Model" - A response to Emmy van Deurzen-Smith's paper "The Future of Psychotherapy", European Journal of Psychotherapy 1997**

# “The professionalisation of motherhood...

“We have to transform what used to be a craft or an art based on moral and religious principles into scientifically based accountable professional expertise.

The craft of motherhood used to be based in biological and intuitive functioning, which was picked up through a process of intimate learning in the very families it would serve.

These were things women just simply did, because they were mothers and their mothers had done it before them.”

Emmy van Deurzen-Smith

# “From craft, through art and religion to science ...”

“So how can we transform what was once the craft of motherhood into something that is more like a science and which articulates and meets the overall needs of the human family?”

“But in all this there is a real risk: that the soft end of the spectrum of motherhood might overwhelm society in a counter-productive backlash that could lead to matronisation and unarticulated, uncontrolled emotional matriarchal domination. Many people who oppose our profession fear just such a backlash of soft and oozing self-indulgence and psychological pampering and they will keep fighting against the rise of psychotherapy until we can show what our profession can provide that is constructive and essential for a new world.”

Emmy van Deurzen-Smith

# The dualism between the 'medical model' and counselling

- paradigm clash could be expressed as the conflict between 'Medical Model Father Fat Controller' and 'Mother Counselling'
- we try to do our job, but on the scientific terms of the 'medical model'
- in a stereotypical image: counselling = the disempowered 'hysterical' woman who does not trust her own reality and feelings in relation to the rational doctor-scientist-man

Now, are you sure you know what you are doing ?



# The dualism between the 'medical model' and counselling

- the history of the profession could be written in terms of its various struggles *within* and *against* its position in that paradigm clash
  - taking 'medical model' for granted
  - trying to fit itself into it (accepting inferiority)
  - refusing inferior position
  - claiming its own paradigm (rather than inferior version of psychology and psychiatry)
  - opposition
  - partly dominated by it, partly opposing it, partly outside
  - third position which embraces the polarities



# A third position ?

syn-thesis

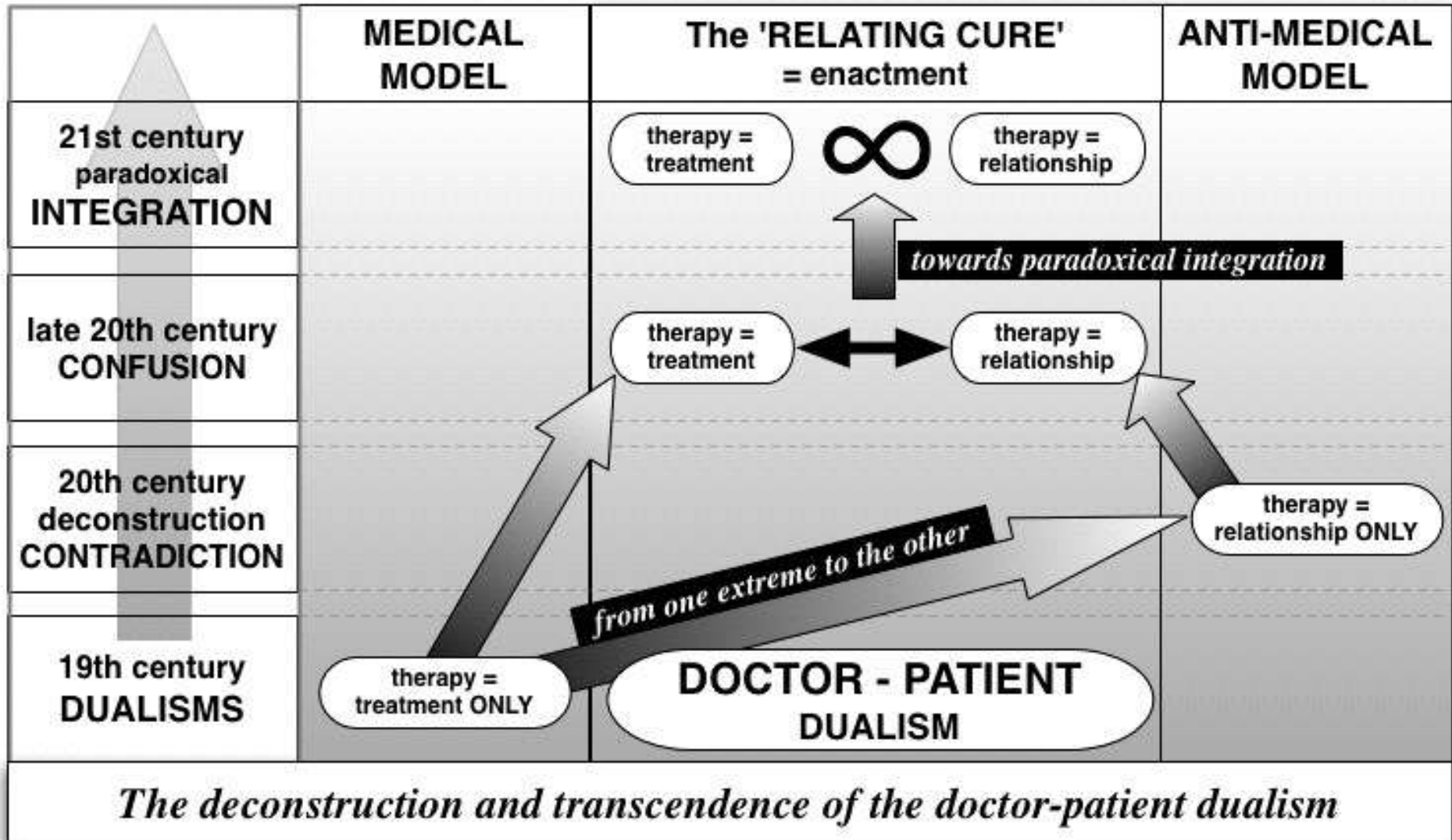


thesis



anti-thesis

# The deconstruction and transcendence of 19th century dualisms



Further Reading: Soth, M. (2007) The integrative project...

# The Fat Controller is dead (never existed)

- **in neuroscience & genetics ...**
  - the fantasy of top-down central control and regulation is seen as partial, misleading, insufficient
  - equally the fantasy of mind over body
  - self-regulation, self-organisation  
order = dynamic process, not static
  - complexity theory: white-water rafting

# The Fat Controller is dead (never existed)

- the 'Fat Controller' has had a bad time over the last 50 years, what with the anti-authoritarian 60's, feminism, postmodernism and the humanistic protest against behaviourism and psychoanalysis
- 'Fat Controller' has adapted and morphed into hi-tec version = internal manager

# The Fat Controller is dead (never existed)

- **the challenge to 19th century hierarchical dualism is at the heart of our profession**
- **counselling is (and has always been) based on some countercultural intuitions**
  - see Soth (2005): The ‘Relating Cure’
- **counselling is (and has always been) based on countering and opposing the ‘medical model’**

# The Fat Controller is dead (never existed)

- whatever the Fat Controller de-values, our profession restores value to, or works with
- Freud was ambivalent about the 'medical model' throughout: wanted recognition via the 'medical model', but resisted its dominance
- it is very difficult to challenge dualism without becoming dualistic and polarised

# The de-construction of dualism?



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a) **psychological (rather than ideological *only*),**

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# Polarisation within counselling field

- as evidenced through the polarised discussion in ‘therapy today’
- polarisations along a variety of dimensions
  - (not all neatly aligned or superimposed)
- ‘being a doctor’ versus ‘being a friend’
- how do we get to paradoxical third position?
- how do we integrate the various polarised positions ?

# 'medical model' vs 'anti-medical model'

doctor	versus	counsellor / therapist / friend
treatment	versus	'relationship'
monological: I-it (third person)	versus	dialogical: I-Thou (first-and-second person)
role	versus	person
a-symmetric	versus	mutual
expertise / authority	versus	shared humanity / woundedness
guide / healer / leader / doctor	versus	witness / companion / friend / facilitator
biological explanations	versus	psychological-relational explanations
diagnosis & treatment plan	versus	existential encounter (open-ended, unpredictable)
objectivity	versus	subjectivity & intersubjectivity
like a parent / responsible re-parenting	versus	like friends / lovers
client trapped in unconscious – needs help	versus	client knows best
reparative / transference countertransference r'ship	versus	authentic relationship
do a good job in client's interest	versus	be in a healthy jointly-created relationship
stereotypical father function	versus	traditional mothering function
structured, goal-oriented, 'making better' = symptom-reduction	versus	therapeutic space without agendas = existential encounter
business	versus	love



# No true integration by fudging the polarisation

- the confusion obfuscates the underlying conflict / paradigm clash
- before we can integrate, we need to get clear about the polarisation, the opposition, the conflict
- before we can integrate the duality, we need to allow the polarisation
- before we can embrace the paradigm clash, we need to *have* it, differentiate the polarities and be fully aware of the polarisation

# We need integrative models that give validity to *both* positions.

- abstract ideological questions not resolvable in principle, but need to be entered and lived over and over again with each client
- what integrative models are available ?

Further exploration: **Clarkson “The Therapeutic Relationship” :**

- 1. working alliance**
- 2. transference / countertransference**
- 3. reparative**
- 4. authentic**
- 5. transpersonal**

# Perception, Understanding, Intervention

- How can we describe the differences between polarised positions in more detail rather than keep the polarisation general ?
- How does a ‘medical model’ or ‘anti-medical model’ belief manifest in the counsellors therapeutic presence and interaction with the client ?
- The implicit relational stance can be described as manifesting in terms of the practitioner’s **perception, understanding and intervention.**

# Perception, Understanding, Intervention - General Definition

PERCEPTION	UNDERSTANDING	INTERVENTION
my un-interpreted 'observations'	how I make sense of my perceptions, impressions and 'observations'...	how I respond; what I <u>do</u> ('outwardly')
recognise significant information	translate perceptions into understanding	translate understanding into action
what do I notice ?	what's going on ?	what do I say, do, suggest ?
what am I aware of ? what do I pick up and observe ? what do I pick up and observe ?	how do I understand it? what's the dynamic? what is most important to work with ?	what technique is appropriate? methods, strategies, interpretations, suggestions
<b>'INPUT' 'raw data'</b>	<b>'PROCESSING'</b>	<b>'OUTPUT'</b>
	THEORY (what)	TECHNIQUE (how)



# Perception, Understanding, Intervention

## within a 'medical model' perspective

PERCEPTION	UNDERSTANDING	INTERVENTION
neutral, rational & objective observer	scientific procedure (hypotheses)	treatment
dualistic subject-object split (accurate perception depends on remaining 'outside', unaffected and uncontaminated by the problem / pathology)	general principles (i.e. theory); repeatable outcome of experiment (irrespective of context/r'ship) as verification; then application of theory to particular client	power-over: solution imposed; practitioner prescriptive & directive: e.g. treatment, remedy, operation, technique, strategy
= investigation / examination / research (gathering data)	= (external) diagnosis	= treatment plan



# Perception, Understanding, Intervention

## within an 'anti-medical model' perspective

PERCEPTION	UNDERSTANDING	INTERVENTION
engaged, holistic, subjective & intersubjective perception based on empathy and identification	intuitive understanding; tends to be based on holistic and non-rational or transrational framework	helping = facilitative, maybe educational, more mutual conception of relationship
phenomenological 'bracketing' of prior assumptions; perception through accurate empathy and identification rather than objectifying separateness	insisting on subjective & intersubjective, contextual, relational understanding of each individual in their own right; power of 'real' human connection; refuses external criteria for evaluating <i>inherent</i> vibrancy of contact (Gestalt)	denies hierarchy and contradicts power-over; refuses authority and solutions; practitioner defined as ally, champion, witness or available for authentic relating; often biased towards 'reparative relationship'
= refuses distancing, objectifying stance = involvement and use of therapist's self	= refuses objectifying, pathologising diagnosis and all labelling or typology; sometimes anti-theory, values intuition	= going with the flow, based on principles of self-organisation; refuses imposition, manipulation, authoritarian strategies



# Example: subjectivity and objectivity

- are unreconciled and polarised, e.g. between humanities and 'hard sciences'. People do polarise around this, disciplines specialising in one over and against the other. People's identity is shaped around these dualisms, identifying with one polarity over and against the other.
- From a third position the split seems unnecessary, but the culture really is polarised. People's identity really gravitate towards one to the exclusion of the other.

## Further exploration:

- Schumacher: The Four Fields of Knowledge (Schumacher, E.F. (1977) "A Guide for the Perplexed")
- Wilber: Four Quadrants (Wilber, K. (2000) "Integral Psychology")

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# The polarities within our own practice

- **both** ‘medical model’ *and* ‘anti-medical model’ are valid
- **both** ‘medical model’ and ‘anti-medical model’ can be seen as *relational* positions
  - they do *not* help us as *ideological* positions;
  - they help us if understood as *relational* positions = they contain information about the relationship and the client’s inner world
  - *both* arise in the therapeutic relationship in response to the client’s conflict

# The polarities within our own practice

- **therapeutic relationship between Scylla & Charybdis of**
- **collusion versus objectification:**
  - there is more wisdom in what each position *objects to* than in what it claims:
  - **Thou shalt not collude!**
  - **Thou shalt not objectify!**

**Thou shalt  
not collude!**

**Thou shalt  
not objectify!**



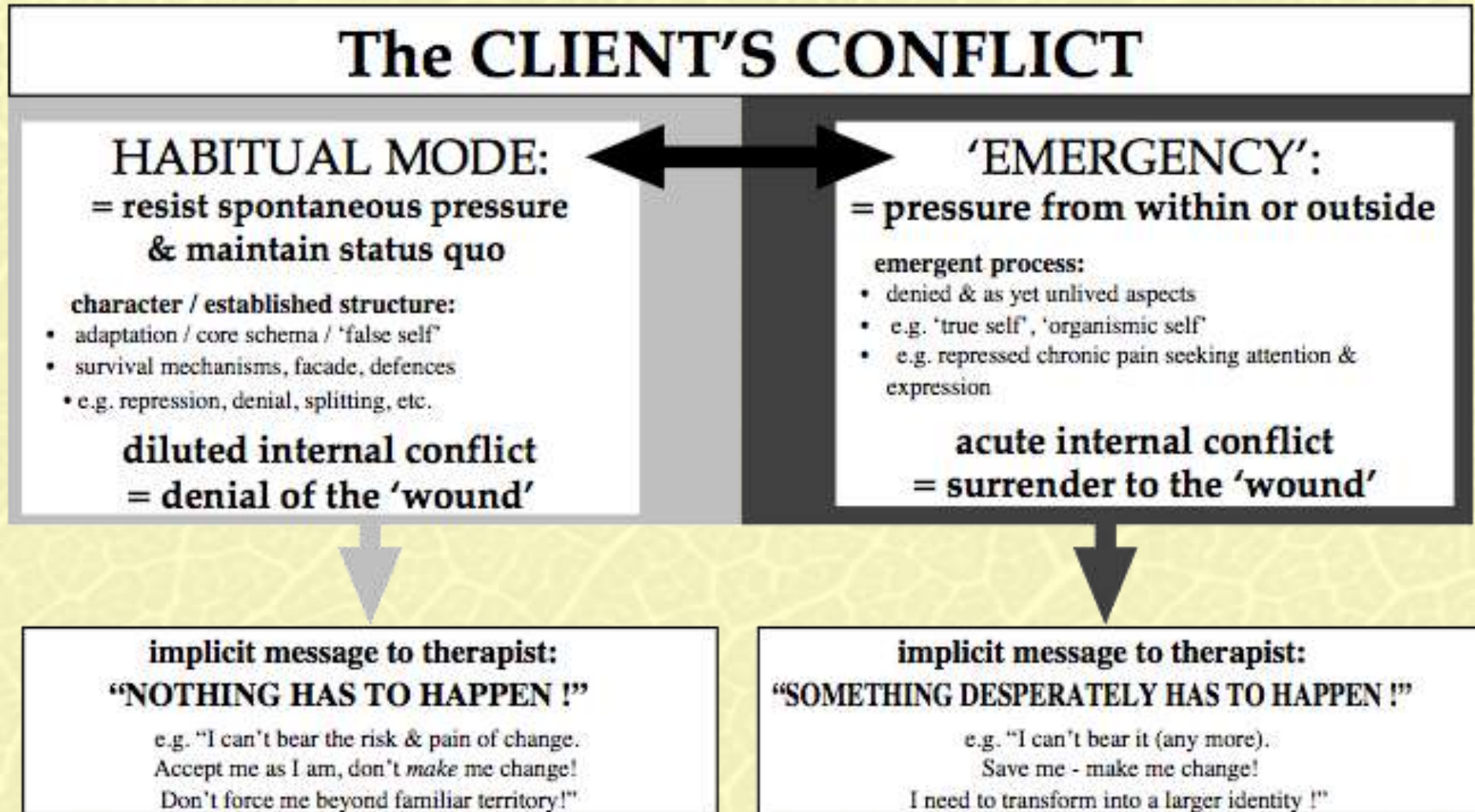
Both 'medical model' and 'anti-medical model'  
can be seen as *relational* positions:  
our therapeutic impulses to collude and objectify  
*both* tell us about internal conflict in the client:

- **what the 'emergency' is**
  - what is the pain ?
  - what is unbearable
  - the inner experience
  - the potential for the 'Real Self'
  
  - what is being defended against

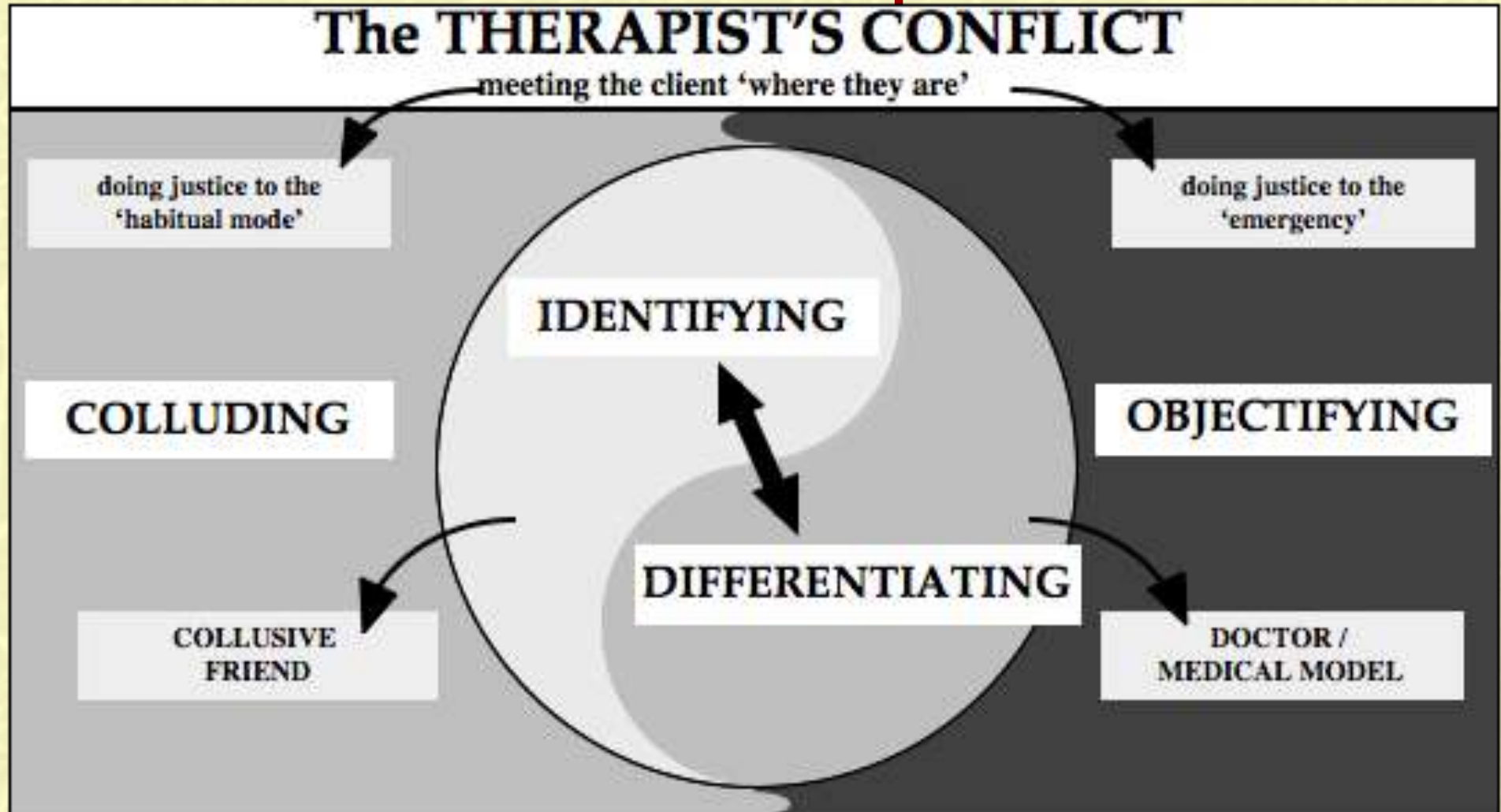
- **what the habitual mode / survival mechanism is**
  - what the fear of pain is
  - the ego position
  - how the 'False Self' operates
  - what rules and roles need to be obeyed
  
  - what the defense is



# The most basic model for internal conflict in the client

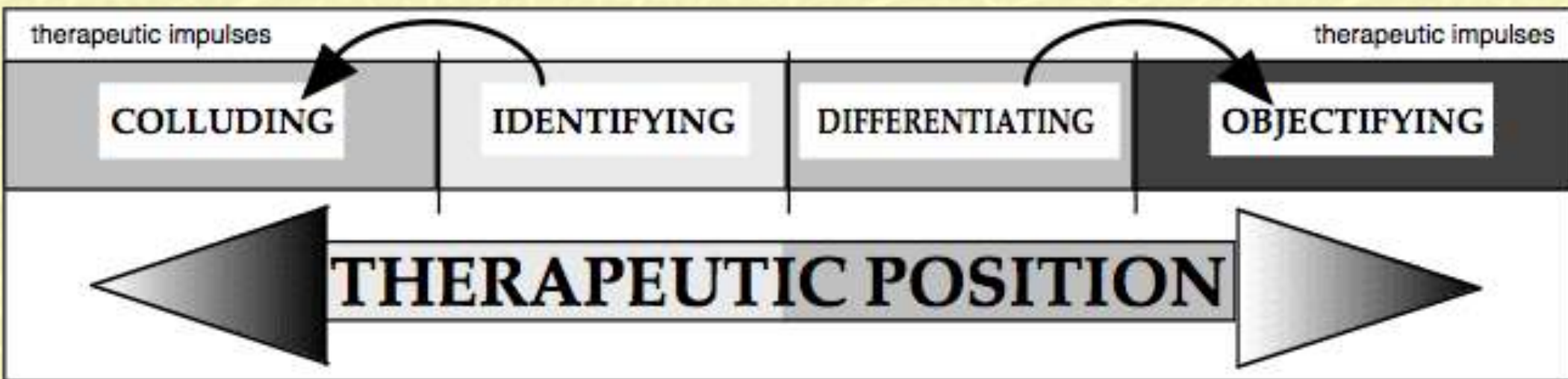


# The client's conflict becomes the therapist's conflict



# Integrating the 'medical model' within therapeutic position:

the relational spectrum between:  
colluding, identifying, differentiating, objectifying



# The Therapeutic Position between colluding & objectifying

- when the therapist follows their therapeutic impulses of both identifying and differentiating, they pressure in the relationship will occasionally incline them towards falling either side from identification into collusion, or from differentiation into objectification
- in these moments a potentially transformative enactment occurs

# The pressure on the therapist

- **what inclines the therapist towards collusion or objectification ?**
  - the pain at work in the client's conflict
  - how unbearable the pain is experienced as
  - the pressures to help avoid the pain = denial
  - the pressures to help confront the pain

**= the pressures of enactment**

# The client's demand for symptom - reduction = self-objectification

- often it is not simply pressure in the relationship which inclines the therapist towards collusion or objectification
- often the client explicitly demands a 'medical model' approach and success
- this is based on the client's internal self-objectification and denial of pain
- = the client's lack of faith/experience that pain can transform

# The absence of the 'transformative object' and the 'medical model' (1)

It has often been observed that when patients need the illusion that science and medicine have got it all 'under control', doctors are treated as 'gods in white coats'. The hope and expectation that there must be *somebody* out there who can command the mysteries of life and death implicitly confers god-like status onto the practitioner.

The equivalent expectation in therapy amounts to the demand for a guarantee against any kind of emotional-mental pain and distress - the therapist is expected to provide instant soothing on tap.

# The absence of the 'transformative object' and the 'medical model' (2)

Christopher Bollas in "The Shadow of the Object - Psychoanalysis of the Unthought Known" proposes the notion of the mother as 'transformative object'. In the infant's reality, the attuned mother is indeed capable of magical feats: one moment I am in hell, then she comes along and holds me, rocks me, attends to me, and the next moment the pain is gone, I feel soothed and I am in heaven. As the infant's ego at this stage is considered to not be sufficiently differentiated to comprehend the sequence of events by which this transformation is effected, its source and origin seems to be located in the magically transformative mother whose presence made all the difference.

# The absence of the 'transformative object' and the 'medical model' (3)

We can surmise that if the infant does not get sufficient experience of this transformative event, a faith in its reliable re-occurrence - when needed - does not develop.

The infant is then left with a vague sense of its possibility, but mainly an aching, unfulfilled hunger for it, which later gets projected into the medical practitioner.

The unconscious hope is that the doctor is as omnipotent as the mother who might have been.

# The absence of the 'transformative object' and the 'medical model'

It can therefore be argued that the demand for a medical-type cure to be administered by such a powerful therapist (which is what clients often think they are paying for) is rooted in an infantile need for symbiotically attuned quasi-magical omnipotent mothering, and is *both* an expression of that need for a 'transformative object' *and* a defence against it.

# Quotes from:

- **Soth, M. (2005) Counselling: the 'Relating Cure'**  
**Healthcare Counselling & Psychotherapy Journal,**  
**October 2005, Vol 5 No 4**
- **Soth, M. (1998) Collective Mothering and the**  
**Medical Model**  
**AChP Newsletter 1998**
- **Soth, M. (1997) Collective Mothering and the**  
**Medical Model - A response to Emmy van**  
**Deurzen-Smith's paper "The Future of**  
**Psychotherapy",**  
**European Journal of Psychotherapy 1997**

*Next weekend (Oct. 24/25/26) in London:*

# *Working with illness in counselling & psychotherapy*

- **see: [www.chiron.org](http://www.chiron.org)**



art of dualism polarised  
motheringdeconstruct in field

PUI

polarised not coll.  
practice not object.

client's therapist's  
conflict conflict

therapeutic self-  
position objectific

transform.  
object

quotes

website

# website: [www.soth.co.uk](http://www.soth.co.uk)

**Michael Soth**  
Integral-Relational Body Psychotherapist

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