My Country, My Way

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My Country

I'm 30, a PhD clinical psychologist and psychotherapist. I have an institutional and private practice and sometimes lecture in universities. In my country, France, for various reasons, the question of integration is not raised. I explore this in my first book, which I am currently writing on the subject "The integrative approach in psychotherapy : an anti-manual manual for therapists." French psychotherapists are integrative in practice, even if they are not familiar with the term or the concept. Integrative practice grows out of a rich and influential involvement in psychiatry. France is responsible for the release of the insane (Pinel & Pussin), the concept of hysteria (Charcot), trauma and dissociation (Janet), hypnosis (Liebault & Bernheim, Puysegur), suggestion (Coue), and antipsychotics (Delay & Deniker). In more recent times, France has embraced psychotropic drugs along with two other important currents: an enthusiastic recognition of psychoanalysis and an equally enthusiastic but opposed adoption of cognitive behavioral therapy.

Psychoanalysis entered in our society in the 60's in response to two deep French characteristics: the love of theories and need for individuality. French thinking is historically individual and psychoanalysis found here its perfect ground. Then CBT, and its offshoots (MBSR, MBCT, ACT, EMDR) gained inroads in the past ten years. I think that the energy with which CBT was embraced came in reaction to an excessive grip of psychoanalysis and too many derivative phenomena in the hands of a few powerful men. Psychoanalysis and its sacred texts had become a perfect justification for outlandish and inappropriate conduct. CBT brought a dose of reality and pragmatism that French people fear but desire at the same time.

In my country, the introduction of new theories and the almost religious elevation of people associated with them have historically taken on more importance than the theories themselves. Soon the forces pro and con become diametrically polarized. We are forced to choose one side and oppose the other. We have to be radically for or against psychoanalysis or CBT with or without having a adequate knowledge of either. In the media, great and well known professors from one side caricature the practice of the other side to discredit it.

The problem is that within the university where we teach psychiatrists and psychologists, teachers and researchers are often "radicalized" to one or other position and have a little knowledge of opposing theories and practices. I think the consequence of this is suppression of diversity and the lack of development of humanistic, systems oriented and broad minded approaches.

Public universities teach psychology but are not involved in training for psychotherapy practice. A PhD is not required to practice psychotherapy and training for this is relegated to private institutions. Only recently was the practice of psychotherapy regulated at all. Psychologists could pronounce themselves "psychotherapists" without any training or oversight. A recent law, has established legal status and the title of psychotherapist, but fails to distinguish between psychologists, psychiatrists and anyone else who meets requirements. Those who voted for the law had no understanding of the domains of psychologists and psychiatrists or of training in psychotherapy!

In France we do not speak about psychotherapy integration because we haven't thought of theory and practice as related. There was a passion for psychoanalysis and then a place for CBT. Dogmatism was more important than pragmatism. A few institutions have begun to teach what they call "integrative psychotherapy," but actually they separate psychoanalytic, cognitive behavioral and systemic therapy approaches, without integrating them or joining theory with practice. But it is still an improvement. Six years ago when I was student, the major teaching was almost exclusively

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psychoanalytic although few courses were about brief therapies.

I have established a new French SEPI Regional Network composed of only four members. Three articles exist on the subject including two I wrote, soon three in February. I'm trying to trace a path that doesn't exist in France, I'm writing about a nonexistent social phenomenon. But I'm hopeful.

My Way

During my own studies I had the impression that each course was a new manifesto praising the merits of an idea or technology and I had the feeling none was concerned with clinical aspects. My professors looked solely through their more or less convoluted theoretical prisms. It is extremely rare to meet a teacher who speaks more than one language (language of drive, of learning, of communication, and systems theory...).

Though I may be idealistic, I want to see our discussion trace the path from initial intuition to concept to theory and back to the embodiment of ideas in practice. In doing so, it becomes natural to integrate theories into a more cohesive fabric, of use in helping people in distress. I think that therapists do not choose their "tools" by chance. A friend of mine, Dr Jean Bruxelle (intensive care anesthetist and specialist on chronic pain), suggested an analogy between the therapist and *homo faber*, a man capable of making his own tools. This philosophical concept has been used to explain what distinguishes *homo sapiens* from the rest of the animal kingdom: it is not only biological but also intellectual. As Benjamin Franklin said, "Man is a tool- making animal". In contrast to other mammals, *homo faber* uses different tools to do different tasks. We need to recognize the difference between the tool, itself, and its use. When we apply a tool to a task, we should do so out of knowledge and experience with its use. Some professionals are more interested in being right and demonstrating the importance of their sacred books and theories than to be close to humans. They remain devoted to the tools they see as their own precious creations, and resist change because, to do so, would pose a heavy risk to their pride.

During my training, I went through different explanatory systems, understood some of their subtleties, their justifications, their peculiarities, their specifics, and similarities. Four universities have shaped my training, including a Canadian one. In this way I have crisscrossed the world of cognitive behavioral therapy, hypnosis and a passage through psychoanalysis. My latest explorations are in the fields of phenomenology, existentialism and systems theory. For twelve years I have not been able to choose, not by indecision, immaturity or a wish to annihilate the differences. I reject the kind of dogmatism that labels and forces everything to fit a theory that then shapes and restricts observation. I still recall an internship experience in Montreal where I was reluctant to follow a manual of CBT in working with a patient. I was 21, and she had already met too many psychologists. Fortunately I had the presence of mind to talk about this instead of rushing through the steps of various textbooks that I had on hand. Even if I was willing, what protocol should I follow? Each one addressed a specific disorder and this patient had four or five of them from a DSM point of view. The need to step back rather than yield to the pull of urgent symptomatology seemed clear to me in this encounter. I tried later to generalize this approach even with the "simplest case" (apparently!). Then I read and wrote about the therapeutic alliance, I work with it with in all my therapies and I think it forms a focal point for integration.

I quickly realized I was not practicing in an orthodox way. Soon I understood that therapists around me did not either, nor did those I was watching or reading about. I tried to move towards practices that I did not know and did not hesitate to open the books that were never borrowed in university libraries. Without that, I had little chance of finding enough subversive counter-examples to make me think about what I was doing. To avoid hopeless confusion, I had to move in the direction of both clinical and theoretical integration. I wondered by what right I could move from one theory to another, from one strategy or posture to another. I questioned my own motives. Was I driven by personal discomfort or lack of effectiveness? Or was it eagerness to experiment? As my conceptual world shifted so did the reality I co- constructed with my patients, and the resulting uncertainty created a constructivist pit of anguish with which I had somehow to cope.

No final consensus in terms of integration has been found, and I think that's a good thing. I also think that integration raises the issue of the phenomenology of the encounter. Theory is a way to protect oneself from the uncertainty of a true human interaction. It organizes the apparently illogical nature of all phenomena reported by patients. To integrate is to ask how to meet the world of the other with more honest internal models. We need models to train our intuition and observation, but then we must deconstruct what we have laboriously built to finally understand human beings.

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Reference

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