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### **Psychodynamic counselling and complementary therapy: towards an affective collaboration.**

**Robert Withers**

School of Integrated Health

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Robert Withers for Adrian Hemmings

## **Psychodynamic counselling and complementary therapy: - Towards an effective collaboration**

### **Introduction**

The term complementary therapy conjures up an image of acupuncturists, osteopaths and homeopaths happily collaborating with doctors and counsellors in an integrated health care setting for the benefit of their clients.

Sadly, though perhaps not altogether surprisingly, the reality is usually somewhat different- especially in private practice. As a flood of counsellors and complementary therapists (CTs) graduates from private colleges and university courses, practitioners are forced to compete for the limited number of clients willing and able to afford the cost of treatment. Such are the dynamics of the market place that even those therapists lucky enough to work in a successful independent clinic tend to operate in splendid isolation. Nobody pays a private practitioner to consult with colleagues. Cross referrals are therefore relatively few and often inappropriate, understanding of other modalities is limited, and creative interchange between practitioners is rare- in what is essentially a protectionist situation. Meanwhile waiting lists often run into years for those patients 'lucky' enough to be referred to a counsellor or complementary therapist for the severely limited services available within the statutory sector.

It is surprising perhaps, given the ironies and injustices of this situation, that any collaboration between CTs and counsellors is possible at all- especially in the private sector. But there are an additional series of implicit conceptual clashes that further complicate this essentially economic conflict of interests. These focus around opposing models of symptom causation and cure.

In CT, as Kaptchuk (2001) and others have convincingly demonstrated, disease is nearly always regarded as emanating from some sort of imbalance in the 'vital force'. This force is conceptualised as lying behind both the physical expressions of the body and the psychological phenomena of the mind. In this sense CT promotes itself as 'holistic' and opposed to the dualism that underpins modern culture's polarisation of physical and mental illness. In a philosophical sense we could therefore characterise it as advocating a kind of 'dual aspect theory' (see e.g. Young 1990). That is- mind and body are both regarded as aspects of some single underlying substance- in this case a vital energy or field.

In contrast, psychodynamic counselling does not offer a challenge to Cartesian dualism; and this is probably one important reason that it has been more readily accepted by modern medicine. It is a psychological

therapy offering to treat disorders of the mind. By and large it leaves treatment of the body to the physicians. Where it does treat the body, it does so by purely psychological means. Its theories of somatisation may pose a radical challenge to conventional conceptions of mind and of mind-body interaction- involving as they do the notion of the unconscious. They also clearly imply an expanded view of the mind's area of influence. But, to utilise Wittgenstein's (1958) metaphor, they do not challenge the basic rules of the different 'language games'. Orthodox medicine can continue to use the rules of the scientific language game to talk about the body, while psychotherapists can continue to use the rules of the psychological language game to talk about the mind. It may be possible to dispute the best game from within which to articulate the aetiology and treatment of a particular patient- but the games themselves remain intact. CT, with its notion of the vital force, in contrast challenges the rules by undermining the very distinction between the games.

As I hope to show later, this conceptual clash can have profound consequences that effect attempts at collaboration. But, before going on to look at this in more detail I would like first to describe my own journey from CT to psychotherapy and out of that to raise a few initial questions.

**From Complementary therapy to psychotherapy: A personal journey.**

My early trainings in complementary medicine gave me an excellent understanding of the principles of acupuncture and homeopathy but only a limited understanding of Western Medicine, and very little clinical experience. So the transition from classroom to consulting room came as something of a shock. I was expected to take responsibility for real people- often with complex and serious health problems- as the following case illustrates.

### *An early case*

Jon was a twenty-year-old university student. Following a medical examination and blood tests, his doctor had suggested a diagnosis of Hodgkin's lymphoma- a potentially fatal cancer of the lymph glands. All that was needed to verify this diagnosis was a biopsy. Jon however refused to undergo the necessary surgical procedure, stating that in his opinion it carried an unacceptable health risk and that if the biopsy were positive he would refuse orthodox treatment anyway. I was in the final stages of my training when he asked me for homeopathic treatment. I tried to encourage him to reconsider his position and have the biopsy. But

he was adamant that he would not, so I attempted to master my unease and agreed to take him on. The situation was further complicated by the fact that Jon was a close friend. I knew I was taking a risk treating him- what if it didn't work, and he died? On the other hand homeopaths were scarce in mid 1970's Britain and no more experienced colleague was available to refer him on to- even if he had been open to this suggestion and able to afford it. Quite apart from my own need for more clinical experience then, I found myself wondering how I would feel if I didn't treat him- and he died. So with Jon's active participation in the process, I compiled an exhaustive list of all his symptoms and duly prescribed lycopodium 200 in accordance with classical homeopathic principles. Over a period of about a year, we watched as the lumps on his neck first receded then disappeared and his general health improved. He remains well to this day.

### ***Reflection***

Although this story has a happy ending, it immediately highlights a number of issues. Perhaps the most obvious of these concerns boundaries. From a counselling perspective of course the case illustrates my shocking lack of awareness of the importance of boundaries at the time. Some of this shock results no doubt from differing attitudes to the body within counselling and complementary therapy- a crucial point to which I will return later. In addition to this however, it is fair to say that no self-respecting counsellor would agree to treat a friend, let alone one with such a life-threatening condition. Quite apart from the risks to the patient, the emotional strain on the therapist would be considered unacceptable and the

distortions imposed on the therapeutic relationship likely to render effective treatment impossible.

From a complementary therapy point of view however the situation is not quite so clear-cut. Unlike the counsellor, the CT is of course expected to treat physical symptoms. It is also not uncommon, especially for newly qualified practitioners or those in training, to gain therapeutic experience by treating their own friends and relatives for free. In a similar way the early pioneers of psychoanalysis used to analyse one another's dreams (Jung 1963) and it is not unknown, even today, for counsellors to use friends to meet training requirements for case material. But notwithstanding these occasional lapses, it is fair to say that boundaries that seem self-evident to counsellors and psychotherapists can by no means be taken for granted by complementary therapists. It is common practice for CTs, in contrast to counsellors, to treat friends and relatives of existing patients professionally, in much the same way as a family doctor, for example. And while this might not matter in CT, the real knowledge that patient and practitioner already had of one another could undermine the crucial role of fantasy and unconscious fantasy (phantasy) in the evolution of the transference and countertransference within counselling.

Of course today, with homeopaths flooding the market place, I would easily be able to refer a friend in Jon's position to a colleague. Nevertheless I cannot be sure I would not behave in exactly the same way in the same situation. The only practical alternative to my treating him was no treatment. Most boundaries are context related

rather than self-evident or universal; and when practitioners forget this, problems can arise. A CT might for instance divulge inappropriate information about a counsellor if they are unaware of the role of ph/fantasy in psychodynamic counselling. A counsellor might then condemn such a CT for keeping 'sloppy' boundaries if judged by their own standards. Simple problems like this can easily undermine mutual respect and disrupt effective cross-referral and collaboration.

But quite apart from this issue of boundaries, there is another question with links back to the conceptual clash outlined in the introduction. 'What made Jon well?'

Questions about causality in medicine are notoriously hard to answer. Healing often seems to have something of an element of mystery about it. And as the philosopher David Hume (1739) famously remarked, the whole issue of the apparently 'necessary connection' between a cause and its effect is deeply problematic. Nevertheless both Jon and I felt pretty confident that the conventional homeopathic explanation of the remedy's effects was the most likely. On this account the vital force in the remedy (liberated by the process of homeopathic potentisation) had interacted with Jon's own 'vital field' in such a way as to restore his health. The process was equivalent to immunisation except that it operated on an energetic rather than material

level. We didn't worry that conventional science had been unable to confirm the existence of such a vital force. We assumed that this was due to the inadequacies of its investigations to date and that it was only a matter of time before more subtle experiments demonstrated the truth of what homeopaths had been saying for years. In fact I was personally involved at the time in a series of 'ground-breaking' experiments at the University of Sussex that aimed to use 'Kirlian photography' to prove just this. A group of Soviet researchers (Ostrander and Schroeder 1971) claimed to have succeeded in photographing the human 'energy field' using the technique, while a group of British researchers (Milner and Smart 1975) claimed to have photographed the vital energy of homeopathic remedies. And I was attempting to verify their findings.

It was with a growing sense of disappointment however that I came to realise that these researchers had not demonstrated the reality of the vital force at all. In fact they had merely succeeded in presenting a series of poorly controlled experiments as sensational findings, while ignoring perfectly plausible conventional explanations for their results. I was faced with a dilemma- either I could continue with my experiments and publish these negative findings or abandon my research. I chose the latter and in so doing gained first hand experience of what is known as 'positive publication bias'. Researchers tend to publish positive findings in preference to negative ones and this creates a bias in the literature.

Perhaps this was a mistake. I still read accounts that claim Kirlian photography has demonstrated the existence of the vital force in complementary medicine (Vithoulkas

1980, Whitmont 1997). In general they refer back to the same old discredited literature. But I had had considerable first hand experience of the positive effects of both homeopathy and acupuncture in my clinical practice by this time and was too intrigued to find out how they worked to waste more time and effort researching up a blind alley.

Returning to the question of what had made Jon (and the people like him) well, I realised that if something physically real was at work, even as just one aspect of the 'vital force', then homeopathic remedies should perform better than placebos in a double-blind trial. But a literature search revealed no relevant well-controlled studies. Since then there have been a number of double-blind trials on homeopathy and interestingly none have yielded unequivocally positive results despite the aforementioned positive publication bias (Ernst 2001), (Shang et al 2005). Nor have there been any repeatable, well-designed experiments, demonstrating a physical mechanism for homeopathy's effects to date. On the other hand the limited number of studies that compare homeopathy's effects to other medical interventions in a variety of conditions have generally been positive (Mathie 2003, Dean 2004).

So although homeopathy appears to work, the evidence seems to suggest that the chances of finding a physical explanation for its effects are fairly slim. And theoretical considerations render these even more remote. It is possible to use Avogadro's theorem to calculate the number of molecules present in a particular homeopathic pill. This revealed that the chances of finding a

single molecule of lycopodium in Jon's 'potentised' remedy were several billion to one against.

But if homeopathy's effects are not physically induced, could they be caused psychologically? If such an account should prove possible, then this would certainly seem to offer an advantage on the basis of Occam's razor, over the more esoteric 'vital force' hypothesis of CT. But it is at this point that the conceptual clash between psychodynamics and CT begins to bite. CTs tend to offer accounts of sickness and recovery that seem inherently implausible and paradoxically materialistic to both scientists and psychodynamic therapists, while psychodynamic accounts of the same phenomena can seem implausibly psychological and unnecessarily blinkered to CTs.

Over the years I have continued to search for an understanding of homeopathy's effects. But in the absence of any plausible physical explanation, I began to review my own cases with the possibility of finding a psychological one. When I did so I realised that patients sometimes seemed to get worse despite my 'good' prescribing, and better despite my 'poor' prescribing. Choosing a remedy that mirrored my patient's symptom picture accurately certainly seemed to help. But it was by no means the only relevant factor. The ability of both my homeopathic and acupuncture patients to express meaningful emotion in sessions, especially around significant events that coincided with the onset of their symptoms, seemed particularly important. And leaving aside those people who were never going to get any better, the quality of their relationship with me also appeared to be relevant. Put simply, those people who had a good feeling about me tended to get better. Those who had a difficulty with me often did not (see Withers 2001). Looking back I can see that this was probably a

significant factor in Jon's recovery. I also realised that the onset of his symptoms coincided with the heartbreak of a failed love affair. Numerous researchers have commented on similar links between life events and the onset of illness (Taylor 1987, Cohen and Herbert 1996, etc.).

Around the same time as beginning these clinical reflections, I discovered Herbert Silberer (1917) and Carl Jung's (1943 etc.) works on alchemy. They argued that the alchemists had projected the contents of their own unconscious into the substances they worked with. As these physical substances were transformed, so were they- via the symbolic transformation of these projected unconscious contents. I wondered if it was possible that something analogous was happening with homeopathy. If patients projected their unconscious complexes into homeopathic remedies, could taking them in potentised, detoxified form somehow have therapeutic consequences? (Withers 1979) After many more years of clinical practice as both a homeopath and psychotherapist, I was finally able to articulate this in a form I was happy with (Withers, 2001, 2003). And I will attempt to describe this later in relation to Jon's recovery.

Meanwhile, at this relatively early stage in my career, I had already begun to feel that psychological factors were far more important than I had previously realised. And paradoxically, despite most homeopath's insistence on the potency of the vital force, there is a strong strand within homeopathy itself that contends that illness comes from the psyche or 'inner man' (Kent 1911 etc). But if my CT training had left me with only a limited understanding of Western Medicine, it had been even more inadequate in equipping me to understand and work with these largely unconscious

psychological factors. It was at this point that I decided to train to be an analytical psychotherapist and attempt to work with these forces in a more ethical and effective manner.

### **Some observations concerning CTs**

It might be pertinent to pause at this point and attempt to draw together a few observations for counsellors wishing to work collaboratively with CTs in an independent setting. Of course CT has become more widely accepted since I trained and most of the trainings are more broadly based and professionally set up. The change of name from alternative to complementary therapy has also been helpful- in so far as it indicates a genuine desire to work more cooperatively with other disciplines. Nevertheless it is worth bearing in mind that many of the anxieties and insecurities that beset me still apply today and may militate against effective collaboration.

The first anxiety I noted affects counsellors as well as CTs and concerns *making a living*. If anything this pressure is worse today, given the increased competition for patients mentioned in the introduction. There is no easy solution to this, but the anxiety could be addressed along psychodynamic lines. If it is consciously acknowledged rather than denied, it is less likely to be acted out defensively in ways that disrupt communication and cooperation. In addition, it is helpful here if both counsellor and CT can establish jointly recognised limits of competence, so that they minimise the risk of poaching from one another. This is not always easy to do though because, as we have already seen, accounts of aetiology and cure sometimes rival

rather than complement one another. Not only this, but competence is effected by individual factors such as personality and experience- not just the discipline practiced. So to a certain extent it probably needs to be flexibly negotiated between individual practitioners. On the other hand there is clearly also a need for the development of a more general interdisciplinary code of ethics and practice to establish rough limits of competence between the different professions- where this is possible.

Another anxiety concerns responsibility for the treatment of physical symptoms. There is a large amount of research that suggests connections between psychological conflict and physical or psychosomatic symptoms (Alexander 1950, Weiner 1973, Taylor 1987 etc.). Nevertheless it is highly unlikely that patients with physical symptoms- certainly ones as severe or potentially life threatening as Jon's- will give a psychodynamic therapist primary responsibility for treatment of those symptoms. Such patients do however constitute a significant part of the CT's practice. But the vast majority of CTs in private practice are not medically qualified, and so they carry high levels of anxiety about their responsibility for these patients. I have certainly found myself wishing I had a medical qualification at times and feeling like a quack or a fraud without it. Under these circumstances, I nearly always try to work cooperatively with the patient's doctor, but have, no doubt, lost clients because of this apparent lack of confidence. It is not uncommon however for CTs to react defensively to these anxieties and denigrate orthodox medicine while omnipotently elevating their own healing powers. This is especially seductive when patients share this denigration and idealise the CT. The potential for a dynamic like this can be clearly seen in my interaction with Jon. Perhaps if I had been more conscious of this at the time, I would have challenged his refusal to consider conventional treatment more vigorously.

Analogously, CTs often feel anxious about the responsibility of working with their patient's emotional/psychological issues without counselling qualifications. Here too reactions vary. Among the CTs I have supervised, a common reaction is to want to refer a client on to a counsellor the minute an emotional issue surfaces. In this way the client is given the implicit message that the practitioner is uncomfortable with emotions and learns to inhibit their expression. As a result an important therapeutic opportunity can be lost. In addition, the patient, who may be suffering from a problem that presents physically but is reinforced emotionally, is unlikely to be able to see the relevance of, and use, the counselling referral. At the opposite extreme is the CT who reacts to these anxieties by mobilising omnipotent defences and imagining that their own therapeutic intervention is all that is needed to resolve even the most extreme cases of emotional conflict and trauma. Such a practitioner is unlikely to be able to ask for help even when it is needed and becomes vulnerable to work related burn out and various forms of acting out. Under these circumstances the CT usually needs effective personal therapy before being able to work cooperatively with a psychodynamic counsellor at all.

Fortunately however, there are a growing number of CTs who can realistically recognise the limits of their own competence. These practitioners may request psychodynamic supervision for their more difficult cases or, where appropriate, make a referral on to a counsellor. In my experience it is often possible under these circumstances for the counsellor and CT to continue working with the same patient. And it can smack of omnipotence for either party to insist otherwise. Of course there is a danger of the client splitting feelings between practitioners, but it is usually

possible to work with this (Withers 2003). Of course there are some clients who reach the point where they recognise the underlying emotional nature of their problems and move on altogether from CT to psychodynamic counselling or psychotherapy. There are also certain clients who make the reverse journey. Then of course the problem of splitting is less likely to arise.

Before closing this brief section, I would like to make what amounts to a plea for tolerance towards CTs. They may sometimes seem like arrogant, money grabbing, new age charlatans with a magical world-view. But they are also often dedicated professionals attempting to offer a service to the many patients who do not fit neatly into either the purely physical or purely mental, illness categories. They work without the secure base of a generally accepted world-view, without the professional recognition or status of either doctors or psychotherapists and often without these colleagues' respect. Counsellors and other therapists wishing to work collaboratively with them should not be surprised if they sometimes act defensively under these circumstances.

### **The body in psychodynamic therapy**

There is a general supposition that permeates through into popular culture (See e.g. Hustvedt, S. 2003) that the classical hysteric, that once-beloved patient of traditional psychoanalysis, has mysteriously disappeared since Freud's day. In his recent book 'Hysteria' (2000) however, Christopher Bollas questions this. He believes that the hysterical patient is merely in hiding. In psychoanalysis she often ends up being wrongly diagnosed as suffering from either 'borderline' (Bion 1962 etc.) or 'false-

self' (Winnicott 1942 etc.) pathology. And he refers approvingly to Elaine Showalter's book 'Hystories' (1997) in which she argues convincingly that our culture's continuing denigration of psychological disturbance can result in hysterical patients presenting themselves as suffering from a series of apparently physical disorders. These range from M.E. or chronic fatigue syndrome, through Gulf War syndrome, to a variety of common complaints such as headache, back-ache and insomnia. These are, of course, the very patients who tend to end up presenting themselves to complementary therapists. The irony of this situation is that if Bollas and Showalter are right, then the people psychoanalysis evolved in order to treat, have ended up avoiding it. They go instead to practitioners, less well trained to treat them, who tend to collude with the view that their suffering is physical or 'energetic'. Despite the 'Freudian revolution' our culture clearly still has difficulty even accepting the reality of the psyche- let alone asserting the dignity of those who suffer from a psychological disturbance!

How has the hysteric's infidelity to the psychoanalyst come about? I believe that a part of the answer can be found within the history of psychoanalysis itself.

When Freud began treating hysterics towards the end of the nineteenth century, they had only recently been regarded as possessed by evil spirits (Foucault 1988, Hustvedt 2003). Freud, of course, challenged this view by looking for the sense in their symptoms. And he operated with a model and a method that was remarkably similar in many respects to that employed by present day holistic practitioners. On the practical side he was not afraid to touch his patients. He hypnotised them by applying pressure to their foreheads and asked them to recall the traumatic events that underlay

both their bodily and psychological symptoms. On the theoretical side, his notion of 'libido' has been understandably criticised for being too firmly based in the metaphors of nineteenth century hydraulics. But in its favour it did at least have a solid physicality alongside its more psychological side; and it is remarkably reminiscent of CT's vital force, which attempts the same job of uniting the mind/body divide. In addition, his early works such as 'The Project ...' (1895) clearly intend to formulate a therapeutic model that integrates psychology with neurology.

It was only after he had observed Anna O's erotic attachment to his colleague Joseph Breuer (1893) and experienced a series of similar erotic transferences to himself (see Jones 1961) that he stopped touching his patients. Around the same time he abandoned the seduction theory (based on a trauma model), in favour of the conflict model of neurosis (see Jones 1961); and psychoanalysis as a purely psychological therapy was born. It seems to me that in this drift from an integrated mind/body therapy towards a purely psychological one, Freud succumbed to a combination of inexorable cultural and personal pressures (see Masson 1984). The personal pressure presumably relates to the fear of becoming embroiled in unmanageable erotic transference/countertransference dynamics. On the cultural side, it is as if our society is afraid of vesting physical and psychological power in the same individual or therapeutic system, and therefore impels us towards one side or other of the divide. Perhaps this arises from collective fear of losing the hard won freedoms that go with separating church from state, and science from religion. (Descartes 1641). Or perhaps Freud's radicalism just waned with his youth.

Whatever the cause, subsequent theoretical developments within psychoanalysis have tended to add to this alienation from the body. With the demise of the hysteric, came the rise of the borderline personality and of the false self. These diagnoses and others like them place the body in a far less accessible area of the person, and liken psychosomatic to psychotic states, where early damage in the capacity to symbolise is hypothesised (Winnicott 1949, Bion 1962, Taylor 1987). These developments may have added valuable techniques such as the use of the countertransference and of projective identification in psychotherapy. But arguably, they have also contributed to the alienation of those suffering psychologically influenced physical symptoms, including hysteria, from psychoanalysis and driven them towards the CTs.

Patrick Pietroni, a respected colleague and former mentor of mine used to tell a Mulla Nasrudin story that can be used to illustrate this point (Shah 1983).

One day Nasrudin (a sort of holy fool) was spotted by a neighbour on his hands and knees under a street light outside his house.

‘What are you doing here?’ asked the neighbour.

‘Looking for my key’ replied the Mulla.

‘Where did you loose it?’ asked the neighbour, getting down on his hands and knees himself.

‘Inside the house’

‘Then why are you looking out here?’

‘Because it’s brighter out here!’ answered Nasrudin.

There are supposed to be seven different levels of meaning in these Nasrudin tales. But I am concerned with the one that goes something like this- though you can probably already guess it. For the psychologically orientated analysts- the later Freud, the object relations and attachment therapists etc. - the streetlight is like the mind but the key has been lost in the darkness (unconscious) of the hysterical or psychosomatic patient's bodily symptom. For the more physically orientated CTs and body therapists, the streetlight is like the body, but the patient needs to look in the darkness of the psyche to find the key that might free them from their symptoms. We are all like Nasrudin, looking in the area that we know about- but failing to find what we seek as a result.

### **Towards reintegration**

#### ***Conceptual collaboration***

I do believe that it is possible for orthodox psychodynamic therapists to work effectively with emotionally influenced bodily symptoms. But I also believe that there is an analytic culture that tends to resist the body and blind us to the meaning of its symptoms and sensations (both our own and the client's). And I have certainly found it far harder to effect symptomatic relief of bodily symptoms with psychotherapy than with CT. Some of the reasons for this will be clear from the above considerations. But paradoxically the very theories that alienate analytic patients from the body, by equating psychosomatic with psychotic symptoms, can help offer a plausible explanation for homeopathy's relative success with them.

Bion (1962etc.) found that working analytically with psychotic parts of a patient's personality entails paying special attention to the countertransference and in particular to the process of projective identification. Toxic, symptom-producing parts of the patient's experience, including unmanageable emotions, become forced into the analyst. If the analyst is able to contain these and use his 'reverie' to detoxify them, they can eventually be safely returned to the patient through analytic interpretation. They can then be thought about, symbolised in words or dreams and generally reintegrated by the patient. Bion thought of this as a process of transformation of toxic, symptom-producing beta elements into detoxified alpha elements.

The parallels with homeopathy are uncanny- except that here the remedy, rather than the analyst, acts as a container; and the homeopathic process of potentisation (dilution and succussion of the remedy), rather than the analyst's reverie, acts as the transformer of beta into alpha elements. Swallowing the remedy is the symbolic equivalent (Segal 1957) of taking in the analyst's verbal interpretations. But since the whole process is happening in homeopathy without being consciously acknowledged it can bypass the patient's resistances- thus relieving symptoms more quickly.

Applying all this to Jon now, let us assume that unmanageable feelings about his failed love affair were acting as toxic beta elements to his psyche-soma. Perhaps they were also somehow undermining the efficiency of his immune system (Taylor 1987) and contributing to his Hodgkin's disease, if that is what he really had. At any rate he 'knew' he was taking the safe form of a substance that could produce his symptoms in a healthy state. But since he also knew on an unconscious level that his split off grief was contributing to his condition, it was a small step for him to imagine he was

internalising a detoxified version of that grief when he swallowed his remedy. Containment and symptom relief could follow without him ever having to consciously experience the frighteningly crazy feelings associated with his failed love affair. And the whole process could take place without the necessity of any physical effect from the lycopodium.

Interestingly, lycopodium is made from the spores of a moss that relies on a symbiotic fungus to provide its water and nutrition (Gutman 1974). If this association to the life cycle of lycopodium is regarded as the equivalent of the analyst's reverie, it may offer a clue to lycopodium's special capacity to act as a symbolic container for unmanageable symbiotic parts of Jon's personality following his failed love affair. Certainly an aversion to being alone and 'silent grief' form a well known part of lycopodium's symptom picture (Whitmont 1980 etc.). Having briefly sketched out the possibility for a conceptual collaboration in this way, I will conclude with a clinical example of collaboration. (I refer readers wishing to investigate this conceptual collaboration further to Withers 2003).

### ***Clinical collaboration through supervision***

Chris was a complementary therapist who had trained in a form of bodywork that utilises touch and movement to treat a variety of conditions. He had recently started the university course I teach, exploring the psychodynamics of the therapeutic relationship for body workers and practitioners of complementary therapy. He had no other specialist psychological training. His client 'Anne', was suffering from chronic back pain, and had had several years'

psychotherapeutic treatment that had proved very useful without having any lasting effect on her physical symptoms. When Chris placed his hands under the affected area of her back, he could sense significant muscular tension and asked

'Why do you think you are holding onto your pelvis?' At first Anne could not answer, but as Chris encouraged her to relax her muscles, she replied.

'My father always told us: - Good is not good enough, you can always do better, you must always succeed'

'So perhaps you are just pulling your waist together to look thinner?' He said, attempting to soften his question with a laugh.

'Well you could be right.'

Replied Anne- and she began to cry, going on to speak shamefully about a time that she had been anorexic. While she cried, Chris noticed she remained in control of her body despite the loss of emotional control. Her pelvis stayed stuck in a contracted state. In (group) supervision Chris bravely reported the following dream.

'Several nights after the consultation, I dreamed I was having sex with Anne. The remarkable thing about this dream was that whilst having sex, we were engaged in animated non-sexual conversation, and I remember thinking that

Anne was not at all feeling what we were doing. The situation felt oddly casual. Our conversation and our physical movements were completely unrelated.'

No doubt this dream says something about Chris, and also the state of the therapeutic relationship. In the supervision group we chose to focus on what it might be saying about Anne however. From this angle the dream could be treated diagnostically- as confirmation of her emotional disconnection from her body. In it their conversation was entirely divorced from their bodily actions, just as Anne's sobs had been cut off from her pelvis in the preceding session (an example of the mind/body dissociation so common in our post-Cartesian culture). This diagnostic insight, which arose from Chris' reflection about the dream, crucially informed the rest of Anne's treatment, which eventually achieved a degree of physical symptom relief not afforded by psychotherapy alone. And Anne, who had been in a committed relationship for many years, actually became pregnant shortly after the reported consultation!

## **Conclusion**

In this chapter I have outlined some of the opportunities for and obstacles to collaboration between complementary and psychodynamic therapists in private practice. I have suggested that there are potential conceptual and economic rivalries between the two disciplines. In the first part of the chapter I have used homeopathy to illustrate some of these conceptual rivalries. In particular I have argued that therapeutic effects attributed within homeopathy to the vital force could be due to the

operation of largely unconscious psychological factors. I have not had space to consider other CTs. But although physical factors may play a larger part in their effects than homeopathy, they too generally play down the importance of psychological factors.

In addition I have used my personal experience to illustrate some of the anxieties carried by CTs and have suggested that these can interfere with effective collaboration if not acknowledge and adequately contained. I have also outlined some of the reasons for my own move out of complementary medicine into psychodynamic/analytic therapy. Though these may well also have unconscious determinants of which I am only dimly aware.

While CT tends to emphasise the importance of a quasi-physical vital force, psychoanalysis tends to underplay the importance of the body and of bodily symptoms- despite its origins in a more holistic paradigm. This has tended to discourage a large number of patients who identify themselves as suffering from physical symptoms from consulting with psychodynamic therapists- even though those symptoms may be maintained by emotional factors. Such patients are more likely to consult CTs who are however less capable of dealing with the emotional components in their complaints.

In my final section, I have returned to the issue of homeopathy. In particular I have attempted to use the insights of Wilfred Bion to open up a potentially fruitful area of conceptual collaboration with psychodynamic therapy. This may feel like a dismissal of homeopathy to those who mistakenly regard the physical as the limit to the real. I

prefer to regard it as a relocation of homeopathy within the psychological language game, which is the richer because of this, especially in terms of conceptualising the mind's influence upon the body.

I have concluded with an example of psychodynamic supervision that illustrates some of the potential for fruitful clinical collaboration between the disciplines.

Robert Withers April 2006

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**CV** Robert Withers trained to be a homeopath, then an acupuncturist after completing a degree in philosophy. He went on to research homeopathy academically and finally trained to be a psychotherapist and Jungian analyst. Throughout this time he has maintained a busy private practice initially as a complementary therapist - then as an analyst and supervisor of counsellors and therapists. He is in addition a senior lecturer in the School of Integrated Health at the University of Westminster and visiting lecturer at the Inter-university College, Graz. His publications include *Controversies in Analytical Psychology* Hove and New York; Bruner Routledge 2003 (editor/contributor) and *Psychoanalysis Complementary Medicine and the Placebo* in *Understanding the Placebo Effect in Complementary Medicine* Peters, D. (ed.)

Edinburgh: Churchill Livingstone (2001). Correspondence to  
bob.withers@ntlworld.com