Psychotherapies and Psychoactives of Submission and Engagement

Introduction

One of the lectures I give at the University of the West of England is on the therapeutic use of psychedelics. A central speculation in this lecture is whether certain types of psychoactives – illegal and legal – can serve a similar purpose as certain kinds of therapy, indeed certain types of spirituality and religion. Is there a class of escapist drugs such as heroin or tranquilisers that, like therapist-led psychotherapies and monotheisms, tend to move people towards submission? By contrast, is there another class of drugs such as LSD and psilocybin that, like client-led psychotherapies and shamanism, might move them towards engagement?

The picture is complex of course, and it is important to note that the ever competing modalities of psychotherapy – psychodynamic, cbt, cognitive analytic, existential, for every day new flavours are added to the list – populate both strands. There are for example disempowering psychodynamic practices encouraging submission (Kernberg, 2004) just as there are mystical psychodynamic practices promoting engagement (Eigen, 1998). In a similar way, ketamine or cannabis can be seen to have both dulling and engaging aspects.

The aim of this paper is to illuminate the two aspects using Nietzsche's *On the Genealogy of Morality* (1887/1994), and then look at the implications for both psychotherapies and psychoactives.

Nietzsche

Before we attend to psychotherapy or psychoactives specifically, we must zoom out and look at more overarching patterns of human existence. One such pattern is the slave - master - priest phenomenon identified by Nietzsche (1887/1994). One way to look at this triune phenomenon is to see mastery as the part of an individual who engages with their life proactively, using the tools available to them in order to achieve the goals they freely imagine. This does not have to be in the style of some Aryan master race or bully, it can equally be the sense of calmness in a Zen monk truly taking in their situation and being in it. This is the path of loving one's fate, no matter how un-lovely it may be. Of course, life is difficult, many of us lack the strength to bear it all, and Nietzsche's concept of the slave is useful here. This is the side of us that folds, that gives up, that does as it is told. There is a certain relief in not fighting, not striving, and simply accepting. Nietzsche has no problem with these two aspects of being human, nor do I. I may be tapping into my mastery side in writing this paper, whilst I'm most certainly tapping into my slavish side by accepting to do it in Microsoft Word on a PC. Looking at it from a genetic viewpoint, we can allow ourselves to be enslaved to the propensities our genes give us, or we can choose to be masters in what we do with these propensities.

The problem is the priests. The priests rally the slaves to oppose the masters, not in a masterly way but rather in a resentful way. They tell us not to become strong like the masters, for we cannot, we are but slaves – instead we should glorify our weakness and be disgusted by the master's strength. Inactive in our weakness, we shall seek solace through the priest, for only they have the wisdom and divine access. This sense of impotence is then weaponised into active resentment and scorn of anything that grates or offends. In my impotence, I became precious, wary of any infringement or micro aggression, to the point at which my moral story begins to oppress the flow and life of others. The priestly engendered slavish

impotence and preciousness has become an oppressive morality – perhaps we could call it oppreciousness?

Thus the world proceeds – parts of us embrace our situations, parts give in to it, and parts are encouraged to be resentful and impotently passive-aggressive about it. How does this pertain to psychotherapy and psychoactives?

Psychotherapy and psychoactives of submission

I have spent years in therapy hanging on to my therapists' every word, trying to learn from their wisdom. I am not alone in this; indeed the profession and its professionals often actively promote such dependency and power imbalance. The psychotherapist is taught to remain anonymous and boundaried, untouchable and neutral (Simon, 1989, Smith, 1991, BACP, 2015). If information is power, the power imbalance is considerable, with the client baring their soul to the silent and analysing psychotherapist. The client's account is then interpreted through the modality and worldview of the psychotherapist, a new story is created according to the psychotherapeutic modality the therapist favours. What the client thought was genuine sadness over the loss of a loved one is largely fuelled by the eternal repercussions of the occasional absence of the maternal breast (Klein, 1946). What the client thought was fury against a system that does not allow them to be who they are is actually mostly unskilful thinking and feeling loops (Padesky, 2015). The slave is kept dependent on the priest, rarely mastering their world or their experience of it. It would be easy to blame the priestly psychotherapist here, but they are only following the rules of the profession, indeed actively holding themselves back, actively trying to retain fidelity to the model (Cucciare, 2016).

The oppressive tendencies of some versions of psychotherapy grew further with the development of psychiatry, a science aiming to identify diseases of the mind that, unlike diseases of the brain observed within the field of neurology, had no clear biological base. There are of course genetic predispositions to our traits and personalities, but taxonomising some of these traits as pathological allows the psychiatrist to pathologise entire swathes of human experience, some from genuinely distressed patients seeking help, and some phenomena that simply characterise what it is to be alive, from excessive joy to misery to social eccentricities (Plomin, 2018). As psychiatry became embedded into Western medicine, it also acquired power from the state to enforce treatment and even incarceration without the consent of its patients.

As the range of medications that could be sold to 'cure' mental distress and eccentricities grew, so did the categories of things they were supposed to be curing. Each year saw new areas of human affect and cognition adopted into the category of disease. Traits of personality, ways of relating and ways of behaving entered an odd grey zone in which they were supposedly pathological in character, and thus became diseases seen to be a real and observable thing in the same way that illnesses of the body are a real and observable thing. However, as we look over time and across cultures at these traits, we find that there is scant evidence for them being persistently seen as problematic. Being aggressive is seen as an illness in Stockholm, whilst it was seen as imperative in Sparta; being unassuming and sad in a difficult environment makes sense, whilst it looks depressive in other environments.

The effect of this medicalisation of the mind is that an element of your experience is taken away from you and made into an object apart from you. Your sadness is not an intrinsic part of you and your journey and your choices and Life – you have simply caught a bit of depression. The effects of the social isolation you experience, living alone without family or friends, and those feelings of fear and mistrust that beset your perception of the outside world, are Generalised Anxiety Disorder or social phobia. If certain versions of

psychotherapy promote submission, traditional psychiatry risks doing the same thing but in a harsher and sometimes state-sanctioned manner.

People living in difficult situations, whether socioeconomic deprivation or high-conflict environments, are more likely to experience distress. In a world where many people have few options other than to struggle on in these suboptimal environments, the prospect of being given a magic tool (a psychiatric diagnosis or perhaps a psychodynamic theory that pins it all on mum and sorts it all out through the care of the therapist) to fix all this is highly appealing to both client and practitioner. Psychiatrists and psychotherapists genuinely want to help. The need to provide help feels important, even urgent. But both are encouraged to deploy simplistic taxonomical tags in order to somehow fix the endlessly complex enigmas of human individuality and social complexity. Power is never without its complications, and being empowered to identify what is wrong or who is to blame runs the risk of creating a class of priests colluding in the disempowerment of their clients.

This then brings us to the question of self-medication. Suppose your taxonomical system leads to an assumption that there is little hope of the client mastering their difficulty; suppose it leads to even less hope of a social revolution that would reshape the environmental sources that tend, at the very least, to contribute; suppose furthermore, that pressures of time and funding are thrown into the mix. The priest despondently seeks to dull the pain, to divert the slave's gaze from the here and now, knowing that the here and now is something that the slave cannot bear. Mild agents (SSRIs) to blunt mild suffering, heavy-duty sedatives (so-called antipsychotics) for severely unorthodox thoughts, feelings and behaviours. These medicines don't engage with so-called depression or so-called psychosis as a cure, or a means to changing it – their job is to dull and divert (Moncrieff, Cohen and Mason, 2009). Like religion, they are the opiates of the mind that soothe the pain of the world, but they also hamper the revolution that would change it (Marx, 1844). The analogy has become reality.

The new wave of genetic insights into psychological traits will offer a depth of understanding into endogenous causes of mental distress, but getting stuck into a deterministic rubber-stamping of the old psychiatric taxonomies creates a God-ordained truth for its priesthood. Even within a biological paradigm, environmental factors and individual autonomy are at play. Reducing complex stories and experiences to pathological dysfunction is no more sophisticated than reducing them to God's will.

Psychotherapy and psychoactives of engagement

There is, however, hope. There is a strand of psychotherapy and psychiatry refreshingly devoid of priests, and it is unsurprisingly the strand that promotes joy and relieves distress most effectively.

There a solid body of research into the efficiency of differing psychotherapeutic modalities, with the majority of this research establishing support for the preferred modality versus the others. All modalities are the best, just pick one, and make sure that you only read the research that supports it. This counter intuitive research situation is explained by the minute levels of difference between the results from the different modalities, and the scientifically problematic ways in which the experiments were set up in order to 'prove' the preferred theory. CBT can be shown to be more effective than other therapies if you pick the right clients, compare trained CBT psychotherapists with untrained therapists, and then choose to interpret a miniscule improvement rate as significant (Cromby, Harper and Reavey, 2013).

What the research *does* show conclusively and consistently is that modalities do not matter. What matters is the quality of the engagement (Cooper, 2008) and the level to which the client's own strengths are recruited and empowered (Duncan, Miller and Sparks, 2004). This fits well with the description of mastery and slavishness above, where masterful

engagement empowers the client to find masterly qualities within themselves, and also finds solace to accept the slave aspects. By truly engaging with the client based on the client's experience and interpretation of the world, actively bracketing out the psychotherapist's world view, there is a creative space within which the client can flex their wings, gradually strengthen both muscles and courage, and eventually take flight themselves, leaving the psychotherapist smiling below. For example, whereas traditional psychiatry tries to sedate away the experience it calls psychosis, and psychotherapies of submission fit the client into their systems, the psychotherapist of engagement actively engages with the individual's experience. As traditional ego boundaries dissolve and sub-personalities take more solid forms, there is an opening to enter a form of engagement with the multiplicities of ourselves (Nietzsche, 1878/1984) and the world that can be deeply healing and enlightening. Indeed, there is a growing body of therapeutic work that engages with the 'illness' psychosis, seeing the emergence of this experience as something potentially organic and beneficial (Marohn, 2003).

The psychotherapist supports but crucially couples this support with faith in the client's own ability. The psychotherapist relates to the client on the client's terms, bringing their whole being without unnecessarily rigid boundaries. This is demanding work - the psychotherapist cannot simply rely on or rest in established theory. Indeed, a new theory has to be built up for each client. I as the psychotherapist need to be extremely flexible and need to have experienced as wide a possible world myself in order to challenge all that I 'know'. Be it through art or my own life's journey, be it through following many religions or querying all, be it through depth engagement with self or other, preferably all these things, I need to be able to be as open as possible to all that the client can be.

If the epitome of psychotherapy of submission was the traditional psychiatrist, the epitome of psychotherapy of engagement that emerges in the sketch above is the shaman. I am certain that there have been priestly shamans promoting adherence to vacuous rules and hierarchies, but the ones I am talking about here are the brave ones who accompany their clients deep into their lifeworlds and beyond. The shaman is part of the community and engages with individuals as well as groups, without insisting on artificial divisions. We noticed above how priestly Truth corralled our complex individual realities into one dominating story of religion or biological psychiatry – the shaman goes in the opposite direction. Starting out from the complex story of the client's lifeworld, the shaman *adds* even more stories. Call them analogies or alternate realities, the effect is a broadening and deepening rather than reduction and confinement.

Correspondingly, if sedatives were the drug of choice for the psychotherapy of submission, psychedelics like LSD, psilocybin, ayahuasca and peyote are the psychoactives resonating with the therapy of engagement. Considering the importance of flexibility, a wide range of experience and openness to the unfamiliar identified above, the psychedelic journey strengthens the qualities the psychotherapist relies on. This is the territory of the shaman, the archetypal psychonaut, and I believe that a psychotherapist or psychiatrist becomes better at their calling should they choose to enter it. Equally, given a safe and useful set and setting, allowing a suitably robust and prepared adult client to psychedelically trip whilst supported by the practitioner, and for them both to subsequently integrate the experience into the client's everyday life, could well be the most powerful, transformative and healing way of psychotherapy. Perhaps this is why shamans have done it for millennia, and perhaps this is why psychiatrists, psychologists and psychotherapists are showing renewed interest in these ancient medicines. Indeed, defying my wish for neat delineations, one free thinking psychiatrist is even labelling MDMA as 'psychiatry's antibiotics', praising its ability to simultaneously strengthen the client's confidence in self and therapist, elevate mood, and promote new ways of thinking (Sessa, 2017).

Conclusion: psychotherapy engaging with shamans and psychedelics

Imagine two settings, one for each strand I have described above. In one, the broken client pours their heart out to the blank faced therapist, as she has done once a week for years. In the other, we see a circle, a community of people. There's a therapist (be they shaman, psychotherapist or psychiatrist) guiding the proceedings and perhaps ayahuasca is involved, but the community is holding a space together. Everyone in the circle brings their distress, their joy and their beauty to share. There is a complex and textured dynamic of the many drives and challenges we face in our worlds. Maybe some people in the circle will struggle with parts of this process. The role of the therapist, if this happens, is to follow them on their journey and intervene in their world, within their paradigm, to positive effect. Not to simply reflect stuff back at them, or offer an interpretation the therapist finds useful, but to lend them his or her energy and assistance in dealing with their demons, literal or otherwise.

The world out there and our worlds within us have suffered priests too long. It is time to throw off their yoke. In the world of psychotherapy and psychiatry, the way to do this is to engage beyond modalities, engage directly with the experience of the client and their strengths and weaknesses. This is the way of the shaman, and as such can be deeply supported by psychedelics. Through the psychedelic encounter with the unfamiliar and the innermost, the therapist learns to be intimately in difference as opposed to indifferent. Furthermore, there is conclusive and current international research on the safety (Winstock, Barratt, Ferris and Maier, 2017) and benefits of clients using psychedelics and integrating their experiences with psychedelically experienced therapists, much of it even done in this country at for example Imperial College London (Nutt, 2012), Cardiff and Bristol (Sessa, 2017). An unprejudiced and open society is duty bound to honour such research and cease the prohibition of substances so useful for human experience and joy.

About the author

Dr Niklas Serning is a doctor of counselling psychology and a child psychotherapist. He is the Consultant Psychotherapist of Bristol's award-winning young person's charity Off the Record, a Senior Lecturer at the University of the West of England (UWE), on the MAPS register, and sees clients and supervisees in his private practice. He teaches psychotherapy, ethics, therapeutic uses of psychedelics, and sexualities at doctoral level, and also brings extensive experience from managing several United Nations operations in complex international emergencies.

Bibliography

BACP, (2015). *Ethical Framework for the Counselling Professions.* Lutterworth: British Association for Counselling and Psychotherapy.

Cooper, M. (2008). *Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly*. London: Sage Publications.

Cromby, J., Harper, D., Reavey, P. (2013). *Psychology, Mental Health and Distress*. Basingstoke: Palgrave Macmillan.

Cucciare, M.A. et al. (2016). *Assessing fidelity of cognitive behavioral therapy in rural VA clinics: design of a randomized implementation effectiveness (hybrid type III) trial.* In Implementation Science, Volume 11, Issue 65. Available at https://doi.org/10.1186/s13012-016-0432-4

Duncan, B., Miller, S., Sparks, J. (2004). *The Heroic Client: A Revolutionary Way to Improve Effectiveness Through Client Directed, Outcome Informed Therapy*. Hoboken: John Wiley & Sons.

Eigen, M. (1998). *The Psychoanalytic Mystic*. London: Free Association Books.

Kernberg, O. (2004). *Discussion: "Problems of Power in Psychoanalytic Institutions".* In Psychoanalytic Inquiry, pp 106-121, Volume 24, Issue 1.

Klein, M. (1946). 'Notes on some schizoid mechanisms'. *Envy and gratitude and other works*. London: Hogarth Press.

Marx, K. (1844). 'A Contribution to the Critique of Hegel's Philosophy of Right'. In *Deutsch-Französische Jahrbücher, 7 & 10*. Paris: Jahrbücher.

Moncrieff, J. (2014). *The Nature of Mental Disorder: Disease, Distress, or Personal Tendency? I*n Philosophy, Psychiatry, & Psychology, pp 257-260, Volume 21, Number 3.

Moncrieff, J., Cohen's, D. and Mason, J. P. (2009). *The subjective experience of taking anti-psychotic medication: a content analysis of Internet data.* Acta Psychiatrica Scandinavica. 120(2): 102-111. Available online: http://www.ncbi.nlm.nih.gov/pubmed/19222405. Accessed 11/05/17.

Marohn, S. (2003). *The Natural Medicine Guide to Schizophrenia*. Newburyport: Hampton Roads Publishing Company.

Newnes, C., (2015). *Inscription, Diagnosis, Deception and the Mental Health Industry: How Psy Governs Us All.* Basingstoke: Palgrave Macmillan.

Nietzsche, F. (1878/1984). *Human, All Too Human: A Book for Free Spirits.* Lincoln: University of Nebraska Press.

Nietzsche, F. (1887/1994). *On the Genealogy of Morality*. (trans. Carol Diethe, ed. Keith Ansell-Pearson). Cambridge: Cambridge University Press.

Nutt, D. (2012). *Drugs - without the hot air: Minimising the harms of legal and illegal drugs*. Cambridge: UIT.

Padesky, C. (2015). *Mind Over Mood, Second Edition: Change How You Feel by Changing the Way You Think.* New York: Guilford Press.

Plomin, R. (2018). *Blueprint – How DNA makes us who we are.* London: Allen Lane.

Sessa, B. (2017). *The Psychedelic Renaissance, 2nd edition*. London: Muswell Hill Press.

Simon, R. (1989). *Sexual exploitation of patients: how it begins before it happens*. Psychiatric Annals. 1989; 19:104-122.

Smith, D. (1991). *Hidden conversations: introduction to communicative psychoanalysis*. London: Routledge.

Winstock, A., Barratt, M., Ferris, J., Maier, L. (2017). *Global Drug Survey*. Available online: https://www.globaldrugsurvey.com/wp-content/themes/globaldrugsurvey/results/GDS2017_key-findings-report_final.pdf. Accessed 24/05/2017.