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Title: What Bonding Psychotherapy can learn from structure-related therapy

Summary: "Structure-related psychotherapy" by Gerd Rudolf was published in the same year as Konni Stauss' book on bonding-psychotherapy.

The structural view on deviant behavior initially implied an untreatable (or difficultly treated) mental disorder. In both books, it is now described as a set of treatable psychological functions, by which the self relates to itself and its fellow beings: how the patient treats others, he treats himself.

It is not "pathologies" that are to be treated, which would suggest a therapeutic nihilism; rather, therapy is given to patients with specific psychological functionalities. The observable relationship pattern is a "joint creation" by patient and therapist. Bonding-therapeutic competence can be seen in, amongst other skills, the ability to enter into an interactive dialog with the patient.

Dear bonding friends,

I was encouraged to give a lecture here especially by some of the members of the society who think that strengthening ecological and systemic aspects might be desirable within a theoretical new concept of bonding psychotherapy and – indeed:

The inter-relational aspect in psychotherapy is crucial.

I am convinced of the importance of strengthening the inter-relational aspect in psychotherapy in general, and especially in bonding psychotherapy; that is, when psychological phenomena are concerned, it is advisable to look at that what happens between human beings. This holds, of course, for therapeutic working alliances. Therapist and client will always be part of the interrelationship which develops between these two human beings.

Looking at man as an isolated individual separated from the therapist is a seemingly scientific procedure, but in fact it is fiction, "science fiction". According to the Watzlawik

axiom, you cannot but communicate. As a therapist, you cannot decide not to have a relationship with the client. You can decide only to start a helpful or a less helpful alliance. In my lecture I will take a closer look at the following question: What is the influence on a therapeutic alliance, if the therapist puts forward diagnoses?

Experiential therapy, as bonding psychotherapy is (even if Casriel was an analyst), stands in the tradition of humanistic psychology, which came into existence in the sixties of the last century. This humanistic psychology puts human experience in the centre of its interest, in contrast to the then psychological mainstreams of behaviorism and psychoanalysis. Thus it focused on subjective experience, inner life and emotions, which take priority over explanations and interpretations. A positivistic scientific objectivity is replaced by subjective sensibility.

The subject of therapy goes beyond diagnosis

It is generally accepted that a good therapeutic alliance is the safest predictor of a successful therapeutic outcome. A precise diagnosis is no hindrance for a good healing process, but it is not as important as a good relationship with the patient. The theory of change teaches us that disorder-specific factors are less important than the so-called unspecific factors like the relationship between therapist and patient.

In April 2003 I was offered the chance – on the occasion of our conference in Lisbon – to closely analyze “Indications and counter-indications of Bonding Psychotherapy”. In some respect my thoughts today about a structure-related procedure in bonding therapy continue that lecture. Psychotherapy has of course further developed in many ways in the past years. I want to focus here on Gerd Rudolf’s practical experiences and scientific results, which he published in his book “Structure Related Psychotherapy”.

He writes e.g. that his structurally related psychotherapy is not focused on diagnosis, but on specific psychological ways of functioning, which may show up with various disorders, e.g. eating disorders, borderline, or somatoform disorders.

This background throws a new light on indications or counter-indications which are established on diagnoses. In my essay of 2003 one of my central concerns was to show the danger of pathologizing a patient by putting forward a diagnosis. And I wanted to show that it is the therapist who introduces his diagnosis into the relationship between himself and patient. Sometimes the outcome would be that using diagnoses in such a way construct the reality of an incurable disease like psychoses, psychosomatoses, addictions, personality disorders, borderline. And this prevents healing . Karl Krauss made fun of that: “One of the most common diseases is diagnosis” .

Structure Related Psychotherapy

Structure related psychotherapy is a psychodynamic, ego-structural concept of relationship. Structure related techniques of treatment aim at the improvement of the capability of self-regulation and relationship regulation.

Therapies are applied not to diagnoses but to patients with specific psychological functioning on different levels of structural integration.

Structural viewing of psychological deviant behavior originally implicated a disorder which could **not** be treated or which could be treated under great difficulties only, and which is now described as a set of treatable psychological functions, through which the ego relates to himself and to his human fellows. This is described in the books of Gerd Rudolf as well as by Konni Stauss.

Structure related psychotherapy is a further developed form of psycho-dynamic treatment of “difficult” patients or patients who seem "untreatable" by using psychoanalytical techniques. However, psychoanalysis is very successful with conflict neuroses, i.e. with patients with a high level of ego structure, but not with problems of personality, or with formerly so-called "pre-oedipal early disturbances". Here structure related psychotherapy is to fill the gap.

Structure stabilizing, structure improving techniques had not been worked out in psychodynamic therapy for a long time, and had only vaguely been described as ego

supporting sessions. In structure related psychotherapy today, the modification of analytical therapy treatment for structural ego disturbances is described more precisely:

1. Strengthening one's own effectiveness
2. Regulating emotions and
3. The capability of interrelationship.

In Germany there is a difference between psychoanalysis and depth psychologically founded psychotherapy and this difference is also true for structure related psychotherapy today:

Transference and counter-transference dynamics will be noted, but not interpreted. And Counter-transference phenomena are used for diagnosis, but not for treatment.

The OPD (operationalized psychodynamic diagnostics) allows the description of how the ego regulates the relationship with itself and with others. Diagnostics are oriented towards directly observable inter-relational activity and behavior patterns, which facilitate recognizing the structure of the inner self, which in turn allows conclusions on the following:

Self-perception

Self-control

Modes of defense

Object perception

Emotional communication

Patterns of relationship

Perception of oneself

Coherence of oneself

Separation of one's ego from others

Ego structural patterns are manifest in interrelated acting and behavior and can be perceived there directly.

The knowledge of interrelationship is stored long before language is acquired.

It is not stored in words, but it is stored in behavior.

According to the results of the Boston Study Group, which studied the changes in PT, implicit memory, i.e. procedural knowledge, plays a leading role for the outcome of psychotherapies. The procedural knowledge can be perceived only in patterns of interrelationship, rather than in words.

One form of remembering such implicit instinctive relational knowledge occurs on the level of acting in the sense of re-enacting inner conflicts and relational patterns e.g. in the form of distributing roles to people involved. This field of re-enacting can be the relationship between therapist - Patient, but also the therapeutic community, the partnership, the own family, the working place, the club, etc. The patient takes his conflicts and relation patterns **with** the therapeutic community and **with** the therapist on stage. Staging is a “joint creation” of patient and therapist. Enactment serves the re-actualization of conflicts and is a means of (non-verbal) communication.

Part of therapeutic abilities is to understand the scenes in order to decode the scenes of unmet needs.

Fragments of earlier interactive experience, which cannot be remembered, are tied together with similar relational contexts according to a key – lock principle, actually a coproduction.

Re-enacting means that the patient presents relational patterns or self-object-representations in a place outside the inner self. The patient is projecting parts of himself into other persons.

The therapeutic means of mirroring

Let us assume a client attacks his therapist verbally, accusing him, putting him down, showing a hostile attitude towards him, the therapist will listen to him and – as he is expert in self-observation he will differentiate between a possible concern of his own and phenomena of transference. Which emotions does he have, which impulses does he feel?

How does he handle them? Which interventions does he use, which answers will he give?
Which procedures will he pursue?

Recommended tactics of structure related psychotherapy is mirroring, which may be expressed in the following way: Do you treat yourself, just as you are treating me now, sometimes in the same way? That is, the focus of attention lies on the patient's introjections.

Or: Have you been treated in the same way formerly, just as you are treating me now? That is, the focus of attention lies on the patient's internalization.

Intentional remembering is an act of the soul – a repetition within the inner self. Patients on a high structural integration level talk about their conflicts and take recourse to verbal, symbolic means of communication during psychotherapy.

Patients on a lower structural level, however, stage their inner emotional difficulties in the sense of re-enacting. This form of remembering is not an inner emotional act but a social act, a repetition of the un-met needs between humans. The competent therapist might start an interactive dialogue with the patient, e.g. giving him containment, and support, providing structure through helpful alliance.

What can we learn from the structure related point of view for our bonding therapeutic competence?

Psychotherapy, bonding-therapy included, must be relationship therapy. Relationship therapy means to provide a stage for the nonverbal or pre-verbal implicit knowledge of interrelationship set in a reliable frame (e.g. by giving rules for living together).

The bonding therapist would realize that re-enacting earlier relational and attachment experiences connects to relational contexts here and now, making the relationship between therapist and client difficult for a short time only, or so we hope.

The bonding therapist would say: The relationship is difficult - and not: The patient is difficult because of his pathological deficits.

The bonding therapist does not treat the possibly grave disturbance, or a disturbance, which cannot be healed; instead he treats specific ways of the patient's acting and relating, which

are part of a more or less grave psychological disorders. Helm Stierlin, the German family therapist from Heidelberg defined this as the liquidation of diagnoses.

A bonding therapist will not take the patient's deviant behavior and ways of relating as disorders in the sense of pathological dysfunction, but as indicators of elementary human needs for relational safety, stability of one's own worth, for emotional openness and physical closeness. Figuratively speaking: Pathological conditions may result from unsatisfied hunger, but hunger itself shows only a state of deficiency and is not a pathological condition per se.

A bonding therapist allows personal encounter and offers an interactive dialogue. Explanations and interpretations do not constitute the main issue, but a containing environment offering help, offering a safely guarded space, in which the patient can communicate with the mute inner self in an adequate fashion.

A bonding psychotherapist makes use of the informative power of acting out and offers interactive dialogue (instead of prohibiting acting out). Emotional processes are more important than explanations and interpretations.

The therapist stabilizes structurally and communicates emotionally. He is mirroring counter transference. The therapist offers himself as a helping ego. He will make sure that the patient takes over responsibility. Responsibility of one's own self is related to a sense of self-efficacy, which shows whether the patient has achieved the therapeutic aims of regulating himself, his emotions and his relationship to others.

Self-efficacy means to find an internal locus of control and to switch to an active mode of dealing with experiences, instead of suffering passively: The aim is not just to survive, but to be back right in the middle of life.

As Otto Rank said, the therapeutic process is defined as a re-enactment of earlier relational experiences with hopefully better results and this is true for structurally oriented bonding therapy as well.

At the end of my lecture, I will relate to the discussion yesterday:

I agree that risk management is important. But for me, risk management is beyond making diagnoses like borderline, etc or psychometric measurement. Of course, doing this is no hindrance for a good risk management, but risk management is for me, first of all, to be in good contact with the patient, to have a good relationship to the patient. As a therapist, I could never feel secure without this. Maybe others do not underline this so much, because the therapeutic necessity of having a good relationship is as natural to them as breathing, and everybody is doing it anyway. But for me it is crucial to have it in mind as a guideline. And I did it this way for the last 20 years and maybe I was only lucky that I had no major problems due to bonding.

A second main issue of my lecture is to bring forward that Gerd Rudolf said that his therapy works beyond diagnosis of diseases.

And the third message of my lecture is that we can recognize functions of the inner self structure by watching how people relate to others and that these structural functions can be treated.

During a conference in April, I had the opportunity to ask Gerd Rudolf how he treats patients whose structural functions are on a low level of integration and he recommended nonverbal therapy like imaginations and I recommend bonding therapy. Maybe the topic of my lecture should be changed into: What can structural related psychotherapy learn from Bonding therapy.