

## Self-referentiality in clinical psychology and psychotherapy

by Franco Di Maria\* and Ivan Formica\*\*

### *Self-referentiality*

The term “self-referential” is particularly used in logic field and it is used to indicate an utterance that somehow already refers to itself (for example we can think about Cretan Epimenide’s paradox which affirms that “all Cretans are liars”); the “self-referential” dimension helps to find out the paradox according to the same statement “all the Cretans are liars” should also be considered a lie.

In literature, we find several examples of “self-referentiality”. Just think to the *Don Chisciotte della Mancia* by Miguel de Cervantes, *Se una notte d’inverno un viaggiatore* by Italo Calvino, *Sei personaggi in cerca di autore* by Luigi Pirandello. In other words, the “self-referentiality” appears everytime an author refers to his own work within the context of the work itself.

The “self-referentiality” is a very common concept and it is used in mathematics, philosophy, informatics (computer science), systems theory and linguistics.

On the contrary, it’s rarely used in psychology. From our point of view the topic of “self-referentiality” should not be omitted and we believe that it is a moral and deontological duty to face this subject, especially in clinical psychology and psychotherapy, to highlight the large (many) risks that an extremely self-referential position could assume in these professions’ ambit.

From a historical point of view, we could affirm that the “self-referentiality” and psychoanalysis were born together. As a matter of fact, Freud’s self-analysis can be read as an attempt to look at things everytime with the same lens. Furthermore, we think that also the invention of *resistance* is a clear example of a self-referential attitude. In fact, Freud asserted that if the patient nodded to the interpretations that himself was given, it meant that these were correct; on the other hand, if the patient withstended (resisted) it meant once again that his interpretations were still correct but he had some difficulties in receiving theme since unacceptable. In other words is just like saying “if it’s heads I win, if it’s tails you loose”.

We think that Freud hasn’t seriously asked himself about the resistances he used to act in front of patient’s resistances.

We can find an opposite direction with the creation of the Middle Group (there are different authors: Winnicott, Fairbairn, Balint) that arised around the 40s of last century, when the British psychoanalytic Society went trough a period full of contrasts rising from the different position assumed by Anna Freud and Melanie Klein. This dispute had important relapses and there were several problems concerning who had to be authorized to educate future analysts. So two different groups were created for taking care about students’s training: group A composed by Kleinian analysts and group B composed by the ones who were closer to Anna Freud’s ideas. Each student had to have 2 supervisors: the first could have been choosen from the ones belonging to one of the two groups; the second, to avoid risks coming from an unilateral training (we could say “self-referential”), it couldn’t belong to any of the two different groups but had to be “in the middle”.

The aim was to give every candidate the possibility to freely do their choices eventhough if inside the psychoanalytical movement. So the Middle Group was born and afterwards it described itself with the adjective independent (Lis, Stella & Zavattini, 1999).

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As a group analyst, Lo Verso (2006) had the merit to having denounced the self-referentiality of the group analysts often guilty of having been myopic regarding the overall evolution of the psychotherapy and the sciences that join it. What Lo Verso specifically underlines is an inadequate attention towards international evolution, studies done in neighbouring fields, scientific evolution of psychotherapy and work with the groups. The texts on which everyone studies and updates refer to his own parish (which is often a little church but we think is the whole world).

Fornero (2006) foresees that parishes and little churches in globalization times are going to multiply because they are, historically, phenomena tendentially proportional to the diffused perception of reducing and mingling up of boundaries (ideological, scientific, ethical, role and gender ones, etc.).

### *Self-referentiality as a sedative*

The uncritical acquisition, with the consequent repetition of thoughts, models, theories transmitted by the teachers of one's own little church, by our way of seeing things, it comes from a diffused uncertainty and insecurity condition that characterizes the psychotherapist or the clinical psychologist especially at the beginning of their profession.

Let's make an example: if a swimmer is swimming in the open sea and, at a certain point, the sea starts to stir, what do you think the swimmer will do? He will look for a hold, a rock for example, something on which he can lean on.

The more the sea will stir, the more the swimmer will desperately look for any life preserver in order to survive.

We can say the same thing regarding the psychotherapy. It is not a coincidence that the sea, together with the journey, is one of the most used metaphors to describe the clinical work. If the relationship psychotherapist/patient starts to stir, to be uncontrollable/uncontrolled, the psychotherapist will search for grips, supports on which cling to. These supports, in psychotherapy, are more often everyone's models of reference, theoretical apparatus, sentences heard from one's teachers.

The references to one's own teachers act more as a confirmation of one's own doing than as an incentive for the research and comparison; as if the daily contact with the patients suffering and our own would take us to look for reassurances inevitably more enjoyable in what we know and within the theory, rather than see again and think again about our references and methodological hypothesis (Nosè, 2006).

One question that we could at this point ask ourselves is: why the clinical work is able to generate so much uncertainty, insecurity and fear?

We could briefly answer saying that the known reassures us and the unknown, on the contrary, frightens us. Each psychotherapeutic journey, whether we like it or not, is a trip in the unknown. We don't know the way, we don't know where we'll go, every single step could hide snares, difficulties, inconveniences. There will be uphill ways, others will be downhill, but we could not be able to know in advance but only *in itinere* (ongoing). Every psychotherapist has to construct a therapeutical project which, in some way, outlines the distance it has to be made; but anyway, the psychotherapeutic trip it will never be an organized journey but it will always be a step by step organizing journey. It is a trip of which we don't know the purpose and the end.

Winnicott loved to say that the psychotherapist has to follow the patient and go where the patient wants to take him.

The only thing we have, and that we know more about, is our suitcase where are deposited our education, our learned models, our experience, our theories of reference. Our suitcase knowledge, even if detailed and competent, doesn't make the journey free from snares and enigmas. In any case, it has to deal with a little-known itineraries route.

Kavakis is right when, in his beautiful poem *Itaca*, says: "When you'll start your journey to Itaca you must hope that the route will be long, fertile of adventures and experiences"; similarly, the same principle has to be valid also for the psychotherapist: he has to be able to live and stop in the adventure of a journey, he has to visit those places apparently hidden, inaccessible, threatening but which can consent new discoveries, new knowledge and enrichment without fearing to get lost in the meanders of little-known and dark paths, because only experience of getting lost gives us the chance to find ourselves.

Unfortunately, what we can see is the fear of losing ourselves, the need of reassuring certainties, sure maps, compasses that drive and orientate us.

Let's try to approach the mental field of any psychotherapist (especially one at the beginning of his profession) and to take a picture to what happens to him when he's in front of a patient who talks, talks, talks, but who says nothing according to the psychotherapist.

Psychotherapist thoughts: "*I'm not understanding anything...what can I say to him now?...shall I interpretate or not (classical Hamlet-like dilemma of the psychotherapist)...I don't have anything intelligent to say but if I wont say anything what will my patient think about me?...Maybe that I'm poor and inexperienced..., nol have to try to say something...that will above all result credible especcially for my patient...it doesn't matter if it's not credible enough for me, the important thing is that it is for him...the important thing is that he doesn't think I'm unprepared otherwise I risk loosing him...and I'll remain with only two patients...and that means with a few hundred euro a month*".

This trip inside a hypothetical mental field (and it is not much different from what really happens) is the dimonstration of what we have already written, that is of this unending need of certainties, holds, bastions on which lean on.

The self-referentiality becomes a process through which, leaning on a well-known, domesticated and familiar thought, I can soothe the anxiousness of a trip without navigator.

Another explanation could highlight the reason why the most of the psychotherapists who are on the point of starting the profession feel like lost, scared, frightened: the feeling that the training performed until that moment is evanescent. The evanescence deal with the feeling to be unable to touch things by hand. Experiences as the school of psychotherapy, supervisions, clinical workshops, personal analysis are all extremely important, but as intangible escape clinical psychotherapist who will ask himself: "How come in spite of all the training done, I feel so unskilled and scared thinking about meeting a patient? Afterall I've done several experiences and according to what Bion has teached us (to learn from experience) I should have learned many things. So why am I feeling so inadequate and unsuited to put into practice what I have learnt?"

Our conviction is that we don't learn anything from experience, but (we learn) from the *thought of experience*. But what thought are we talking about?

*From the "already thought" to the "to think"*

The foundation of the independent growth of each individual is the dialogue continuity-\discontinuity. Continuity consists of remaining in the identical or in the *idem* that determinates in the interior world of a child an organization of images and concepts that reflect, repeat and reproduce that kind of knowledge and adaptment to environment suggested by the identity with which one identifies himself. All the almost automatic, creature of habit, unthoughtful behaviours that lodge in everyone of us are just the expression and result of remaining in the continuity phase that is in that phase of permanence in the physiological dogmatism, understood as mental necessity for the child to have an already written script to act and coordinates belonging to the shared world register, indispensable to realize his existence.

Passing through the dimension of continuity to the discontinuity one (Napolitani would say: from *idem* to *autos*) is the same as being able to re-write the register of the already known to open

one's mental scenarios to the new and unknown; it means starting to think autonomous thoughts instead of thoughts already thought by someone else somewhere else; it means, at last, starting to speak an original language instead of repeating echolalically words said by others. The discontinuity founds also the possibility to avoid the risk of self-referentiality as pathological dogmatism, that is the permanency in the shared world register reflecting inside of a repeated thought, as strongly saturated by the thought transferred by one's masters.

In our profession, living the discontinuity's universe involves, therefore, the ability of thinking again regarding our own models of reference, our own theories and paradigmas in every context and each peculiarity of each clinical relationship.

On the contrary, being in the register of continuity involves acting already written scripts and obeying in a dogmatic way to dictates, rules imposed and taught without considering the different peculiarities. It means to let the patient disappear with his story.

A training psychotherapist who doesn't consent the access to discontinuity, doesn't do a good job because he just fills up his students minds which are destined to become too armoured and full of bars crossable with difficulty to be able to house a thought different from the only one of which they have been invested and that they will sequely become holders; so remaining prisoners inside the same mental field turned into a prison.

So it happens that what we learned during our formative course, that is the saturation of thought is the beginning of each psychopathology, is totally removed and it seems to uncount when we become trainers.

The outcome of a rigid continuity so becomes the creation of a thought reflecting dogmatic intendings of a rigid thought highly saturated, which doesn't allow subject to construct an autonomous sense around happenings, because saturated of sense. In other words, the reflecting thought domesticates the event in the register of the already established knowledge.

Only an intelligent discontinuity, on the contrary, allows the creation of a reflexive thought; that is that kind of thought that can ascribe to an event an original sense or an invention of sense. (Di Maria & Formica, 2005).

As Diego Napolitani (1987) taught us: *to know reality doesn't simply mean reflecting it in one's own perception-knowledge system, but, on the contrary, it means inventing it; so discover reality is production of symbolic sense around the perceived fact (datum).*

Reflecting thought and reflexive thought follow two different routes. The first one follows the route in which the happening is filtrated by the register of anteriority and already known and it turns into an event (from ex-venire) that is the attribution of sense which occurs out the subjective elaboration; the way of reflexive thought, on the contrary, consent the transformation of the happening into an attribution of sense coming from the subjective transformative elaboration of thought; only in this way the happening changes into invento (from in-venire) and that is in original, personal attribution of sense in the sphere of conceptivity and polysemic transformative attitude.

In other words, happening changing into event refers to the already known; the changing into invento, on the contrary, proposes the not yet, the possible, the convertible, allowing the construction of an autentically generative thought.

#### *Unproductive self-referentiality and generative self-referentiality*

The meaning that we have until now used for the word self-referentiality was negative. Actually, we think, this is not always true. From our point of view, as a matter of fact, it would be useful and correct to distinguish the unproductive self-referentiality from the generative one.

The first one, of which we have written above, in fact comes from the belonging, often rigid and dogmatic, to one church perceived as the only possible and thinkable church. In this case, we are in front of the fideistic acceptance of a model that is perceived as the only one possible and the church becomes the comfortable and justifying container able to mitigate and/or soothe the

physiological and/or pathological anxieties that cross the clinical therapist. In this case is a self-referentiality that has the task to reassure and answer to interior needs, rather than to scientific-professional motivations.

On the contrary, the second one consists in a critical and aware self-referentiality, not necessarily negative, coming from the acquisition of a specific style that each psychotherapist should act in his individual and/or groupal work. (Di Maria & Formica, 2007)

The unproductive self-referentiality it seems to derive from the influence coming from the medical model that seems to have made uncertain the empirical evidence. The psychologist oriented, according to the medical model mimesis, to diagnose the state of health has to refer to his theoretical references, reading the "problem" of the patient according to the therapeutical model in which he was formed; after, applying the techniques he practises and reading the reintroduction of the state of health according to the methodologic grille which refers to these techniques (Del Corno & Lang, 2000). How much this process is now advanced in Italy too, is easily deducible from the data of a research on the psychotherapeutic training Agencies, from which emerges that the most psychologists end up recognizing, from the point of view of their own technical-professional belonging, only the trend and school in which they developed (Lombardo et al., 1991).

If the self-referentiality of clinical psychology seems to seriously mine the evidence and recognizability of therapeutical results, we must also say that the same parcelling out in schools and trends seems to act in a way as much confusive on the individuation of psychotherapy's specificity.

Studying the relationship between the specific techniques of the several psychotherapeutic schools, it was seen that the change's factors are, for all trends, two types: specific (concerning the used techniques) and unspecific (which have a little relevance to theoretical models and operating praxis).

### *The fleeting moment*

Let's do a game.

Try to read slowly (only one time) the below English sentence and immediately after try to say how many "S" you have seen.

VIRGINIA WOLF IS NOW RECOGNIZED AS A MAJOR TWENTIETH-CENTURY AUTHOR, A GREAT NOVELIST AND ESSAYIST, AND A KEY FIGURE IN LITERARY AS A FEMINIST AND A MODERNIST.

After you have said to yourself how many letters "S" you have seen, go back to the sentence and count the letters "S" slowly. You'll see they are 9.

Many of you, in this moment, are saying: "I did wrong, I've seen 3 rather than 4 rather than 7 and so on".

Actually nobody was wrong. In fact, what we asked you was not how many letters "S" there are in the sentence but how many "S" you can see in the sentence.

We have to stop thinking we all have to see the same thing.

In the beautiful 1989 movie entitled "Dead Poets Society" (L'attimo fuggente), there's a scene remained in the cinema's history in which the protagonist (Robin Williams in the role of a teacher) invites his students to get up out of their own chair, to climb on the desk to look at things from different viewpoints.

In the movie Robin Williams says: "Just when you think you know something you have to look at it in another way. When you read don't just consider what the author thinks; consider what you think. You must fight to find your own voice; as longer you wait to begin, the less likely you are to find it at all. Don't drown yourselves in mental laziness, look around you, just dare to break out and find new grounds".

The lesson that the movie gives us, reminds as sometimes happens that in front of a patient who repeatedly shoots off the time of the end of session, the psychotherapist asks himself: what shall I do?

Shall I try to finish on time, so I satisfy that part of me which has to uncritically adhere to the teachings learned (in this case the one concerning the importance of session length), or I give him another five minutes in order to let him finish his speech?

And it's in this swing between the two opposing forces which act inside us that we lost the aim of our job: that is to take care of our patient (as a user of a service).

Maybe the question we should ask ourselves and that should become subject of dialogue during the session should be: "what is the meaning of this shooting off for me therapist and for my patient (himself in a relationship)? What does finish on time mean for my patient and what does it mean for me? What kind of relationships have I, and what relationships does my patient have with rules? What role did rules have in my patient family's story? What is my difficulty to say: "The session is over"? Obviously we could continue indefinitely.

In other words, we have to be able to transit from the register of answer (or I finish on time or I grant him another five minutes) to the register of question (as an opening of a thought, research of new meanings that could help therapist and patient to enlarge each one's stories and their relationships).

Thank to the process of identification, human being learns (that is take inside himself) all that the collective (parents, contexts in which he lives, groups of which is part, etc.) teaches him. If the construction can be read as the outcome of continuous grafts that aim to make the subject a perfect replicant of preconstituted scripts, submitted to his own belonging groups, also another process happens luckily and it consists in an expressive attitude which allows the subject, during his way to the construction of his identity's meaning, to re-conceive the world that conceived him.

This process, that Napolitani calls symbolpoietic, allows the subject to become curious, make original choices, have his own idea of life and to re-watch the world that concerns him.

The key word is, therefore, creativity. Only being creative we can free ourselves from the restrictions of an established culture. Only being creative we can transit from the register of answer to the register of question, and be able to open new and original considerations horizons that can allow us to ascribe donations of meaning, with regards to difficulty in finishing the session on time.

Only the creative thought, able to create and not only act already known scripts, is a thought in relation to growth. It's important to remember that the verb to grow is the iterative of the verb to create. To grow means being able to produce subsequent creations. In other words, the more we create the more we grow.

We think that only a creative thought could be able to escape the risks of a self-referential position. We need, therefore, to be able to develop our creative thought. A thought that, here, we want to define "eminent thought" according to the etymological meaning of the term eminent in Italian "egregio", that is out from the herd (ex gregge). Only an eminent thought, that can differ from the herd, from the mass, from the already thought, can characterize a profession as it is the clinical psychology and/or psychotherapy.

#### *To think politically of clinical psychology and psychotherapy*

Considering what already written, we think it is indispensable to exercise an action of political reflection of clinical psychology and psychotherapy.

The first move to make in this direction, in our point of view is reflection on the training theme. Today, we assist (at University and Schools of Psychotherapy) to an enormous parcelling out of the formative offers, most of which originated from power needs rather than from real abilities.

About 3500 degree courses in Italy are the sad proof of a fragmented and unproductive scenery.

Moreover, when we refer to the training in the area of clinical psychology and/or psychotherapy, we have to highlight the importance of a training which is not only seen as a simple transmission of techniques or operative praxis because if we did it we would lose sight of clinical relationship with its infinite specific quality.

We necessarily have to move on from an explanatory training (characterized by the transmission of contents and competences to learn in a replicative way) to an implicative training (seen as space of subjective elaboration of the meanings that are structured in the specific learning situation).

As Grasso (2004) rightly affirms, the replicative training is poorly functional when one wants to acquire, for example, the capacity to use his own emotional world as a instrument for the reading of the present relation. In fact, we can repeat behaviours or even whole sequences of behaviours but it is not possible to repeat emotional dimensions to which give contextual meaning.

In this direction, some authors (Salvatore & Scotto di Carlo, 2005), even if from a different perspective, underlined how university training, in the psychological field, has often taken the features of a pure and simple transfer of disciplinary knowledge, giving to every single individual, achieved the final title, the task to create a connection between the achieved learning and the possible use in the professional sphere.

The way to interpret the training in the clinical psychological field, *in primis* in the university one, it has to be intended as a way of continuous query, of acceptance of the events complexity and of the lack of univocal and reassuring answers towards this complexity. This to be able to, as Grasso says (2006), move from the dogmatic assertiveness to the dimension of exploration.

We often notice the high risk to characterize the training course (curriculum) more in the sense of determining a belonging than acquiring a competence.

As Montesarchio and Venuleo write (2006) it is necessary to compare once again with technicality issues that can't be longer intended as unproductive repetition of rigid and ritual sequentialities, bound only to greater or lesser adherence to any orthodoxy, but as elements which find their meaning according to the relationship and setting to which it refers.

This implies, on training level, a move from a training to use the technique to a training of thinking about the technique and its use.

At last, we'd like to spend some conclusive words regarding the theme of evaluation of psychotherapies. From our point of view, if we really want to try to get out of the self-referential dimension we can't still think as the orthodox psychoanalysts who did not consent the entry of machines audio/video because these, according to what they said, would spoil the setting. We believe that, if the recording of the sessions could be useful for research and so to recall the clinical work, the spoiled setting must be.

The research made over the last years, as well as demonstrate the efficacy of the psychotherapy and increase the knowledge of its internal mechanisms, has consented every single therapist to think of the work putting in a more conscious way the important issue of the *responsability of treatment*. Thinking of psychoterapical treatments not more as art (even if this could be romantic and evocative) but in terms of *methods of cure*, this involves, with responsibility, the problem of efficacy, of the comparative treatment indications, of the achieved results. Outside the structured areas of research, this contributes to elevate the ethical attention to what we really do, to what happens to patients, to therapist's limits and of his models of reference, to drop-out, to mistakes, to failures, ecc. From this point of view, it has been found useful, for the comprehension of the clinical work, exceeding the analitic-psychiatric tradition that studies the case concentrating his attention on the patient, to observe the theoretic-clinical device and what founds it: the fact that the therapist creates his work, and through it "reads" the patient and his story.

Scientific comparison has increased the dialogue, integration and mutual respect between the different schools of psychotherapy. We are gradually reaching the aim of sustainable or otherwise consensual definitions on important issues like care, its methodologies, the purposes. It's now more frequent the exchange of tools, data, clinical experiences which contribute to secularize the professional scientific community. To this the foundation of s.p.r. has much contributed that besides being the main scientific point of reference for students in this field, aims to form a sort of "bank" where everyone can enter and collect knowledge. All this seems to be a good step towards the embanking of self-referential tsunamis.

We also believe that, however useful, we speak too often regarding the "clinical efficacy of psychotherapy", while we have never heard, not once, about the "clinical efficacy of the psychotherapists".

Regarding the "clinical efficacy of the psychotherapists" we think that this must be the next direction to take.

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