Podcast - Edited Transcript

Psychotherapy and Neurobiology - an interview with George Halasz – Andrew Amos

Australasian Psychiatry, 25, 3, June 2017; 218.

Andrew — Welcome to the June 2017 edition of *Australasian Psychiatry*. The June issue has a broad range of articles on the theory and practice of psychotherapy and modern psychiatry, addressing transference, infant observation, psychotherapy with children, adolescents and older patients and forensic psychotherapy, among other topics. I'm Andrew Amos and today I speak with Dr George Halasz, child psychiatrist and author of an article on child and adolescent psychotherapy alongside an editorial introducing the special topic in the June issue.

George, welcome to the podcast.

George — Thank you very much Andrew; really excited about this.

Andrew — What do you think of the common perception that the clinical and commercial success of psychopharmacotherapeutics alongside the proliferation of psychotherapeutic options provided by allied health staff, has reduced the relevance of psychotherapy for the modern psychiatrist?

George — Wow, what an opening question. That really is a multi-part question which requires a multi-part response. I'd simplify it in one way to say that psychotherapy whether it's on the drug side augmentation or the multi-branding, multi-disciplinary talk type of therapies and play therapies as they're

commonly known, at the centre of it is the irreplaceable and irrefutable essence which is the relationship, that is between someone who is stressed and troubled and suffering and a professional mandated in our culture to relieve that suffering through various means. And so, all the others sort of topics and pressure groups and interests and personnel are of course major topics in themselves but I don't think we should ever lose sight of the central issue. It is to relieve suffering in an ethical way.

Andrew Do you think it's true though that what the psychiatrist actually does may have changed even if the use of psychoanalysis improves their understanding?

George Andrew, there's absolutely no doubt that if we look at the last hundred years say, or roughly a hundred years, the very nature of the profession both of psychoanalysis and psychiatry, and especially in relation to this June edition which is on the update of psychotherapy, the hundred years has seen the most radical changes, often termed as a paradigm change.

Now there have been paradigms as patterns of practice which establishes basic frameworks of knowledge both within psychoanalysis on the one hand and within psychiatry on the other, that have changed from the time of the First World War which was really warfare in the trenches and the language of that time reflected it, it was actually, the experience was called 'shell-shock'.

Over the hundred years in fact it has been many of the major conflicts and wars that have resulted in both psychoanalysis and psychiatry responding to trauma and by the Second World War both of the specialties had new language.

So in psychiatry it was more commonly now known as 'war neurosis' and in psychoanalysis itself, the concept of 'psychic trauma' became the dominant paradigm as opposed to real trauma. This tension in

the middle of the last century culminated by the end of the Vietnam war, in the acknowledgement that PTSD – Post Traumatic Stress Disorder – was now a recognisable real state as a consequence of trauma and both psychoanalysts and general psychiatrists had to acknowledge that the lasting effects of trauma were irrefutably present in culture.

By the end of the 20th century, the idea of trauma being a military conflict based event-defined experience moved with the phenomenal work of Judith Herman in the early 1990s in her book, *Trauma and Recovery* to domestic violence, sexual abuse and civilian trauma and so there have been – if you take an overview of the last century that this most dramatic change in the conceptualisation of trauma both in psychoanalysis and psychiatry, with consequent need for change by the psychoanalyst, the professional, and the psychiatrist, the professional – in how they are in the consulting room with patients from old age to middle age to children and indeed mother and infants.

Andrew Yes. At the same time as the change in paradigm that you mention, there has been the introduction of perhaps a competing paradigm which I might broadly characterise as cognitive therapy. Do you have a framework for understanding the difference between psychoanalysis and cognitive therapy?

George What a wonderful pointed question. Cognitive therapy or cognitive behaviour therapy really was the dominant paradigm for the latter part of the 20th century. Now that has been in constant tension in a way as the name implies with its emphasis on cognition which in general – I don't want to be too particular here, but we could go more particular later – but generally that's attributed to a left brain function.

Now one of the radical changes in the paradigm that occurred as a result of the 1990s, known as the 'decade of the brain', where major research occurred with scanning and other techniques where we could

actually gain direct sighting of the brain in action, new data, data of what happens in the brain and lo and behold the emphasis shifted from the cognitive left brain to the affective or emotional and intuitive right brain.

And that culminated in the early 2000s with Allan Schore's epic description of relational trauma - his new term, a term that had never been previously used.

Allan Schore coined this term to describe the experience of trauma between people, hence the term 'relational' - even in the absence of what was classically known as the 'events' of trauma: sexual abuse, neglect and various other forms of either excesses of stimulation or withdrawal and abandonment. So the quality of the relationship itself could become traumatic. Now the radical shift here was that this was pre-cognitive, in other words this relational trauma was happening in mother-infant relationships or caregiver relationships before any language was actually used, so at best one would have to say it was pre-cognitive.

This is the current paradigm and the radical shift that has happened and the tension is still being lived out even in the June articles. If you read them closely you will see that there's tremendous tension and almost a sense of crisis of identity.

Do we as practitioners of mental health – psychiatrists, psychologists, psychoanalysts, family therapists – do we follow a brand that is cognitive or psychoanalytic or so on, or are we really open to this new data, this new paradigm?

Andrew Yes. There's a broad spectrum of the ambition of theories that try to incorporate neurobiological understandings into psychotherapy and some of them are just the basic realisation that the brain's a dynamic organ, it's increased in size and density by growth hormones and decreased by stressfulness, to more

ambitious theories which link specific brain regions to specific mental phenomena such as mirror neurons in the frontal parietal cortices that substrates for attachment and mindfulness, where would you place yourself along that sort of spectrum? Do you use these concepts in a general way? Or do you have specific understandings that are more prescriptive?

George Yes, Andrew that's a wonderful question and summarising in fact what the paradigm change is. That is, that in the olden days, the last century, we had a more generalist view of the brain and psychopathology. And that was embraced in the paradigm of George Engel in the latter part of the 20th century, the bio-psycho-social model that embraced biological, psychological and social factors to converge, to create a certain environment that either was or was not conducive to healthy development.

Now this isn't an either/or situation, it's an evolving and developing situation that with the decade of the brain in the 1990's became more specific in the bio-psycho-social's 'bio' part. And so the generalist bio part of stress hormones and the hypothalamic-pituitary-adrenal axis, reacting in stress and so on, that is something that has been built on, it's not either/or.

So that knowledge has been subsumed under the highly specific, as you raise the specificity, mirror neurones, there's many more like Stephen Porges' 'polyvagal theory' which has given our understanding of the vagus nerve a whole new perspective - multiple complex functions, beyond the so-called autonomic nervous system. In fact it's divided, as the name 'poly'-vagal suggests, to more than one vagus system.

Now this doesn't mean that the old system isn't valid. It was the building block. However a paradigm change means that whatever you lived by in the past, is now outdated enough to require an update obviously in the theory but most specifically for us clinicians, it's extremely important that we translate

these changes from the research lab, the research literature journals and textbooks, into our consulting room in clinical practice.

Andrew Yes, indeed. You mentioned earlier an interest, or your interest in the treatment and understanding of trauma and you have publications on transgenerational trauma associated with the Holocaust, are there psychotherapeutic or psychoanalytic models or concepts that you have found useful in this area?

George Absolutely. The experience of trauma is central to this whole paradigm change and the neuroscience of trauma. And earlier you asked where do I stand and where do I belong in this spectrum of various positions? Now all of us, and I include obviously myself in this, having trained in the late 70s early 80s, and now still fortunate enough I’m blessed enough with good health to practise now in the 2010s, but I have actually been trained in the old system where trauma in, the Holocaust trauma, the intergenerational trauma and all traumas, was generally informed by the ‘event’ of the trauma in general psychiatry or ‘psychic’ trauma in psychoanalysis.

Following the decade of the brain, Allan Schore and others including van der Kolk and so on, I really had to take another look at my own understanding and this goes down to my personal level, indeed to my personal relationship with my mother who’s a Holocaust survivor. How would I now understand our mother/son relationship, leaving myself as a doctor to one side; how do I feel; how am I informed by my profession in the relation to my mother’s own trauma and to the degree that it has been transmitted to me, to my trauma.

And so where I found the most relevant, what could I say, authentic, genuine explanation was offered by this new paradigm. The trauma in fact is not to be event-defined, but experience-defined.

A trauma that’s experience-defined, has to be integrated with its dissociation which Allan Schore described as the ‘bottom-line-defence’ a simple set of words but carrying a profound meaning.

That it is actually the way that we survive trauma, by normally dissociating, that is to activate our survival reflexes, triggered as you mentioned earlier by the biology: fight, flight, freeze or faint reactions that are governed by the autonomic system.

Now this is something that occurs both in a mother/ son relationship or a trauma/intergenerational relationship, and in the clinical consulting room. I find as absolutely central to informing my current psychotherapy practice. That is just as much as the patient’s trauma impacts on me, and this is now called ‘vicarious trauma’, so therefore I am prone to dissociate in the presence of that trauma, but the profound paradigm change is this process is bi-directional; it goes two ways.

If something of my own experience in the session is traumatic, I can actually traumatise the patient in this new paradigm sense, it is not because I transgress ethically in some way, but rather because there are micro- moments, literally fractions of a second, where experiences from the right brain of the patient pass to me, or my right brain events pass to the patient. these exchanges take place between us at a sub-verbal level.

Now this is what I refer to the paradigm change. In the old system I was trained in, it was called ‘transference’ and ‘counter-transference’. Now they are still relevant of course, not all therapy is trauma therapy.

However, where trauma therapy is involved, counter-transference and transference is no longer adequate. It is, let’s say, it was necessary but it is by no means

sufficient to inform me in my current practice and that’s really part of the article that is my contribution to the assembled series of papers.

Andrew One of the things that you mention in your article is that an understanding of these neurobiological concepts has helped expand the framework of psychotherapy beyond the two persons dynamic, particularly in the treatment of intergenerational trauma, could you expand on that a little bit?

George Yes, the traditional framework of training as a doctor is, we have a patient. The patient is the one who is unwell; the doctor’s role is to actually do a problem solving diagnostic formulation exercise to find the cause if possible, the pathogenesis and then intervention follows.

Now the first turnaround was informed by psychoanalysis in fact, that there are two people involved in the process and this was Freud’s revolutionary idea that you actually have to listen to your patient.

It’s hard to imagine, but there were in bygone days, hopefully never to be practised again, where doctors didn’t actually listen. He actually listened and came up with the idea that there was a lot more going on between patient and therapist than just what was being said, hence the ‘unconscious’. Now it is quite accepted that even if you don’t believe in the unconscious, there are things that are going on implicitly. This is beyond awareness.

Now from that two person relationship as ‘we’, I just mentioned the bi-directionality, it goes further than that and we have to turn now here to genetics in mainstream medicine to look again at intergenerational pathology to genetically transmitted diseases, the classics like Huntingdon’s chorea and so on.

With modern neuroscience we have learnt about a phenomenon called epigenetics and the best way to explain that is the experience of a butterfly and a caterpillar, they in fact have the same genes.

The DNA of a caterpillar is the same DNA in the butterfly. If you look at the two and you'd say they're totally different beings, I mean they metamorphose literally, yet by definition they cannot but have the same genetic DNA makeup. So the question is what on earth has gone on here? And this is one of the current models which I think is so evocative of what an epigenetic phenomenon is. It switches between one state and another in different behaviour and expression of how that organism is.

When we turn to inter-generational trauma we now move the medical frame beyond even the two person and let's say in my case at a personal level, my mother went through experiences called the Holocaust which no one I think would reasonably doubt is trauma-based experience.

Now my question is, I was born in '49 so many, some years after she was liberated so my question is, did her experiences, although prior to my birth, possibly have any impact on me born after that trauma? Now traditional science didn't even think of that thought, could not think of that thought, it was unthinkable, inconceivable.

Gradually there were enough accumulated experiences in the clinical literature that so-called 'second generation', that is children of survivors, were regarded as being more at risk for certain issues and we now know that to be a fact from studies on Vietnam veterans and their children, the second generation of soldiers who were in the Vietnam war. A much higher risk for mental illness, suicide and many other problems.

Today we even go further with the 9/11 episode in New York, we can push the impact of trauma even prior to birth where we have cohorts of mothers who were pregnant at the time of 9/11 and elegant controlled studies – Rachel Yehuda and others in New York with longitudinal studies now from 2001 to 2017, so 16 year follow-up.

Children of mothers who were actually pregnant at that time and the two cohorts were mothers who lost a partner and therefore were very stressed obviously and traumatised versus controlled studies of mothers who were pregnant but did not lose a partner. And we then find that the cohort of those children to the stressed traumatised mothers are developmentally at risk for a whole spectrum of problems.

This is what I mean by extending the frame of the traditional doctor/patient relationship.

At the very narrow end of the frame is the doctor looking at the patient in the bed, looking at nothing else but the symptoms and signs in the body as it were. Next, we extend that to the ‘two-person’ relationship or in the psychoanalytic frame of listening beyond just the words, implicit or unconscious. Finally, what I mean by the fully extended frame is how we now must look when we talk about trauma at also the intergenerational frame.

For example, taking the case of my mother and I, and her experiences before my birth, that is my pre-birth ‘generational’ experiences, prior to my actual birth, did the experiences my mother had, could they have switched on her epigenetic makeup which is then transmitted to me?

And by the way, if you’re interested in this line of thinking there are some very elegant studies with butterflies or moths and caterpillars that you can actually transmit fear from the caterpillar which then undergoes this metamorphosis and the butterfly is

actually afraid of certain things that the caterpillar was taught to be afraid of, using coupled fear-stimuli experiments stimuli. So there's an amazing paradigm change in the very 'frame' of our clinical practise.

Andrew In addition to the two person and expanded dynamic, your article mentions these changes and understanding have affected your approach to your own self-care. Can you describe this process?

George At the heart of the trauma experience is what is called 'unsafety' and it's so obvious that we're not safe when we're traumatised, it almost has gone below the radar as a discussion point.

Now there's a most elegant paper actually in *Australasian Psychiatry* which I refer to by Sophie Isobel which appeared I think in December; I got the pdf prior to publication, titled *Trauma Informed Care* in which she raises the confronting question, is this a radical shift or is it basic good practice?

Now, when we talk about trauma as real trauma, this is part of why the paradigm is so important to appreciate that it is not just psychic trauma, it's real trauma. If we're sitting with traumatised patients, it is inevitable that in this two person bidirectional process we as therapists must be exposed, it's an occupational hazard. We must be exposed to the trauma of the patients we treat.

This being the case, in any other occupation where trauma is impinging on the practitioner, they put on protective clothing or goggles or gloves or whatever, to ensure that the trauma that they're exposed to, radiation whatever it is, is minimised. Now the question obviously comes to the fore if we're now serious about trauma-informed care as discussed by Sophie, then what is it that we do to self-care, to preserve our safety?

In the 1990s the literature on vicarious trauma was very clearly stated that you really have to take care and do exercises, yoga, have a balanced lifestyle and so on, which of course are necessary but they're experiences between sessions. There was nothing that addressed, as far as I could see in the review of the literature, what a therapist did *inside* the session where the trauma is actually occurring *in vivo*, moment to moment. And this is where my emphasis in the paper is that in the modern current paradigm of trauma-informed care, the onus is on organisations and institutions to become aware, trauma-informed care demands self-care practices being taught and practised by the practitioner, that is us, as therapists.

Andrew Are there techniques that you routinely use to fulfil that purpose?

George Absolutely, well I mean once one calls for the need for these self-care as an essential part and indispensable and non-negotiable, then the question is well what is it? So, one of the basic principles of trauma is that in the traumatised state we literally lose our breath, I mean trauma takes our breath away and that's not just a figure of speech. We go into shallow breathing or the panting if we could do the responses that I mentioned, to the fight or flight or if we freeze we actually go into the shallow rapid breathing and eventually we faint.

Therefore our breathing becomes one of the barometers as a practitioner. If I track my breathing I've got a pretty good clue that I'm heading out of my safety zone, the window of comfort, and window of regulation into an extreme either sympathetic overdrive at the upper end or the parasympathetic lower end and I start to withdraw and dissociate. Once I am able and trained myself and this is really what I have done over the last decade to train myself to become sensitive to tracking my own biology, as it were bio-feedback.

Breathing being the central position, many other things are also included in bio-feedback like my posture. If I find myself that I've become like a stone statue, I haven't moved for 40 minutes, then I'm pretty sure after the session my leg's going to be half asleep when I stand up and that the next time I should take note that the patient I'm with has induced a sort of dissociative state in me where my mobility has been paralysed, I've been so engrossed or so dissociated. Now I've maintained over many years recently, there is no virtue in two people being dissociated in the consulting room.

Andrew No.

George The patient comes with trauma and if they get dissociated that's part and parcel of their problem and suffering. There is no virtue in the therapist joining in, in the dissociation. The key phrase I use here is a fantastic concept by a colleague in New York, a wonderful psychiatrist, Karen Hopenwasser, I've referred to her work of dissociative attunement.

And this construct is really the precondition for me to understand that if I go into a breathing state characteristic of dissociational trauma, I've entered a dissociative attunement state.

Over the decades, as therapists we have given privilege to being attuned with our patients and that is a wonderful thing, empathic attunement and sympathic and so on. But we mustn't forget the other side of attunement, it is dissociation.

And this brings me to what I mean by taking care of ourselves, that self-care to be registered, it is inevitable that we will be dissociated, and then we will enact in the therapy. However to minimise that, to reduce the amount and to catch ourselves earlier and earlier. Thus we are less and less inclined to be in mutual dissociative states. There is just no benefit or virtue in that.

Andrew Indeed. Clearly understanding the neurobiological underpinnings of psychotherapy leads to a number of theoretical and practical insights, but do you see any dangers in psychiatrists incorporating these theories into their clinical frameworks?

George I think that where there's power and potency in any intervention there must be equal and opposite risks and danger. You take any major discovery in any field of science, it can be misused. Now, if, let's take the last example, if I'm super-sensitive to my self-care and I avoid and minimise my dissociative state, I might be inclined to say, well look any dissociation's probably a risk, therefore if I null and void my dissociative states I'll be the safest. Well I will be, but I'll be the most useless of therapists.

So appreciating the nature of dissociation means that you allow yourself a certain degree as Philip Bromberg says, to be 'safe enough', this is not about all-or-none, either I'm safe or I'm in danger, there's a middle ground and each of us on a given day have a different tolerance for risk and safety.

The operative word here would be to aim to be 'safe enough'.

To be an ethically competent therapist, not 'too-safe' and therefore detached from your patients' suffering and therefore not be attuned and therefore be ineffective, but equally not to over-empathise, empathise, that is empathic listening has been one of the cornerstones especially of Kohutian self-psychology.

Now we might say that there is a profound risk and even danger in becoming over-empathic and over-identified, so either extreme is a potential risk and danger, and therefore all I would say is that like in any other potent new intervention mode or therapy, we must be mindful of the strength as well as its limitations.

Andrew Yes. Well George it feels like we could explore these concepts for hours, but for listeners, for listeners who would like to follow up for themselves, can you think of a particular author or a specific book or resource that you particularly recommend?

George Look if you'd like a door stopper, which is about three books in one, it's a neuroscience book, it's a psychiatric book and it's an art book of the history of art, western art in the last few hundred years, I don't think you could really go past Iain McGilchrist's *The Master and His Emissary*. And I wouldn't recommend you read, I don't know, 700-800 pages from start to finish at one sitting, but you could dip into sections whether you're an art enthusiast.

Now the reason this is such a phenomenal book is because he languages this dramatic shift from the left brain to the right brain and that is actually what is the title's reference, the master and the emissary we've got wrong. We think that the master of our culture as the left brain functions: logic, talk, you and I are having, a podcast. In fact he says that's the emissary, it's the new kid on the block. He suggest that the master is the right brain. That is what we're born with as the primary communicator, sub-verbal, that's how babies function and that's our bi-directional communication from even before birth. The so called higher functions come on line much later which is part of the critique of cognitive behaviour therapy, it doesn't look at the right brain as the foundation, it's really attending to the left brain, new kid on the block.

So that would be the book and the references go into the hundreds and my own personal favourite obviously goes to Allan Schore, *The Science of the Art of Psychotherapy*.

Andrew Yes, I believe you've got reference to Allan Schore in your article, *The Child and Adolescent*.

George Yes, he and his wife Judy are dear, dear friends and mentors who’s really shaped much of my outlook and he’s an extraordinary visionary who was already writing about these things in 1994.

Andrew Thank you. And that’s the end of the podcast for this month. As usual I’ll direct listeners to the Australasian Psychiatry website where all articles can be downloaded as pdf files including the June special issue on psychotherapy. Okay, I’m just stopping the recording.

[End]

References mentioned in the podcast are available in the two articles:

Halasz G, (2017). Promoting Psychotherapy within Australasian Psychiatry, this Journal, 217- 218.

Halasz G, (2017). Special Populations - child and adolescent psychotherapy, this Journal, 222-224.