Style Definition: TOC 3: Tab stops: 5.99", Right,Leader: …

Contents

Comment [S1]: ***Shows in text as: "Is the responsibility of healing with the therapist or patient?"

After "Have you ever been in a situation…" most items in the TOC don't match any of the remaining items in the text

Chp 2: Introduction to Psychoanalytic Counseling

Comment [WS2]: Get agreement about helping and understanding in chapter 2 if you don't have a goal in psychoanalysis and you know the patient is cured and are ready to leave

Make sure you explain the difference between psychoanalytic counseling and psychodynamic

Define control case

Go into more detail about whether you would see somebody in an altered state of consciousness

Make sure there is an example of talk versus action in chapter 2

Overview

This chapter goes into more details about what I mean by psychoanalytic counseling. The question of goals ("helping") and comparisons of psychoanalytic and other forms of helping are further defined. It introduces a Q&A style that is in other chapters of the book.

Goals

Students should be able to:

1) Define psychoanalytic counseling, transference, and countertransference
2) List characteristics of the unconscious and primary process
3) Compare and contrast general counseling with psychoanalytic counseling

Thinking About Psychoanalytic Counseling

There are so many different approaches to counseling. I have always found myself interested in the questions of "What is making it hard for Johnny to learn" and "Why is this so difficult for the person (who is otherwise very smart) to actually be able to do this task?" I think this is what has always attracted me to psychoanalysis—what is happening on the inside that is impacting what is observable (and getting in the way of) performing on the outside.

My own evidence from work with patients over the last decade solidified my feelings about the efficacy of psychoanalytic treatment and the soundness of its theory. For example, I am not as surprised when I see two things simultaneously existing in the unconscious—both the fear and the wish, love and hatred, etc. (Today, DBT or Dialectic Behavioral Therapy, has capitalized on this idea of a dialectic—that there are polar opposites co-existing, and they need to be regulated to prevent their impacting daily functioning.)

For example, a patient may come and say they are sad, but I quickly realize they are also angry. A patient might come saying they don't want any medications, but then spend sessions talking about how they are thinking about trying things for sleep, anti-anxiety, etc. Early on I was taught that the only resistance to learning is not really wanting to learn, and now I understand that even the student who is struggling the most at school, for some unconscious reason, must not want to learn for some strong reason. The evidence from the data is clear to me: it is not what they are talking about that I have to listen to, it's what they are also NOT talking about that could be problematic.

Additionally, we have control only over ourselves and therefore we can work to understand only ourselves, especially those parts of us that are working against us.

Table 2.1 Toward a Common Language: Psychoanalytic v. DBT Terms

Psychoanalytic Term	DBT Term
Optimal Frustration—helping a client grow and develop a higher threshold for impulses, thoughts, and feelings	Distress tolerance—building up tolerance for day-to-day issues
Transference Analysis—working through impulses, thoughts, and feelings to begin seeing what is really in the present (seeing someone for who they are, not the ghosts of the past)	Mindfulness—being in the present, here and now, aware of yourself
Affect Regulation—as talking brings more things to consciousness, being able to choose new ways of reacting as opposed to engaging in repetitive patterns that lead to the same results	Emotional Regulation—exerting some control over your emotions as opposed to being controlled by them
Improved Relationships—although drive and object relations theorists differ on what is mediating the change, the result of an analysis is often thought to be having all your thoughts and feelings, without having to act on them, in order to have better relationships	Interpersonal effectiveness—having sustained and satisfying relationships

Counseling of late has been dominated by other evidence-based treatments like cognitive behavioral therapy and dialectic behavioral therapy—implying that the 100 years of case studies since Freud birthed psychoanalysis somehow is not data—and denying the fact that many approaches have come and gone while psychoanalysis has continued.

Psychotherapy Networker (2014) published a survey completed in honor of their 25th anniversary. In it they compared results to a similar survey issued in 1982 by the American Psychological Association, which had surveyed 800 members with a return of 422. The new survey had a larger return (n = 2558). (http://www.psychotherapynetworker.org/component/content/article/81-2007-marchapril/898-ten-most-influential-therapists). The interesting thing was of course the discrepancies.

One thing they noted was that in both the 1982 and 2006 versions, Carl Rogers (a humanistic, non-directive active listener) was listed as the most influential therapist. *This is ironic for two reasons.* Number 1, as the article points out:

> In other words, the therapist who became famous for his leisurely, nondirective, open-ended, soft-focus form of therapy 50 years ago remains a major role model today, even with the explosion of brief, "evidence-based"

clinical models, a psychopharmacological revolution that often makes medications the intervention du jour, and a radically altered system of insurance reimbursement that simply won't pay for the kind of therapy Rogers did.

How can the most influential person's expertise not be the therapy of choice of other professionals?

Secondly, in practice, the single most popular approach (almost 69% of

Where Can Psychoanalysis and Psychoanalytic Counseling Be Applied? In-Home Therapy and Schools

When I was working as a home-based therapist meeting with patients two or three times a week, psychoanalysis was the only thing that provided a frame for the intensity of the work. Other types of therapy do not really directly teach the service provider how to handle strong transference, countertransferences, inductions, and the resistances that are inherent in systems when there is this much patient contact.

When I was working on my master's, I did interviews with teachers and asked them about day-to-day interactions with students. I was not surprised that they often talked about buttoning shoes and jackets, helping blow noses, and reminding students of various things—all the same actions as a parent or caretaker. It is no surprise then that the students relate to their teachers (have a transference) in the same way they relate to their own caretakers at home—both the good and the bad. In schools, teachers who deal with kids upwards of thirty hours a week are not trained in group dynamics and the subtleties of how a mother or father transference may develop with the child nor how children may develop sibling transference to their classmates. All of these emotional realities of intense work are at the root of many failures and interrupted or prematurely terminated cases, classroom difficulties, and arrested emotional development.

I realize also that not everybody has the ten-plus years that it would take in order to become a really good psychoanalyst (but I would strongly encourage you to weigh that cost against the benefits of a long-term successful private practice!) I was lucky enough to find a school that offered a master's degree that is uniquely psychoanalytic (http:www.bgsp.edu), leading to a counseling degree and eligibility for state licensure as an LMHC (licensed mental health counselor) in the state of Massachusetts. Although this has been a topic of much discussion in different analytic communities, I am in full support of taking many of the truly psychoanalytic principles underlying psychoanalysis and teaching master's-level clinicians how to apply them with patients in the field and in the classrooms in a real concrete and pragmatic way. For too long psychoanalysis has been relegated to the ivory tower; it is time that we take the theory back and, as Freud did in his free clinics, really help people live a life with full access to their feelings.

respondents) was CBT—although 96% of the respondents did identify as eclectic in their approach.

Why do you think there is a discrepancy in practice?

I hope with the advances now in neuroscience, Freud's insights continue to be confirmed as true. (For more information, look at *Discover* magazine's cover story of April 2014, "The Second Coming of Freud." For more information on the evidence for psychoanalytic counseling, follow Dr. Cornelius's YouTube channel at <https://www.youtube.com/watch?v=EkxoExMB9Mw>.)

What people know of psychoanalytic work is sometimes pure theory, literature analysis, or the work that some "guy is doing in his private practice in some major metropolis or affluent suburb." Psychoanalysis is in need of an image consultant. It needs to be known to improve the work in other settings as well as the treatment room!

What Is Psychoanalytic Counseling?

At this point then I have to come up with a definition of psychoanalytic counseling that we began in Chapter 1. This will probably lead again to a lot of debate, but for me, I am going to take the idea that psychoanalytic counseling has a belief in an unconscious (that is in something that we are not aware of impacting our daily lives, something in which there is no "no") and uses the ideas of transference and resistance in order for a counselor to fully understand a patient, and as a byproduct of being understood, that patient has a chance to experience all of the feelings that are part of human experience.

More specifically, as I am trained in modern psychoanalysis (a theoretical framework created by Hyman Spotnitz in the 1950s and taught at schools/training institutes created by Phyllis Meadow and Ethel Cleavens), I believe that there is a maturational component to good psychoanalytic work. I believe that the process of treating a patient helps remove emotional blocks to maturation, restoring the natural path a patient was on. When a person has become fixated on something and diverted from their original maturational path, the work of the analytic counselor is to offer a chance through an analytic structure for the gap between where they are and where they were meant to be can be closed or the gap reduced.

Even if you are currently not working in the intense multisession-per-week format or frame, I believe that psychoanalytic counseling can help because it also provides the knowledge of how to work with a patient beyond other prepacked treatments where twelve sessions are pre-laid out regardless of patient and presenting issue.

Inherently, psychoanalysis does not translate into an introductory textbook. I say this because I want to be clear I am not offering an eclectic or integrative approach. I am a psychoanalyst. Even when I am offering something that sounds like a behavioral social or physiological intervention at times, I am doing it for an underlying psychoanalytic reason. Sometimes I am just studying the resistance that I suspect will happen. I am not necessarily interested in controlling somebody's behavior. Nor am I interested in fixing them or helping them per se. I am, however, interested in understanding. That is what I want you to take from this book. In fact if you really only learn one thing, I would hope that it is "all behavior is an attempt to communicate." I will repeat this many times and there are many times when I myself forget it, both in practice and in teaching, but luckily working with the patient reminds me. When I find myself stuck, it is usually because I am doing something that the patient is also either doing or resisting—struggling against unconscious forces. That is my cue to stop and listen better to understand. (This is in contrast to what I hear many clinicians talking about when they "blame" the patient for not showing up, not following advice, or failing to do their "homework." You can't blame the patient for being a patient—it is what brought them to you in the first place! Instead, think about what you were doing that was at odds with what the patient was bringing.)

I do not believe psychoanalytic counseling is a subdivision or type of social work, approach to psychology, or counseling field. I think it is a standalone discipline. You do not need to have a degree in another helping profession in order to become a psychoanalyst. I think if you are going to be in a hospital or agency setting, the other disciplines can sometimes help since the common language in those places is less psychodynamic these days, but perhaps a multidisciplinary approach with all the insight, social, behavioral, and physiological approaches would actually be a good thing, right?

I do not believe this text can teach you to be a psychoanalyst—it's not the goal—that requires more training, supervision, exposure to the process, and a myriad of other things.

I do not believe that this text alone can teach you to be a psychoanalytic counselor. That, too, requires supervision and experience in the process. I do hope it will help you, however, begin to learn about the work of applying psychoanalytic ideas to your role as a counselor.

So, our starting definition (which admittedly has more terms to define) will be as follows:

Psychoanalytic counseling is an insight-oriented approach that accepts the existence of an unconscious, deals with transferences and resistances, and has "listening" and "understanding" as the core to helping a patient improve their functioning.

There is a whole chapter devoted to the idea of the unconscious and transference/countertransference, but I will spend a little time with formal definitions here.

Table Types of Therapy

Insight—based on a belief that there is something "inside" the person and when the patient realizes it, they have a chance to do something different. Insight approaches encompass all the psychodynamic approaches, including psychoanalysis, psychoanalytic counseling, humanistic and existential approaches, and even contemporary approaches like Schwartz's internal family systems. These approaches have big picture/large goals that, once addressed, are thought to filter down to everyday improved functioning.

Behavioral approaches—based on the belief that the situation has caused the issue and therefore changing the rewards and punishments will fix them. The locus of control is outside the patient—and the therapist has to be the controller of the environment to "right the wrongs." The goals are often very specific and the thinking is that bigger improvements occur as smaller behaviors generalize to larger ones. Skinner and Watson are both into these types of conditioning (or learning) paradigms. Rational and cognitive behavioral therapies, which do assume something "inside"—namely irrational thoughts in the brain's self-talk tape—are really closer to behavioral in their approach, as the control and change is still the job of the external agent—the therapist in this case.

Social approaches—like traditional social work, come at problems through social services and advocacy; these approaches can include helping pass new laws on poverty, violence, etc. Today, many social workers are in the insight zone with their day-to-day practice, but those engaged in the traditional social approaches are the people doing the grueling work, sometimes with families and children in state care, housing, job trainings, etc. Again these are big-picture approaches that are thought to filter down to make day-to-day functioning better.

Physiological approaches—self-explanatory. They are usually trying to fix some small level of a chemical or drug; maybe future gene therapies will apply here as well, in order to get big changes to functioning in the long run.

Modern Psychoanalysis: A Developmental Approach to Character
Much like the infant at birth who is able to produce all of the sounds that make up human languages, children are born with a full range of human feelings. They are biologically endowed with certain quantities of drives—sexual and aggressive (tension creating and tension releasing). Over time they learn and favor certain types of feelings and learn ways to manage tension states. Often some feelings are dropped from the repertoire of expression (or avoided). Many times, these are feelings of aggression.

But they are not gone!

They continue to survive in the unconscious. And those that are not talked about—that is, those that are denied, suppressed, or repressed—get acted on. (This is the focus of my research in a later chapter: talk or action.)

The combination of this genetic predisposition and internal relationship to some feelings creates what I believe is character. It is in fact why I believe everybody should have a theory of personality in order to work as a counselor. Put simply, you have to know how you think someone is put together in order to figure out how to help them. And, **character prevails!** Meaning, once set, the character of the individual will be the lens that everything is viewed through.

So assuming that there is some form of pattern, expressing some feelings and not others, we start with the work of the psychoanalytic counselor, who tries to understand which feelings fall into which category—those being expressed in words, and more importantly, those that are not being expressed in words and are being acted out in behavior.

Transference and Countertransference

Transference is quite simply having a feeling about somebody in the here and now that is really coming from the there and then. It is probably at the core of all psychodynamic and insight-oriented work.

The best dictionary of psychoanalysis is Laplanche and Pontalis's (1973) *The Language of Psychoanalysis*.

Transference
For psycho-analysis, a process of actualization of unconscious wishes. In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy. As a rule what psychoanalysts mean by the unqualified use of the term "transference" is transference during treatment.

Classically, the transference is acknowledged to be the terrain on which all the basic problems of a given analysis play themselves out: the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure.

The use of the term "transference" has on the whole been confined to psychoanalysis, and it should not be confused with the various psychological uses of "transfer."

The reason it is so difficult to propose a definition of transference is that for many authors the notion has taken on a very broad extension, even coming to connote all the phenomena which constitute the patient's relationship with the psychoanalyst. As a result the concept is burdened down more than any other with each analyst's particular views on the treatment—on its objective, dynamics, tactics, scope, etc. (Laplanche and Pontalis, 1973, pp. 455–56)

Laplanche, J., Pontalis, J.B. (1973). *The Language of Psycho-Analysis.* Translated by Donald Nicholson-Smith. The International Psycho-Analytical Library, 94:1–497. London: The Hogarth Press and the Institute of Psycho-Analysis.

You can see that the definition includes an acknowledgment of how difficult it is to define the term. Some case examples might help. Many times when I am working with an adolescent, they come in and immediately want to show me that I am not the boss of them. They want to be in charge. They are fighting my authority before we even begin our work together. The "reality" is that I may have just met them and they don't even know what my "agenda" might be, but they bring in a relational pattern that is one they are having with parents, teachers, and other authority figures—sometimes developmentally appropriate, sometimes they are stuck in the pattern and can't stop themselves from arguing with people, even if in fact they agree. This is a good reason for them to come to treatment, so they don't always have to say "no" when in fact they might want to say "yes."

Similarly, a couple can show up in my office. "She" says he never listens to her and never acknowledges her feelings. "He" says she always wants more time to talk about things, when decisions are at hand and need to be made. They may say these things, but more important—unconsciously in their actions—show me what they mean as she complains that I am not understanding their problem quite right, and

he gets frustrated and wants to end treatment because things are not really changing or improving on his time schedule. All this, and after only three sessions.

The Unconscious, Research, and Self-Awareness: Transference

In both of these examples, it is obviously "not" the reality of the social situation (in the couple's session, to her point, yes, I sometimes do talk, as Winnicott said, to just show the limits of what I understand, and to his point, I do slow down and explore all the options before a decision is made) but there is not really a way for them to know and feel that so deeply in only three sessions. Rather, it is a way for them to show me what their issues are—to show me their unconscious. My job is to work with those resistances and try to figure out what that behavior is telling me—that is my research task: Knowing my own feelings—those coming from them in the transference—and recognizing any that might be personal (subjective) or specific to the patient(s) at hand (objective): countertransferences.

Countertransference

Countertransference
The whole of the analyst's unconscious reactions to the individual analyst and—especially to the analyst's own transference.

Only on very rare occasions did Freud allude to what he called the counter-transference. He sees this as 'a result of the patient's influence on [the physician's] unconscious feelings', and stresses the fact that 'no psychoanalyst goes further than his own complexes and internal resistances permit'; consequently, the analyst must absolutely submit to a personal analysis.

Since Freud's time, the counter-transference has received increasing attention from psycho-analysts, notably because the treatment has come more and more to be understood and described as a *relationship*, but also as a result of the penetration of psychoanalysis into new fields (the analysis of children and psychotics) where reactions from the analyst may be more in demand.

Laplanche, J., Pontalis, J.B. (1973). *The Language of Psycho-Analysis.* Translated by Donald Nicholson-Smith. The International Psycho-Analytical Library, 94:1–497. London: The Hogarth Press and the Institute of Psycho-Analysis.

"Countertransference" is one of the most evolved (and still evolving) psychoanalytic terms. It refers to a feeling in response to the feelings that a patient might bring into a room, and how it is used has changed markedly in the last 125 years as research reveals what works better. Freud originally thought it is something to be analyzed away in the personal analysis of the analyst, but today's schools of thought use countertransference in various ways to learn more about what is going on by studying what is going on in the room. We will return in a later chapter to the topic of countertransference, but let me introduce something from Spotnitz's modern psychoanalysis as a way of thinking about research—specifically, studying what is yours and what is the patient's in the objective-subjective countertransference.

Objective and Subjective Countertransference

Spotnitz identified what is called an objective countertransference and a subjective countertransference.

As is alluded to in the definition of countertransference earlier from Laplanche and Pontalis, the objective countertransference comes from the patient-analyst matrix, and is unique to the case. For example, a patient may try to get me to get rid of them, or to help them by giving them advice, both of which are not commonly how I run my practice. It is something that is emerging in the transference-countertransference matrix. A good supervisor will help identify them and make sure the treatment takes advantage of the rich material these feelings bring.

A subjective countertransference, however, is something that may be seen in many of the analyst's cases and is much more telling about the analyst's own character (and blind spot) than about the patient. The subjective countertransferences need to be worked out in personal psychoanalysis and supervision so as not to interfere with the transferences the patient is bringing in to work out.

POINT TO PONDER-
If the subjective countertransference is really what the counselor is bringing to all the cases, and not unique to the person they are with, is it really more of the therapist's transference?

It is, except that you are studying it in response to the patient, so in that way alone, it is a countertransference.

Goals for Treatment

One thing that is often cited as typical in psychoanalysis is that it is all about talk. That is true. However, much of the most interesting stuff is occurring when the patient is not talking. You will read later ("talk or action") about my findings that what the patient is not talking about is going to be acted upon, which can be destructive if not explored. An analyst at my training institution once said in a class that although we don't encourage it, "If the person wasn't resisting with transference and enactments, then we couldn't actually do an analysis."

Many psychoanalysts do not like to think of themselves as having a specific goal for treatment. But this is really an error, because when pushed, they actually do have goals: for example, they want the patient to show up on time and to talk (and of course, pay). What is sometimes getting confused here is the idea that we want to maintain loosely hovering attention and not be working toward something in any kind of hurry. We have to take what the patient brings and work with the patient where they are. A comparison across the zones might be helpful here.

In the situational zone we have behavioral approaches. In the insight zone we have humanistic and psychoanalytic (psychodynamic) approaches (review Chapter 1). The goals for each type of treatment vary because of the belief each holds about the root of the problems.

For behaviorists, a theory evolving during a time in which psychology was desperately trying to become more scientific—measurable and observable—what is inside does not matter as much as the environment. People are just trained animals and therefore if you can figure out the target behavior or in what way you want a person to behave, you can construct a learning paradigm that changes punishments and rewards. Cognitive behavioral therapy (CBT) just added some attention to the inside thoughts playing in the person's head (shifting the approach somewhat up and to the left on the Bercez chart toward the insight zone, but not really crossing very far into it!).

For humanism, a theory evolving in the 60s and 70s in which people were most interested in exploring human potential and in people becoming all that they can be, it could be generally stated that mental health problems emerge from a discrepancy between the idealized self that somebody wants to be or imagines that they should be, and the real self—who they evaluate themselves to actually be. The goals therefore in a humanistic approach are often centered on deconstructing ideal selves so that they are not so high and unobtainable, and accepting the real self 'as is'. As these two selves become more congruent, the character or personality becomes more fully functioning. If we could remove all of the conditions of worth, or ways in which we only feel valuable, we would be living in the utopia. (Remember also that humanists consider people to be basically good and society's conditions lead to pathology.)

For the psychoanalytic theory, we have to keep in mind that Freud was theorizing in the first part of the 19th century and therefore witnessed World War I and World War II. For him, we have a basic animalistic side (urges, the Id) that become civilized in society. If we did not have rules, it would be *Lord of the Flies.* The conflict or pathology (when someone seeks treatment) comes from all of the pent-up frustration of our animalistic side. The psychoanalytically informed counselor is interested in the person's feelings around their less adaptive and unfulfilling ways of managing their tension states, and hopes to show that there are avenues for dealing with life's frustrations other than the less adaptive pathological ones that the patient is repetitively using.

Now, if a depressed patient arrived at our door, say a child who has been referred because they are not responding to questions that the teacher poses in class and seems withdrawn and sullen, the "goals" set by the clinician are going to be based upon their theoretical approach.

A behavioral goal might be something like "the child will respond to questions from the teacher at least 80% of the time." Or, "have the children increase the sound level

of their responses to be over 30db." For this to happen, the behavioral practitioner will set up some kind of token economy or conditions in which when the child responds, they will be somehow rewarded (or in some way punished for not responding) and successive approximations at being louder in class will be likewise reinforced. In these examples you can see that the question is not, "What is going on with this child?" Rather it is, "How do we get this child to do what they need to do in order to be successful in the classroom?"

If someone were to take a more CBT (cognitive behavioral therapy) approach, they might look at what automatic negative thoughts and beliefs the child may possess that are keeping them from responding. A goal might be to reduce the catastrophizing, or belief that if they give a wrong answer in class, they will be seen as stupid and laughed at. (Ellis and the early rational emotive behavior therapy people came up with really great terms for the "musts" and "shoulds" that we tell ourselves—that is, those thoughts we have that we should always be perfect or we must always get everything done in just the right way. Ellis referred to these automatic negative thoughts as "shoulding on ourselves," or "musterbation.")

Let's say the child goes and sees someone trained in Rogerian client-centered therapy (in the insight zone but under the umbrella of humanistic approaches). They might have the child sit in the room with the therapist who very slowly and carefully begins to ask questions about what's going on and reflects what the child is both saying and doing. The humanistic practitioner is asking silently themselves about the patient, "How come you feel so bad about yourself that you cannot strive to self-actualize?"

A psychoanalytic counseling approach would start with a very basic goal of helping the child to communicate—that is, talk, and over the course of sessions, engage in **progressive communication**: say something more or new about the problem. In this approach, the psychoanalytic counselor is trying to figure out what is going on in the life of the unconscious that is keeping the child depressed and unable to respond in class. The psychoanalytic counselor is interested in what is going on and interested in how willing the patient might be to try something new; however, they do not specifically indicate or show that they have a desire for the patient to get better.

This is probably a good place for a case example.

The Unconscious, Research, and Self-Awareness: Running with the First Grade

When I was running social skills groups in a first grade class, I would go in once a week and ask the students "what's up?" (I am not a fan of the prepackaged and psycho-educational groups that are sometimes conducted in school, when there are usually real-world and relevant things that the kids are experiencing and need help

with—so I go with my patients' instead of someone else's ideas.) I required that the classroom teacher and any of the teacher's aides also be a part of the group. One particular week I entered the class and the teacher responded to my question first, saying that she needed a lot of help. Apparently the class had been running to the cafeteria or down the hallway almost every day. The teacher said that she had tried many behavior modification techniques, including offering them more recess time if they went a week without running, or threatening to take away recess time if they did not stop running. This had been going on for over a month, although she had not brought it up in the group before now. The principal had talked to her and had also come in and talked to the class, saying that this cannot continue. Everyone was frustrated.

Most schools really have only behavioral interventions at their disposal. The need to teach to the content often makes teachers feel pressured and as if they do not have time to deal with the messy emotional unconscious of the students. To borrow from Charles and Mary Beard who said, "Those who don't know history are doomed to repeat it," I say, "Those who are not examining the unconscious in an attempt to understand it are doomed to repeat patterns that often don't work."

I looked at the little faces around me in the group and asked in the most sincere way that I could muster, "What's up with the running?" There was a silence that seemed to last for very long time. I made eye contact with the teacher to encourage her to just sit and wait a little bit while the question fermented. Eventually Susie, a small blonde girl, timidly raised her hand and reported the following. "If we don't get to the cafeteria fast enough, they run out of hot lunches and we have to eat peanut butter and jelly."

The teacher's jaw dropped and it took a moment for her to compose herself. The first thing that she did say was, "I have asked you before why you were running and you never answered." I do believe that the teacher probably asked before; however, the question "WHY ARE YOU RUNNING" can be asked in a shouting way that really means "YOU ARE IN SO MUCH TROUBLE FOR DOING IT," instead of asking why they are running because you are really interested in knowing why they are running. In order to do the latter, you really have to be self-aware and know if you're asking to really know, and this is why psychoanalytic training requires supervision and personal analysis.

With this new information, with understanding what the root of the problem really was, the teacher decided that they would prepare to leave for lunch ten minutes earlier than they had been (they were often the last class to lunch). The behavior of running disappeared in one try. This is a good example of why I like psychoanalytic counseling.

As a postscript, I would say that the teacher also approached the situation from the social zone, letting the cafeteria staff know that these inner-city kids really need hot meals and that apparently not enough are being provided. I believe also a good

behavioral approach probably would have looked at similar environmental situations that were causing the running behavior; however, in the one-to-one counseling situation or in the group therapy situation, we sometimes feel pressured to get a solution quickly instead of taking the time to really slow down and listen, which is more likely to do in psychoanalytic counseling, as it is the one thing you will learn helps the most.

With this as a starting point, I would like to address some of the questions that often come up when people start studying psychoanalytic counseling. Many of these are questions I have received from students and interns, so I have chosen for this chapter to keep the question-and-answer style. Many of these ideas come back in more depth elsewhere. They are answered from a modern psychoanalytic counseling frame.

As a therapist you are always starting with self-awareness as a core skill. Is containing your feelings and emotions and not expressing them unhealthy for you as the therapist?

The short answer is yes, it could be without some outside help.

First—You cannot do this job without support. You need your own balance of work and play. You need your own supervision and your own therapy because you are digesting and processing a lot of the patient's stuff and the patient's stuff intermixes with your stuff.

Second—It is not that you are a blank slate—that is a classic psychoanalytic view of countertransference. The best thing to do is try to use your own emotions in a constructive way in the service of the patient. You are not just holding back, but you are holding back and trying to understand what the patient is invoking in you—and how to respond to open up new experiences—usually avoiding the ways others have treated them in the past. (This is often hard to do and sometimes you have re-created the early family in the sessions with the patient before you realize it. Once you notice this, though, it's not too late to start doing things differently. In fact, that is exactly what you then should be doing.) All this requires putting time and effort into your personal growth and maturational process, which is done though supervision and personal psychoanalysis.

What is the psychoanalytic interpretation of a baby's mind? Is it seen as a blank slate?

I think every branch of psychoanalysis would have a different way of coming at an infant's mind. Most might assume we have a physical brain and it is hardwired for some things. We are hardwired to be social; we are hardwired to be cared for by people. (See Harlow's study with the wire monkey or a cloth monkey mother.) The baby monkey might go in and get its milk from the wire monkey, but when it sleeps,

it will sleep on the cloth monkey mother because it is more comfortable. So there are certain ways we are built, established, and hardwired for creature comforts: love, affection, attention. From that, though, it starts getting a little different depending on where you are and where you're coming from.

My view is the infant has got some hardwiring; some quantity of libido and some quantity of Thantos or death drives. The patterns of discharge and managing tensions are laid down as our drives find aims that work for us and keep us in a state of homeostasis (remember—that is different for everyone).

What about drive theory as a psychoanalytic theory?

Let me try to present drive theory at the most basic level. Drives are the forces determining a person's character and subsequent behavior. It is what makes people go. Some infants are seemingly born thrill-seekers and others are drawn to less tension and fewer thrills. So you have these two polarities and everyone is somewhere in between.

Now these drives have an aim—something to be directed at (these are the object relations people talk about, but we will cover that later). I think your earliest relationships help set the aims of drives and you establish certain discharge patterns (as has been stated now, and elsewhere in this text). For example, you learn that mom takes care of you and you can feel comforted, and that sets down a pattern of saying "Yes, I can go to people and feel comforted and cared about by them." You may end up with a mother who is a bad match for you and who is not comforting and caring to you. So for you, going to mom is equated with coldness, deadness, emptiness, and not feeling good. So you don't lay down a pattern of seeking people out when you want to feel better.

Those macro themes trickle down to small things, creating your personality. You get people who tend to seek out people and you get people who tend not to seek out other people.

Karin Horney talks about these neurotic trends in people and they are based on these early trends. So that is how I see the mind unfolding. Along with what we were just talking about, there are always these internal tensions driving you forward in new situations, like the rose- (or blue or green, etc.) colored glasses you are wearing all the time. Psychoanalysis helps you see what color your glasses are, and then can help you if you want to try seeing through a different lens.

There always has to be tension for the mind to unfold. The mind unfolds through a process of **optimal frustration**. In a way, the mind is unfolding at the edge of our comfort zone—at the edge of what we already know. For instance, when you are a baby, people try to figure out your every need because you are just lying there and cooing away. They may figure out you want a cookie and give it to you, but

eventually they are not going to give you a cookie until you ask for it, and then the next time you will have to say please. Each of those increased demands from the outside are what is building your mind (not unlike behavioral shaping and generalization, but with the person's drives more in charge, as we all have examples of how the same external intervention, it works with one but not the other child—a sign that this is more internal than external). Personality is emerging on top of what is happening. If we were living tensionless, we would be dead. Likewise if we were tension low, there would not be a lot of motivation for doing anything.

It sounds like through therapy and figuring out your unconscious, you discover or acquire tools as you go. Is that right?

I think the most difficult patients (or if you're a teacher, the most difficult of your students; or if you're a parent, the most difficult child) is the one that is falling in your blind spots.

The reason these blind spots are sticking around so much is that something is getting enacted or worked out: there is some kind of repetition that is not pleasurable for either of you, but you're stuck doing it. And until you can see what that is, until you can see what that blind spot is and understand what is going on, you are going to keep doing it. That is what the behavior is communicating. Find the blind spot and work on it.

As an aside, I often use the Margaret Wise Brown book *The Runaway Bunny* when working with teachers. I ask them to think about the ways the mother bunny reacts to her child's threats about running away. She is sometimes active (becoming a blowing wind, tightrope walker, etc.) and sometimes passive (waiting at home, being a tree for her bird baby to return to). Most people (teachers, therapists, parents) tend to be naturally one way or another (it's probably the first piece of data to collect about their drive states). My challenge to them is to think of the most difficult child in the room that they work in, and then to try to interact in a way that they normally don't—if they tend to the passive interventions, try being a little more active with that student. If they are active, try being a little passive. Inevitably, the child responds differently with a little of what you don't naturally do. (This also explains why some teachers report on "problem children" in supervisions, and other teachers quickly chime in "they are perfect in my class, no problems"—again, it's data about the two styles of teachers.)

Is there a person who has been a completely enlightened client who has no blind spots, or is that just the goal for therapy that is most likely unreachable?

When someone can have all their thoughts and feelings, that's when they have really arrived. I don't know that it is possible to be there every moment of your life. But I do believe that you can have more of those moments of having all of your thoughts and feelings in more of your life. I think that it can change as you go through life and I think therapy helps you have more of those types of moments, but not everybody

ends up in the same place. It depends on how hard they work, how hard you work. Some people leave treatment because they get good enough, they don't necessarily get cured or perfect (=blind-spot-free?), but they get to a point where they are saying, "You know what? I don't want to do all this work to have all my thoughts and feelings and I am happy with my life the way it is." In which case you say, "OK, well if you ever want to, you can come back" and you leave an open door.

How do you feel about medication in regards to therapy?

I think for some people, medication helps them get to sessions, and in those cases they should obviously be on medication, and it should help them talk. When you don't want medication is when someone has gotten well enough that they don't need it. So they titrate off it. We eventually want to avoid resorting to medication because either your body will adjust to the medication and it won't work anymore or the medication comes with a side effect that turns out to be worse than the symptoms. It is always hard to put foreign stuff into our bodies, and although we like to think there are studies supporting the drugs we use, most would agree that from a research design, they are not perfect studies and questions should be raised about how transferable the study's population is to the population it is being generalized to.

Sometimes you have to do it. I think we overmedicate our kids now and I have only really seen two out of the 200 kids I have worked with whom I would say truly need it to come in to therapy.

In terms of recreational drugs, I would not work with people who are self-medicating and who will come to my sessions drunk or high. This is because that is an altered state of consciousness and not the one I am contracted to help. If I treat the altered state, when the medication wears off and the altered state has disappeared into a state of sobriety, it was like I was treating someone who doesn't even exist anymore.

What if that altered state shows an unconscious part of the person?

If that shows an unconscious part of them that is really repressed and deeply unconscious so that they don't want to be aware of it, I don't want to be aware of it until it is time to actually integrate it into the character. So if it is really that hidden, there is a good reason for it to be hidden. Don't break that down and make a person aware of something that they are not ready to be aware of. That will make someone crazy or psychotic.

What if it was not extreme—what if a drunken person came in who was less inhibited with his feelings?

I would say "Oh, can you come in next week when you are not drunk?" You can't work with someone's mind when they are not really in it.

Is the responsibility of healing with the therapist or patient?

Comment [S3]: TOC shows "Is the responsibility of healing in group therapy on the group leader or on the other patients?"

It's always on the patient. And it's really hard to understand that. The counselor is only a tool—a very important tool—but we are there to encourage the patient to talk and discover things.

And the thing that you'll find with most psychodynamic approaches is that we take the approach that either people need to be told something—just straight-out educate them about "this is what you need to do in these situations"—or, for the most part, I find people know what they're supposed to do, they just can't do it. They don't need to be schooled, we're not teachers, we're not parents, we want to figure out why they can't do what they want to do. And it might be because they say they want to do something, but there's a part of them that doesn't really want to do it. Something's coming from somewhere else that's keeping them stuck.

For example, say "you know" you want to go out and want to meet the perfect person and get married and you've been saying that for ten years! A therapist thinks, "Well, there's got to be something happening in the unconscious. In ten years you couldn't find someone you could have gotten married to?" There's got to be a part of that person that is somewhat resistant to getting married. The research question in the treatment becomes, "What is that about?" If we can understand that through gathering data while listening to the person, then we can help the patient get in touch with whether or not they actually want to get married.

As a therapist your judgment is neutral. The patient who comes to treatment and says, "I want to get married," after the treatment may come to the conclusion that, "Actually, I don't really want to get married; I'm really happy being single." Which is fine! That's an acceptable change of goals. That's where they are.

You may also get them in touch with some ambivalence over marriage, and the patient may say, "Yeah, I am afraid of actually meeting the right person and getting married. So yeah, there is a part of me that doesn't really want to get married. But I do want to get married." And then you say, "Well, can you take the risk of getting married even if it's not the right person? And what's the worst that can happen?" It may not work out, they may not call you back after the second or third date. But you start exploring those things to help them get to where they want to be and to resolve some of the conflict. And the conflict is never going to be totally resolved. Conflict is just a part of life. But can they at least live with the conflict and get what they really seem to want? [Although not a question about marriage counseling, I will put in a plug for couples work. John Gottman is probably the most well known in the field, and he identified that it is not about "being happy" or avoiding fights—everyone fights even the best couples—rather it is about learning to fight fair and, well, that is a sign a couple can last.)

Is there a concern about the possibility of over-interpreting?

It's in the possibilities. Say, for example, you lose your keys. We could make an interpretation that says, "Well, you were going to go to your mother's house and you lost your keys, so the fact that you lost your keys and didn't get to your mother's house means that underneath you have some kind of motivation against seeing your mother. Something coming from somewhere, like an unconscious that's telling you, 'lose your keys so you won't have to go see your mom.'" That could be an interpretation.

It could also be that you came home the previous night and you were drunk out of your mind and put your keys in the refrigerator. Or it could be that you're just really overwhelmed and don't have a good organization system and you don't put your keys in the same spot every time—so you lost them. There're all those different kinds of interpretations you could make.

They are really more like hypotheses. I think in therapy you must consider all of the possibilities. Your non-therapist friends are going to say, "Well, you don't put your keys in the same spot every time you get home, and so that's the problem." And some people will say it's because you were drunk and you put them in the fridge. Those people are going with their opinions—and it is probably more about them, so don't personalize it.

As the therapist, you have to go about your work differently. You have to gather data to support your hypothesis first. You're never going to make a theory about a person without a lot of inferences. So if you forgot your keys when you were going to your mom's house, and then you went to call your mom but then you blanked on your mom's phone number, and then you went driving to your mom's but on the way there you forgot where you were going and ended up at the mall where you realized, "I meant to go to my mom's,"—if we start having repeating data points, then we can make more than an educated guess. "Seems to be something about your mom that you're avoiding. Like maybe her."

You really want a LOT of inferences that support your theory; to be good research, you also want to have a way to disprove the theory. So, you want to find a time when you're going to your mom's and you actually make it there or proof like if you get lost going everywhere, then it has nothing to do with your mom. You get lost going to work, to your mom's, to the grocery store, and then to school. You need a memory test or something. As the researcher-practitioner, you need ways that can prove and disprove a theory in order to be a theoretician.

Do people just ever understand their own unconscious stuff? What does that look like?

The unexamined life is not worth living! Or so the quote goes. There are probably moments when we have an insight on our own, the, "Oh my God I just realized that I treat every male figure in my life like I'm trying to get approval. Like I never got

approval from my father, so now I'm trying to get approval from my boss and my husband, whoever." But is there movement beyond the intellectual gain there? Perhaps there could be. Are there other insights not self-identified outside of treatment? Most assuredly.

I always say, "I can only fix forward." I can't change the relationship you had with your father—that's in the past. Some people's fathers are dead, but regardless, fathers are living in the patients' unconscious. So you really have no chance of reworking something with your real father, but you do with the father in your head.

You can't rewrite history—history is history. There are some therapies out there that try to have you reframe things and think about things in a positive way, and when it wasn't really that way, that can be very injurious to patients. If it was a terrible situation, denying it will only exacerbate its already negative impact.

What would the patient have to change going forward in order for them to have a different experience?

First is really delving into all the multiply determined dynamics that keep the person where they are. Then, having the tolerance for the discomfort of doing it differently is required for a new experience. Let's stay with the same example. In the past, the patient has always sought approval from the male figure in his life and tried to please them and do everything. Going forward, I'm going to say, "I'm going to please them if it interests me to, but if this is a crummy job and I'm not interested in pleasing them, I'm not going to put fifty hours of my life into it. I'm going to do something else. I don't care if I don't please them. I'm not that interested in this job and they're not my father, so pleasing them isn't going to make me feel different anyway."

That's a whole new narrative. Now, going forward, the patient can do something different if this stays in mind.

A lot of the things we've always known in psychodynamic theory are starting to be shown in how we understand the workings of the brain. We used to think that big brains were smart, but now we know that it's not actually big brains, it's that we have all these nerves that fire and that the ones you use become more efficient at firing. So these are your neural pathways—similar to what we have been calling the patterns of discharge. You have efficient neural pathways that are always being used. They may not be the best ones. They may lead you into repetitive things that don't get you what you want. I see therapy as trying to reactivate the less-used other pathways that were there at some point before they were pruned back. You still may, most of time when not conscious of it, do one of those two things you always did, but after some psychoanalytic counseling at least have the choice of doing

something different. That is how therapy is successful and you're able to go in a new direction. But it takes a long time to get the pathways to be there.

That's why we as counselors really aren't responsible for the healing. We've shown you there are these other choices. If you've decided you're always going to do this, then that's what you're going to do. But at least you have the chance of doing something else, should you decide. The counselor has empowered the patient in the utmost—given them some degrees of freedom of choice—because they will or they won't do something different.

Have you ever been in a situation when you had trouble empathizing with a patient or didn't like a patient?

Oh, yes. I hated my control case. I still hate her. You have to wonder how much I hate her if I've kept her for seven years. But based on everything I said so far, you must also realize that is not the only feeling I had for her. There is something coming from another part of myself that must like her because how else do you explain keeping people you really hate around you for seven years?

If I could have used my anger, been more in touch with my anger, I might be able to use it in a very constructive way to help her more. She might still be in treatment. For example, if after she has tried to change the appointment for the third time in any given week, I was able to say, "I'm getting annoyed that there's so many changes to the schedule," that might be something to make her stop, because her problem is that she annoys a lot of people. She doesn't get what she wants out of life. Most people get angry at her. She's very annoying. I got stuck with being so enraged that I couldn't say much for fear of just blowing her out of the water. If I said everything I wanted to say, I'd just kill her—not literally, but emotionally. That would not be helpful, either. I needed to be able to get in touch with those feelings, especially when they're real, and make them constructive in the treatment, in part because they're generated by the interaction with the patient.

You have to figure out a way to use them. There was a kid in a group I ran who annoyed the hell out of me. And it's just the same thing. I tried to work it in a way—I'm doing better with him than I am with my control case. I can say, "You know, you really are a bully. Do you know you're a bully?" and work with that in a way that is therapeutic. You have to use the feeling in a way that is in the service of the patient.

I am taking a lot about anger and hatred, but any feeling can get in the way if you don't manage it before the tension it creates in your psychic structure exceeds your tolerance. My examples are around hatred because that seems to be the one that gets people in the most trouble—although there are plenty of instances in which libidinal acting out with patients is dangerous as well. Another real problem is ambivalence.

Comment [S4]: Pls reword

I think the people who are around you either love or you hate. And love and hatred are fine; if you have either feeling, you can help a patient. And they might be able to help you. But if you're ambivalent about somebody and you don't care about them one way or the other, you probably won't keep them as a patient very long because there's no feeling to use. There's no deepening of the relationship. There is nothing charging the connection.

Feelings are hard to quantify, so how do you work with them as goals?

Comment [S5]: Not in TOC

In psychoanalytic counseling, one might say, you work until you can have all the thoughts and feelings you want—and can get what you really want out of life.

The reality with feelings is they are meant to be transient. That is, once you have a feeling, it usually goes away and then you have another one. It's just when you're trying to avoid a certain feeling because it's too stimulating for you that it becomes a problem. Over time, if you keep trying to avoid it, it ends up being the only feeling you have. Almost like it's backing up. Like if you're saying, "I don't want to be depressed. I don't want to be depressed. I just want to be happy, and I'm going to take pills and do all these things…," that depression just kind of keeps building and building and building and it becomes so overwhelming, maybe it comes out as physical complaints. Maybe it's coming out sideways. But once you say, "Yeah my life right now does suck, I'm depressed," sometimes when you can get into that, then you're able to say, "Oh actually I can have another feeling." In the fight of trying to avoid a feeling, you end up stuck with the feeling you're trying to avoid. It's a bit of an irony.

Could you explain some key similarities and differences between psychoanalytic therapies and CBT?

The reality is that all therapies are more similar than they are different. That's something that people forget. They put all this energy into fighting about what's therapy and what's not therapy. I think it's ridiculous. All therapies are more similar to one another than therapy is to math. Okay, math we're really different from. There are a ton of differences. Your question is really good because that's exactly the point. What is the difference?

Ultimately, we're all trying to help somebody, just with different theoretical ways of thinking about it and doing it. The differences for most therapies, in my mind, are how deep they go and if they seem to focus more on thinking or feeling. The best integrate both to some degree. The best therapists can pull from whatever tools they need and that work with that particular patient at that particular time. So I am very opposed to any theoretical rigidity. You do what works.

How do you know what works? It works if the patient talks more and can add more to their thoughts and feelings. If they can't, if they stop talking, if it seems like they're stuck or they're overstimulated, then it didn't work. I won't do that again

with that patient in that way. So I have a very simple reductionist view of approaches in therapy. You do what works.

A lot of people will say modern psychoanalysis isn't really analysis because it's not five times a week and it's not on the couch. Well it is on the couch, but we also work with people off the couch to get them onto the couch—which really is better for the patient and therapist. So some people don't call that psychoanalytic therapy. I think that's crap. I think what makes psychoanalytic therapy is your view of thinking about things in terms of transferences and resistances in general, not because of a frequency. If we go back to Freud and say his way is the only way, then you had better be ready to take patients on vacations with you, as he saw people six days a week and even when he was traveling—he had his inner circle come along.

What is resistance?

Comment [S6]: Not in TOC

Resistance, I think, is one of the most important psychoanalytic counseling terms to know. Most patients come for treatment, and the first thing they do is start to resist doing what they came to do. Resistance can be anything. If your job is to come in and talk, and you're supposed to come in a talk, and you're supposed to pay twenty dollars a session, not doing any one of those things could be considered a resistance.

Under the big umbrella of resistances, there's also another resistance. There's a resistance to actually having a relationship with the person you're in the room with. So if a patient comes in and all of the sudden is angry with me over something and is complaining about how the office smells and I don't help them and this is taking too long, some of that may actually have nothing to do with me. It may be the fact that the person has transferred feelings from somewhere else, from a boss, from a wife, from kids, and brought them to the session and is now projecting them onto me as a screen. Or it could be their father or mother or whoever. So that's transference, which there is a chapter on in this text.

Why not give advice in sessions?

Comment [S7]: Not in TOC

You have to be careful about giving advice because sometimes people will interpret it as you being dismissive and judgmental and not really empathizing with them. Sometimes you have to sit there with the negative stuff and say, "Things are really tough right now. It sounds overwhelming. It doesn't seem like there's a solution." That is actually more helpful and really joins with the patient. And sometimes when you say that, then the person actually says, "I know, that's how I feel. I mean, I guess I could take another job, I guess I could ask for a raise." Now they are solving their own problems. I've just been so amazed by how much it frees up the person to think about options when they don't have to try to get you to understand. When you can convey, "I understand, it's really bad. That sucks," all of a sudden the person now is free to say, "Oh, I feel understood." And it somehow frees them up to think about solutions that they weren't thinking about before. But before you can get to that, sometimes you really need somebody to listen to you.

The interesting thing is that it's in Maslow's hierarchy of needs. You need to be fed and feel safety and belonging with a group before you reach self-actualization. Maslow was trained by psychoanalysts. I mean, many of the people who broke away from psychoanalysis were trained by psychoanalysts, so pieces of psychoanalytic theory are in every form of helping. Cognitive behavioral therapists would hate to know it, but the truth is, Freud was really the first person to say that your behaviors are communicating and your thoughts are important. So even though CBT practitioners don't want to say they're psychoanalytic, the reality is, again, we're all more alike in terms of the therapy field than we sometimes like to think. We are different, but we're not that different. There are subtle differences between us, but we're more alike than we are different.

Comment [S8]: Chg to "therapists"?

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