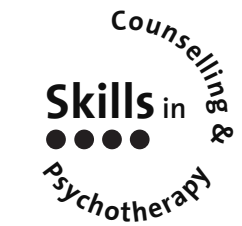
Third Edition

Skills *in* PSYCHODYNAMIC Counselling & Psychotherapy

Susan Howard with Katrina Wynne



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WORKING WITH UNCONSCIOUS COMMUNICATION

Chapter Overview

The previous two chapters have concentrated on creating the conditions for your client that allow his unconscious to reveal itself. This chapter examines the skills you need to tune into and decode your client's unconscious to help him make sense of behaviour or feelings that are currently outside of his understanding.

How the Unconscious Communicates

There is no direct access to the contents of the dynamic unconscious, so we have to infer it through indirect means such as how people behave, the things they say or the dreams they have. This is why we are trained to observe the minutiae of interactions and non-verbal behaviour, to attune our minds to theirs and to understand the latent meaning behind our clients' stories and dreams. It is important to remember that unconscious processes are controlled by primary process thinking, so there is no 'as if'. For example, clients whose functioning is dominated by their inner world can hear 'I wonder whether you might fear I'm angry with you' as 'I'm angry with you'.

Although much of the material in our unconscious will forever remain inaccessible, lack of access to the dynamic unconscious can sometimes be caused by repression. Freud saw repression as a central mechanism whose function is to keep unacceptable beliefs, wishes and phantasies unconscious or disguised. This is because they are a threat to our conscious equilibrium. The modern conception of repression understands

it as 'A strategy used by the left brain conscious mind to cope with potentially dysregulating intense emotional states that emerge in the subcortical right brain' (Schore, 2019: 96).

Although the concept of repression is no longer as central to psychodynamic work, it nevertheless remains significant as a mechanism for protecting the conscious mind from unpalatable knowledge about oneself or others. But, as Freud observed, there is an inherent tendency for repressed material to return to consciousness.

Case Study 8.1: Claudia

Claudia was in her mid-twenties when, on an unexpected visit to Edinburgh, she saw her recently married best friend's husband entering a hotel arm-in-arm with another woman. She was both distressed by what she saw and desperately afraid she would unintentionally tell her friend. Many years later Claudia suddenly remembered the incident, having not recalled it since it had happened.

Claudia experienced a conflict that resulted in unbearable anxiety. On the one hand she wanted to tell her friend, hating to think that she did not know her husband was betraying her. At the same time she did not want to cause her friend distress and was afraid that telling her could irrevocably damage their relationship. By repressing the memory she solved the problem. What she did not 'know' she could not tell.

Channels of Communication

Kernberg (2004) proposes that there are three channels through which we listen to our clients:

1 Channel one is the client's verbal communication – the manifest and latent content of what he says, the sequence of free associations and the things those associations refer to. It also includes the affective aspects of what he says.

2 Channel two is the implicit or non-verbal parts of his communication – how his behaviour conveys affect or motive; how he structures his language and talks.

3 Channel three is the countertransference.

Kernberg makes two important observations. First, that the three channels operate with differing levels of intensity at different times with the same client. Second, that the more severe the client's pathology, the more he will communicate his state of mind non-verbally and implicitly, including through the countertransference, rather than verbally and explicitly.

For example, your client may reveal his true, but unconscious, wishes or conflicts through jokes, or slips of the tongue. Mollon notes 'the unconscious speaks – often

embarrassingly, as if in humiliating mockery of our illusions of conscious awareness and control over our desires and intentions' (2000: 4). Mollon highlights one of the challenges in working with unconscious aspects of our clients' communications – it can be humiliating to have something that you are unaware of pointed out to you. Consequently it's important to frame your interpretations of unconscious material carefully. It is also good practice to interpret your understanding of your client's unconscious only as it reaches near-consciousness. Your client is unlikely to use what you are saying if something is too deeply unconscious; he won't feel the interpretation 'belongs' to him.

Dreams

Dreams remain an important indicator of clients' unconscious preoccupations. Some clients report a series of linked dreams across their therapy; one client's dreams involved her therapist coming to her house. Her dream evolved during her therapy, so that early on the therapist was on the doorstep of the house. As therapy progressed the therapist came into 'public' rooms, like the sitting room. Later the client allowed the therapist into her bedroom, the most private room in the house. Her dreams became a useful vehicle for thinking about the changing relationship between the client and her therapist as well as the progress she was making.

Like all other activities in therapy, the relating of dreams can be used defensively. For example, a new client might spend most of each session describing his dreams in detail, while avoiding talking about the distress and anxiety that brought him into treatment. If this happens, it's important to gently take up with him the things that are not being talked about. If you don't, your client may fear that you can't face them either. You might say, 'I've been thinking that we've talked a lot about dreams. That's been very helpful in understanding certain issues, but I'm aware that when we talk about one thing inevitably something else doesn't get talked about. I wonder whether there are things that we need to look at together that are getting squeezed out as we concentrate on your dreams.'

Skills in Working with the Unconscious

The way that you work with your client's unconscious material is a function of a number of factors that will come together in a unique pattern. They are: your own individual idiom; the defences your client uses; the stage of therapy the client is at; his and your level of engagement at any one time.

Helping your Client to Free Associate

Free association is a way of gaining access to the unconscious through talking about whatever comes to mind, trying not to censor it. Known as 'the fundamental rule', it is central to psychodynamic technique. Your task is to create the conditions in which

your client's right hemisphere opens up, and he becomes less unconsciously defensive, thereby gaining access to thoughts and feelings outside his conscious awareness. The tools that assist you are the frame, the analytic space, and your analytic attitude. Free association is actually quite difficult, and for many clients is an achievement rather than a given. Being able to free associate is a sign of trust, since not infrequently what comes to mind is difficult or embarrassing to speak about. It is also a sign that, at that moment, your client's resistance to the therapeutic process has decreased.

There is no fixed method for facilitating free association. Some therapists overtly suggest that clients say whatever comes to mind, but others do so only if necessary. An instruction at the outset could be: 'Try to say whatever comes into your mind, even if it doesn't seem particularly relevant or it's perhaps difficult to say.' Often there's no need to say anything initially, since most clients quite naturally say what is on their minds. Responding to what they say in an analytic way reinforces the process of exploring their own thoughts. However, at any stage in therapy, clients can struggle and you could say, 'I wonder if you are able to capture what's going through your mind at the moment?' Sometimes a client begins the session with, 'It's your turn today, I've got nothing to say.' It's important not to interpret his resistance; instead you could say, 'Although it might get us started, I'm not sure how helpful it would be, since it might divert us from discovering what's important for you at the moment.'

Sometimes clients need help to realize the meaning of their thoughts, however fleeting or apparently irrelevant.

Case Study 8.2: Mandy

Mandy discarded as irrelevant thoughts or feelings unless they specifically linked with the problem she came into therapy for. One day she was very quiet; she had nothing to talk about. After some prompting, she eventually said that she was wondering if the pot plants outside Saul's consulting room had been watered recently. She was initially resistant to exploring this thought further, saying it was irrelevant to the problems she was bringing. Saul said, 'Sometimes thoughts or feelings that don't seem to have an immediate relevance can still be worth exploring. At the very least if you are thinking about the pot plants it prevents you from thinking about anything else. So I wonder if we could see where it takes us.'

Although initially reluctant, Mandy eventually made a rich series of associations about whether Saul could care for things that could not care for themselves – including her. Discussing her reluctance to share what she was thinking, Mandy said that she only wanted to talk about those issues she herself had identified as a problem. She disliked Saul seeing things that she hadn't yet worked out for herself. This led them to examine how much she hated the power differential between them. She didn't want to 'give' Saul anything that would make him even more powerful.

Clients' relationship to the process of free association can be influenced by the material under discussion, who you are in the transference at that moment, or the stage of

therapy they are in. For example a client might report that his mind has gone blank just as he had begun to explore an area of difficulty. However, like any other activity in psychotherapy, free association can be used defensively. One client demanded of herself absolute obedience to the fundamental rule of free association, forcing herself to express every thought she had. When she eventually questioned what she was doing, she realized that she experienced her therapist as an intrusive mother from whom she could keep nothing private. Paradoxically, by saying everything in her mind, she kept her therapist at a distance. True free association would have allowed her therapist access to her inner world.

Listening with an 'Analytic Ear'

Freud's adjunct for the therapist to 'surrender himself to his own unconscious mental activity, in a state of evenly suspended attention' (1923: 239) remains an important skill. It requires being open to, and moving freely back and forth between your client's communication and your own state of mind. Boyer (1990) described the therapist's evenly suspended attention as complementary to the client's regression during free association. At a neurological level this requires what Schore (2019) calls a regressive shift state in the right cortex in both therapist and client.

To do this you need to be able to tolerate the uncertainty of not knowing quite what is going on in the session, or what your client means at any one moment. You therefore have to be able to resist the need to be certain and provide answers. This can be difficult, especially if your client is very upset or you are feeling inadequate and want to show you have something to offer. Paradoxically, the more we try to think in a session, or the more we try to remember what went on in the last session, the more difficult it is to 'catch the drift of the patient's unconscious' (Freud 1923: 239). Bion put it succinctly when he said, 'In order to exercise his intuition, the psychotherapist has to let go of memory, desire and understanding' (1970: 315). While he didn't literally mean forgetting everything we know about a client (which would be impossible), Bion reminds us that starting a session with a conscious agenda interferes with the capacity to hear what our client is trying to tell us.

While we strive to listen freely and objectively, there is an inherent paradox: in order to do so we need to acknowledge that our own unconscious will influence how and what we listen to. Furthermore, we inevitably listen within a theoretical frame which may distort or restrict what we hear. Kernberg (2004) stresses that those practitioners who acknowledge limits to their capacity to listen freely and objectively are less likely to impose their theoretical frame on their clients. However, practitioners who believe that their listening is not affected by their own theory base are more likely to inflict their theoretical frame on their clients.

It is safe to assume that almost everything your client says and does between greeting you at the door and leaving the premises is meaningful. You may not immediately understand how something is significant. It might become apparent further into the

session, when you are writing your session notes, or even in a later session. It is important to bear in mind that your client has a very short time with you in his week, so how he chooses to use that time is an indicator of what is most important to him at that moment. Paradoxically, the most important thing for him might be to keep you at a safe distance, so he may appear to 'waste' the session by not doing anything very much in it. However, just surviving being with you may be an achievement. The most important issue may not be immediately apparent in what he discusses. The latent communication may not be in the story, but in how he behaves in the session.

Case Study 8.3: Jay

Jay attended his sessions regularly and promptly, usually arriving at least ten minutes early. Over time he became more confident in telling Rhona about the misery of his early life, and she felt an increased connection with him. Jay's therapy started during the winter. Rhona noticed he didn't remove his winter coat, despite the warmth of the room. Rather, as he started each session, he pulled the coat even closer around himself. As the session progressed, the coat loosened; however, Jay often pulled it tighter when Rhona said something empathic or otherwise indicated she understood what he was trying to tell her.

In supervision Rhona and Ralph discussed how, from an early age, Jay needed to protect himself both from attack and from his disappointment that true closeness wasn't possible. They wondered whether, when Rhona made an empathic connection, Jay experienced it as an offer of closeness that, should he allow it to raise his hopes, would lead to more loss and disappointment. While he could not tell her this directly, and indeed was unlikely to be consciously aware of what he was experiencing, the latent communication was very clear.

In listening to your client's communication you need to balance two opposite requirements. First, you need to be sufficiently separate from him that you don't over-identify with him. Second, you need to remain sufficiently identified with him that you are empathic. If you over-identify with him you may not allow yourself to take up inconsistencies in what he says. Or, you may incorrectly assume that you have a shared understanding of the meaning of what has been said. But if you are too separate from him it's difficult to tune into his affective state and you can become insensitive or undermine him.

Listening to both the manifest and latent content of your client's story or dream involves a number of separate tasks. The first is to engage sensitively with the actual story and help him tell it through the use of basic counselling skills such as reflecting, using prompts or summarizing. In doing this you are also facilitating your client in hearing himself, which will help him begin to make his own links. Constructing an understanding of latent material is only meaningful to the client if he has been part of it. If you give in to the pressure to comment on the latent content too soon he may feel (rightly) you haven't really heard him. Demonstrating how clever we are by pronouncing on what a

client is really thinking or saying is something we're all capable of. But we need to resist the temptation to do so, because it gives the message that this is not a collaborative endeavour. It can increase resistance and ultimately lead to overt and/or unconscious hostility disguised as passivity or compliance.

It's important to be aware of how your client tells his story including any silences, gaps and inconsistencies, as well as his body language. You may then begin the process of trying to understand the latent or 'unconscious' story. At this juncture you need to ask yourself questions such as, 'Does this story link with other material in this or a previous session?'; 'How does this story fit with everything else I know about him?'; 'What impact is this story having on me. What am I feeling and thinking at the moment?' The story's transference implications may seem obvious, or you may need to consciously consider them, while also monitoring your countertransference.

Listening to our clients is not a passive activity – it is both active and hard work. Being able to listen with an analytic ear is an advanced skill that develops over time. Lemma cautions us to take nothing for granted when listening in this way: 'It is about a kind of listening that is attuned to the human tendency towards self-deceit and the resistances that are operating to shield the patient from painful affect' (2016: 172). Similarly, you cannot expect to understand everything that is going on during the session itself. Inevitably, as you get drawn into your client's world, you will miss things, and monitoring your own responses in parallel is very difficult. The practice of writing process notes during training (a detailed description of what is said and felt during the session) often helps one to realize what has been overlooked. This includes possible meanings or resistances that were missed in the session, or links that were not previously obvious. Even when you no longer routinely write process notes, it can be useful to do so when seeing a new client, when you're struggling with your countertransference, or following a major event in therapy, such as an enactment. Not uncommonly it reveals previously unidentified aspects of the transference and countertransference, which helps you to listen in a different way in the next session.

Interpreting Latent Content

Interpreting the latent content in our client's behaviour or stories helps him to make links between his conscious mind and an event, feeling, thought, wish or phantasy that he has not been previously consciously aware of. Decoding the latent content in your clients' stories and dreams requires the skills of being able to symbolize and to understand metaphor. We all use metaphor much of the time. Indeed, when people can't symbolize or understand metaphor we describe them as being concrete in their thinking, something associated with high levels of stress as well as being autistic or in a psychotic state of mind. Some metaphors have a fairly consistent meaning, for example talking or dreaming about a roof or an attic often symbolizes a person's mind. Descriptions of being underground or under the sea can indicate a concern about the unconscious. However, it is a mistake to be too deterministic about what things symbolize. A reference to being underground may refer to the unconscious, but

it may be about a fear of disappearing or even dying. Being too deterministic can interfere with the client reaching an understanding of what that particular metaphor means for him at that moment.

In this section we will mainly focus on extra-transference interpretations, ones that are aimed at helping your client make sense of something not directly linked to his relationship to you.

Case Study 8.4: Jay

In the first three months of therapy Jay made a concerted effort to discuss the relationship with his father and the impact that this had had on his ability to relate positively to any male authority figure. He rarely mentioned his mother, and, when he did, it was usually to do with practical issues. Outside of therapy, things were beginning to improve. He had started a fitness regime, discovering pleasure in long-distance running. At work there were discussions about his temporary contract being made permanent. One day he arrived highly distressed because of an event at work. Shaking and barely coherent, he explained that a senior colleague had asked him to take her place in a meeting so that she could leave early. However, she hadn't briefed him adequately, and Jay performed poorly when asked to present. Although his boss hadn't commented on his performance Jay felt sure he was disappointed with him. He was afraid it would cost him the promised permanent contract.

As she listened to him Rhona wondered if Jay's distress was because the situation had powerfully recreated his childhood relationship with his mother. Although he had not gone into detail about it in his sessions, Rhona knew from the agency's assessment that Jay's mother hadn't protected him from his father's brutality. Indeed she had only acted against her husband when he became physically violent towards her. Jay had displayed little emotion when he described what happened to the agency assessor, seemingly split off from feelings of recrimination towards his mother. Rhona wondered whether his current distress was because his female colleague had also betrayed him, leaving him exposed and vulnerable to a fantasized terrifying and vengeful father figure.

Because Jay was so distressed, and possibly dissociating, Rhona stayed in the present, focussing for much of the session on his current distress about being betrayed by his colleague, and his anxieties about whether he'd be offered a permanent contract. She used sensitive and empathic attunement to regulate his distress rather than making links with his past or with the transference. Once he'd thoroughly explored the story's manifest content, he became calmer and was properly present in the room. Rhona then addressed the latent content. There were two potential non-transferential areas for exploration. The first was the link between his fear of his father and of his boss. Rhona offered the hypothesis that Jay was terrified his boss would unfairly and cruelly punish him for a minor transgression as his father had. Rhona made her hypothesis tentatively, implicitly acknowledging that she may not be correct. Jay responded well to this; it made sense to him as he had already done work recognizing how this pattern manifested itself in other relationships with men in authority. The second was the link between his colleague and his mother and their joint betrayal of him. Rhona decided against making this interpretation for two reasons. First, it was very close to the end of the session and

she was concerned that making such a link with little time left would recreate the trauma of his mother's betrayal and subsequent abandonment. Second, she was mindful that direct links between present and split-off aspects of trauma can retraumatize clients and she wanted to discuss with Ralph when and how to make it.

Rhona's careful exploration of the manifest content of Jay's story was particularly influenced by her knowledge of how to work with trauma. But, in general, there is no formula that tells you the right moment to offer a hypothesis about the latent content in a client's story. It will vary with each client and at different times in the same client's therapy. Rhona's use of a graded approach is also appropriate for new clients who are still learning about therapy; with someone who is going through a period of resistance to therapy; with a client who is very distressed or caught up in a story; when you are talking about a new area with a client you have known for a while; or you think that your interpretation of the latent content might be difficult to hear.

However, at other times it is appropriate to interpret the latent content much sooner and more directly, but you need to be confident that you and your client are working well together to do so. Let's imagine that Jay has done a lot of work to integrate his traumatic past. He has come to understand that stories and dreams are communications from his unconscious mind so is able to hear a direct interpretation without such a careful exploration of the manifest content. In this case Rhona might have said, 'I wonder if you became so upset about your colleague because her behaviour in leaving you high and dry in front of your boss put you in touch with your feeling of betrayal when your mother didn't defend you from your father.'

When a client brings a dream to therapy we need to assume it's significant and that something important is being communicated through telling it. Most dreams are forgotten, so the fact that a dream has been remembered and then brought to the session is of itself meaningful. Like other communications, we need to listen not only to the content, but also to how he relates it, particularly if he has difficulties in doing so. Paradoxically, once clients understand that their dreams have meaning, telling them can become more difficult, since dreams are often the vehicle through which wishes or fantasies are expressed. Clients can feel embarrassed relating their content, particularly if the material is sexual or involves evidence of longing for their therapist.

Once the story of the dream has been told you have a number of options. You might decide to ask the client to tell you what he makes of the dream, you might see what associations he makes to it or you might make an initial observation yourself. Understanding dreams is the same as working with any other material in a session – both the manifest and latent content need to be addressed. Some practitioners argue that everything else that the client says or does in the session is an association to the dream because the dream is unconsciously preoccupying him throughout the session and he works on it throughout.

Positive and Negative Interpretations

One of the strengths of the dynamic position is that we thoroughly engage with the negative aspects of our clients' inner worlds and life experience. However, at times we can focus on those negatives at the expense of acknowledging the positives. Symington (2008) argues that, in over-interpreting the negative in our client's communication (for example his destructiveness), there is a risk that we reinforce the negative aspect of him and a pessimistic outlook. By contrast he argues that making a positive interpretation (for example that the client is becoming more constructive) can help access the positive, or generous part of him, which reinforces a more benign outlook. Clearly there needs to be a balance between the two, but we need to consider why we sometimes choose a negative interpretation over a positive one, and whether, as Symington proposes, we sometimes do it to punish or assert power over our client, thereby engaging in a micro-aggression.

One reason for reflecting on this over-use of negative interpretation is that it may have implications at a neurological level. Are we, by focussing on the more depressive aspects of our client's experience and communication, reinforcing heightened activation in right-sided brain structures that dominate in clients with stress, anxiety, fear and trauma? If so, are we inadvertently lengthening therapy?

Cognitive and Emotional Insight

An intellectual understanding of one's difficulties is different from emotional understanding. Intellectual insight involves being able to make links, an understanding that involves left-brain activity – thinking. Intellectual insight can be useful, for example if it provides scaffolding for a client who is very disturbed or distressed. Occasionally, helping a client have an intellectual awareness of what is happening can facilitate the process of therapy when he is finding it difficult to tolerate or make sense of how he is feeling. However, intellectual insight on its own can be used defensively, to protect clients from emotional understanding, thus slowing the pace of change.

Case Study 8.5: Lorraine

Lorraine had tried different therapies over many years for help with her obsessive compulsive disorder. Although intellectually insightful about why she needed her rituals, what precipitated acute episodes and how this impacted on her relationships with others, nothing changed in terms of her behaviour. In desperation she 'watched' herself undertaking rituals, 'knowing' why, but unable to stop herself.

Emotional insight occurs when your client becomes aware of a fact or link that's accompanied by an emotional response and a subsequent change in his relationship to his inner world. This is one of the reasons why we need to work at the client's pace, so

that we don't offer him intellectual insight before he is ready to use emotional understanding. Emotional insight is brought about by right-brain activity within the client that is facilitated by the therapist's right brain through sensitive, empathic matching to her client's implicit feeling and arousal states. Therapeutic change is the result of linking this emotional insight with cognitive awareness resulting in integration of brain systems.

Clinical Intuition

Intuition can be defined as the ability to know something immediately without conscious reasoning. Using one's intuition clinically used to be considered dangerous because of fears it could provide a cover of respectability to 'wild analysis'. It was seen as being grounded in the therapist's inner world rather in psychodynamic reasoning. However, advances in neuroscience led to a re-appraisal. Shaped within the language of neuropsychodynamics, intuition is now understood as the process by which we access large banks of implicit knowledge 'formed from unarticulated person-environment exchanges' (Schore, 2012: 122) which are the result of deep unconscious knowledge and experience stored in our right hemisphere. Whereas reasoning is slow, controlled and effortful (and more common in novice therapists) therapeutic intuition is fast, effortless and creative (and more common in experienced therapists). Intuition is associated with right-brain functions such as spontaneity, immediacy, creativity and a global view. It seeps into conscious awareness without being mediated by logic and rational processing. Writers emphasize the embodied nature of intuition, locating it in the link between the gut and the brain. Gut feelings are implicit bodily memories related to previous experiences allowing us to make decisions with conviction. This makes sense since there is a phylogenic link between the gut and the brain; during evolution the brain grew out of the gut, and consequently they share some of their chemistry (e.g. serotonin, see Chapter 5). It also helps explain the strong link between gut and brain and, for example, sensations of being 'kicked in the stomach' in response to a powerful distressing experience.

Although intuition is usually experienced as an intense bodily feeling, experienced therapists also report seeing pictures flash across their minds or words or sayings that arrive without any obvious trigger. Over time they develop confidence that these experiences illuminate something that the client is trying to reach. Schore (2012) proposes that the mechanisms underlying intuition are to do with how, in moments of heightened affect, the psychobiologically attuned therapist accesses her preconscious right brain. Importantly, when the free-associating client does the same it results in a mutative exchange.

Working with Vertical Splits

Vertical divisions of the mind are often experienced by people who have suffered significant childhood trauma. The task for therapists is not so much to make unconscious

material conscious, but to heal the vertical splits so that the client's conscious experience is more continuous.

Clients who experience significant vertical splits are those for whom there is a discontinuity or dissociation in their experience. Vertical divisions lead to dissociative states – a client in one state is unable to feel, or perhaps even know, about how he experiences other states. This means that he might be in touch with powerful feelings in one session or at one point in the session, and then cut off from them. Mostly such clients remember that they had the experience as a fact, but are no longer able to access the part of the self that experienced it, so it does not feel as though it belongs to them. Dissociation is the process by which the client walls himself off from intense traumatizing experience. It's associated with people who have suffered significant trauma in their early lives. Modern writers understand this as a deficiency in the right brain. Trauma has had a growth-inhibiting effect, preventing the development of an effective affect-regulation system and leading to chronic dysregulation.

Case Study 8.6: Jay

Not long after the episode at work there was a frightening incident at the agency during Jay's therapy session. An ex-client of another therapist had returned demanding to be seen. Believing that his therapist was available but was being kept from him, the man had bypassed the receptionist and gone from one consulting room to the next searching for her. He stood in the door of the consulting room and demanded in a loud voice that Jay tell him where his ex-therapist was. Jay froze, terrified. Rhona persuaded the man to leave and escorted him back to reception. When she returned Jay was very dismissive about what had happened and talked about the incident as though it was an amusing story. At the same time his body language expressed distress. He looked cowed and he'd become rigid. Rhona hypothesized that Jay had walled himself off from the intensity of the experience in order to manage his fear. She was unsure what to do, concerned about what would happen if she breached the wall but also anxious about doing nothing. He had almost certainly re-experienced the trauma of his father coming to his room as a small child. But this had happened in a place that had started to feel safe for him. If she left him to manage the emotional impact on his own in the presence of his therapist-mother another aspect of his childhood trauma would be recreated, this time in the transference. Rhona began to talk gently to Jay about what a shock it was for this man to burst into the room. As she did so he began to weep.

As Cozolino (2014) reminds us, brains rely on other brains to remain healthy through connectedness, especially under stress. The kind of interpersonal trauma Jay suffered as a child lies in the experience of needing physical or emotional protection from the person who should be available to comfort him, but wasn't. This presented him with an unbearable conflict in relation to both parents, but in different ways. In order to survive he created a vertical split in which his traumatized self was cut off from the part of him that continued to exist as though nothing had happened. Schore (2003) has made a

number of recommendations as to how to work with clients to heal these splits. Rhona needs to bear the strength of Jay's feelings, both about past events and in the transference. She also needs to focus on being attuned to his emotional states, track those states, and help him empathically identify and regulate strong emotions through right-brain to right-brain connection. She needs to be consistent with him and continue herself to reflect on what is happening between them. Lastly she needs to help him to move beyond experiencing strong feelings into being able to reflect on them and on himself experiencing them. There is a balance that needs to be maintained in this. While Muller (2010) cautions not to collude with clients' reluctance to address trauma, at the same time it is important to ensure that the client is not dissociating when exploring it.

Resistance

One of the most frustrating things for all concerned is when, despite wishing for change, your client undermines the help he seeks. This might be quite overt, for example by regularly arriving late for his session, so that he never gets the opportunity to fully engage. Or it might be much more subtle, such as when a client agrees with everything his therapist says so that his hostility is hidden and cannot be explored. The more overt forms of resistance are 'in the room' and therefore can often be worked with. However, the hidden forms usually only become apparent because the client is not changing, sometimes despite the fact that therapy appears to be going well.

Case Study 8.7: James

James suffered from long-term bulimia nervosa and maintained a healthy weight through vomiting after over-eating. In therapy he was insightful and worked hard. Anja enjoyed the experience of working with him and felt that therapy was going well. However, after some while it became apparent that little was changing in James' internal world or, indeed, externally. It was only when he told Anja that after each therapy session he binged and then vomited that she began to understand the role resistance played in his lack of progress. By bingeing he continued the cycle of taking care of his emotional needs himself. This prevented anyone from entering his closed defensive system. Bingeing then vomiting was a way of negating his therapist and anything that she had given him in the session.

While there is a close link between resistance and defence, many writers have emphasized that these are not the same thing. While defences are a part of the client's psychological structure, resistance is his way of protecting himself from the threats to his psychological equilibrium that therapy represents. As Greenson (1967) notes, not only does resistance oppose the therapist but it also opposes the client's own wish to change, thus maintaining the status quo. Resistance can be the consequence of conflict within the client between the part of him that seeks change and the part that resists it,

perhaps out of fear of the consequences of that change. Experiencing conflict assumes that there are mental structures in place that can be in conflict with one another. However, an apparent resistance might in fact represent a developmental deficit; in other words, the client doesn't have the psychological structure in place to resist with. It's not that the client won't – he can't.

We can contribute to resistance in our clients at any stage of therapy, often through faulty technique. For example, identifying something as resistance when it is not, for example wrongly interpreting disagreement with something we have said as resistance. In extreme instances this can lead to therapeutic impasse. It's important to underscore that disagreement is not necessarily the outward manifestation of resistance. It might be a sign of trust that your client feels able to disagree with you, or an indication of a growing maturity that he can think for himself about the value of what you have said. We have to be able to manage the injury to our own narcissism when a client disagrees – we may just be wrong! On the other hand it's important to also remember that, when trying to help a client recognize resistance, he will use both justification and rationalization to ward off any attempt to explore what he is doing.

Shame can also heighten resistance. For example, some clients find reference to the infantile parts of themselves shame-inducing, and this needs to be handled sensitively in order to avoid resistance.

Resistance at the Start of Therapy

Although resistance can arise at any time, it is often most evident at the beginning of therapy. However, it's important not to automatically assume that uncertainty at the beginning of therapy is solely due to resistance. There can be other reasons, which are to do with not knowing how to engage with the psychodynamic approach. As they begin therapy, many clients don't have a concept in their minds of what a mutual therapeutic relationship is like, and so are unaware of what interactions are possible or permitted. While it can be difficult to untangle lack of awareness from resistance, it's helpful to keep an open mind while at the same time educating your client to the process.

At other times clients are ambivalent and their resistance can be manifest in the first contact, for example through being unable to agree a time for an initial meeting. Jay demonstrated his resistance by getting the day wrong for his initial session with Rhona. Resistance can also be manifest through inviting you into a more social relationship, by asking personal questions or making comments about where you work.

Case Study 8.8: Ruby

Ruby, a new client, worked in an allied field. As she entered Nell's waiting room, she looked around then said, 'This is a nice set-up you have for yourself here. I've always wanted somewhere like this to work from.' Her comment affected Nell in several ways. First, and immediately, at an emotional level she felt intruded into, as though Ruby had stamped around in the analytic

space Nell had already opened and was about to invite her into. Second, Nell thought Ruby might find it particularly difficult to be a client and engage in an asymmetrical relationship in which she was vulnerable. This was later proved correct. Ruby's anxiety about, and resistance to, being vulnerable were manifest immediately by beginning with a comment that reminded both her and Nell that they could be colleagues and therefore have a symmetrical relationship. Once in the consulting room Nell said, 'It might be quite difficult coming here as a client when you and I could so easily have been colleagues.' In saying this Nell opened a space in which Ruby was invited to reflect.

Asking personal questions can indicate resistance, since it is a way of attempting to balance the relationship through challenging the frame. Many people find it hard that their therapist knows so much more about them than they do her. With more directly personal questions, for example 'Do you have children?', you can respond by saying something like, 'I wonder what it would signify to you if I told you whether or not I have children?' If the client asks again you might say, 'It might be really hard that I'm getting to know so much about you, when you know so little about me.'

Advice-seeking is another area that can indicate resistance. However, it's important to remember that your client may ask for advice out of ignorance – most new clients don't know psychodynamic therapy's rules. Others may do so because they're desperate for help when feeling out of their depth. However, it can feel as though a client is throwing down the gauntlet if he says, 'I know as a psychotherapist you don't give advice, but this time I want you to tell me what I should do.' In this instance start by making an empathic response such as, 'I think it is really hard for you that I'm not the kind of therapist who tells you what to do.' You might then add, 'I'm wondering if you might feel that, if I wanted to, I *could* help you by telling you what to do'; or perhaps, 'Maybe it feels like I'm deliberately withholding my help if I don't tell you what to do.' If the client continues to ask to be given direction you could add, 'It seems to me that you find it quite hard to feel helped by what I *can* give you.' Such an interpretation of the client's resistance begins to tackle the negative transference that may accompany ambivalence about change.

Asking about your qualifications and experience can be a manifestation of resistance, but when done at the beginning of therapy you should always give a direct answer, as discussed in Chapter 7. Having given your reply, it's also useful to discuss the significance of the request. Clients who ask the question well into therapy may do so because they are discontented, so giving a straightforward answer may sidestep a negative transference. You could say something like, 'I would be happy to tell you; indeed I'm glad you've asked, but before I do perhaps we could think about what it would mean to you to know.'

Not uncommonly clients at the beginning of therapy say the thing that is most important right at the end of the session. This can be because they're finding it difficult to discuss painful or conflictual things; because they are finding it difficult to leave; or because they're attempting to take control of when the session ends. It is important to

take it up, and you could say, 'This sounds important, but we have to stop now and I wonder if we can come back to it next time.' If a client repeatedly does so, look for an opportunity in the material of the next session to address the issue raised at the end of the previous one. You can then start the process of exploring what bringing the most important issue at the end of the session signifies.

Generally we would recommend not interpreting resistance too early. While at times it is essential to do so, it can also lead to further resistance if it is experienced as persecutory. This is particularly so with lateness at the beginning of therapy. Often clients come a long way and can find it hard to predict how long the journey will take. Our response is an indication of our particular therapeutic stance, which attends to the importance of external as well as internal reality.

Not free associating can also be a form of resistance, since your client is not engaging in an activity that is central to the therapeutic endeavour. At the beginning of therapy this can be a function not only of resistance, but also of a lack of conviction that saying whatever is on his mind is actually going to be useful. Sometimes clients need time to see the value of free association.

Resistance in the Later Stages of Therapy

Sometimes, after making good progress, a client can begin to resist the process of change. Very often this is because of what change means; for example, alterations in his feelings and ways of relating may have serious consequences for an intimate relationship outside therapy. Resisting further insight might be a way of protecting that relationship from breakdown. Resistance commonly increases as the client gets close to the core of his difficulties, particularly if they are to do with how his character is structured and if change represents a threat to who he is. As he gets better the client also has to face the loss of the relationship with you as the possibility of discharge looms. If he doesn't have many other intimate relationships in his life he may find the loss of his therapist unbearable, and may get worse as the termination date gets closer.

In working with resistance in the middle and later stages of therapy, it's important to keep in mind that clients both wish for and fear the consequences of change. Quite often they themselves become frustrated with their resistance, and we can respond to that with our own frustration and impatience. This can make it difficult to stay empathic and to be in touch with the fear associated with the resistance. If we can remain empathic we have a much better chance of helping that part of the client that does want to change.

Further Reading

Ross, A. (2019) *Introducing Contemporary Psychodynamic Counselling and Psychotherapy: The Art and Science of the Unconscious*. Buckingham: Open University Press.