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1

Two Modes of Psychotherapy and Counselling*

This book is addressed to all manner of students and practitioners of psychotherapy and counselling. It offers a compendium of deep psychological and interpersonal insights and precepts that can serve as a solid foundation for all of the diverse efforts at emotional healing that are in vogue today. While its bias is psychodynamic, the knowledge and principles of technique that will be espoused have a bearing on, and can serve to illuminate, the practice of all present-day treatment modalities regardless of their theoretical underpinnings.

The broad applicability of this book stems from its grounding in explorations of emotional realms where humans share a set of universal attributes that are inherent to *the emotion-processing mind* that marks us as members of the hominid species (Slavin and Kriegman, 1992; Badcock, 1994; Langs, 1996). Regardless of whether they are addressed by a given psychotherapist, these psychobiological features of the human mind are operative at all times and they exert many powerful effects on emotional life and the therapeutic process.

* For ease of presentation, I shall hereafter use the terms 'psychotherapy' and 'therapy' to allude to all forms of mental healing, much as I shall use the terms 'psychotherapist' and 'therapist' to refer to all types of mental health professionals. Similarly, the term 'patient' shall imply all types of recipients of psychological treatment.

Historically, the various schools of psychotherapy have had little to say about shared, psycho-biological fundamentals. The prevailing trend is to stress the distinctive features of a given theory and mode of practice, and the uniqueness of each patient–therapist couple, to the neglect of universal features (Slavin and Kriegman, 1992; Langs, 1998a). This attitude supports the employment of a wide range of ill-defined techniques of therapy which are buttressed with the use of highly abstract, uncertain, clinically distant concepts like ‘symptom relief’, ‘psychic defence’, ‘transference’, ‘cognitive retraining’, ‘inter-subjectivity’ and ‘the unconscious’. This way of thinking also finds support through the avoidance of model-making, a most important scientific tool. The few models of the mind that have been generated tend to be naïve, static, lacking in clearly defined entities and devoid of a precise definition of the unconscious domain and unconscious adaptation (Gedo and Goldberg, 1973). Freud’s (1923) well-known model of ego, id and superego is a case in point (see Langs, 1992b).

The field of psychotherapy is sorely in need of a far more precise definition of terms, theories and techniques (Little, 1951; Szasz, 1963; Smith, 1991). It also requires the development of suitably complex, adaptation-oriented models of the mind that take into account both conscious and unconscious efforts to cope with the many, ever-present adaptive challenges that humans face from day to day. It is for this reason that this book is being written from a *strongly adaptive perspective*. This vantage-point has heretofore been called *the communicative approach* because the theory and techniques that it offered were derived largely from careful investigations of the processes of conscious and unconscious communication between patients and therapists. The shift to the terms *adaptive or strong adaptive approach* was made because, with time, it became clear that the most distinctive feature of the approach is its emphasis on *conscious and unconscious emotional adaptation* as carried out by the psycho-biological structure that has evolved for this purpose – *the emotion-processing mind*. In this context, it’s well to stress that the propositions of the approach have been clinically derived and unconsciously validated, and that they are based on a new way of listening to and formulating the clinical material of the therapeutic interaction and the conscious and unconscious implications of that material. Throughout the book I shall refer to clinical findings that have been developed through the methods of the strong adaptive approach. These references allude to 30 years of unconsciously validated cumulative clinical experience rather than any specific clinical research study.

Adaptation

We begin our pursuit of psychological fundamentals with a cardinal set of questions: As human beings, what is our most essential task? What activities are most basic to our very existence and survival? What are we first and foremost designed to do? And how does this central devotion apply to the emotional realm?

Biologists offer a clear and incontrovertible answer to these questions. Granted that there are basic needs for boundaries, nourishment, metabolism and excretion, nevertheless the most fundamental *task* for all living beings including humans is that of *adapting to their environments* – a term used in its broadest sense to include living conditions, interactions with other living beings, natural events, and the state of our body organs and our inner feelings, fantasies and other affects and thought processes (Dawkins, 1976; Plotkin, 1994; Dennett, 1995; Langs, 1996; Rose, 1997). Except for serious or life-threatening physical illnesses, however, the latter internal events are of lesser importance to the vicissitudes of emotional life than those that arise and impact from reality and the external environment. Thus, fantasies and memories, conscious or unconscious, are far less evocative of major adaptive responses and emotional consequences than disturbing outside incidents – so-called *emotionally-charged traumas* or *anxiety-provoking triggering events*.

Defining the unconscious domain

It seems axiomatic that a fundamental and universally applicable theory of emotional life and psychotherapy must, of necessity, include a sound conceptualization of both the conscious and unconscious realms of experience and coping. Current psychoanalytic conceptions of unconscious factors in emotional life are extremely vague and poorly conceptualized. Virtually anything that a patient is unaware of that a therapist believes to have been expressed in the patient's behaviours, words or feelings has been defined as operating unconsciously. This includes patterns of thinking and acting, relational trends, self-attitudes, the need for so-called narcissistic supplies, fantasies, memories, and many of the implications of patients' manifest communications (see for example, Kohut, 1971; Kernberg, 1975; Mitchell, 1988; Bacal and Newman, 1990; Orange *et al.*, 1997; Langs, 1998a). The appellation 'unconscious' has thereby been reduced to a waste-basket term that is lacking in specificity, credence or clinical utility. Much of this arises because the bulk of psychotherapeutic work carried out today deals

with conscious experiences and, in respect to communication, with the manifest contents and the evident implications of patients' material. From a strong adaptive perspective, it appears that many therapists have a rather vague conceptualization of the unconscious realm and are truly lacking a sense of the distinctiveness and specificity of unconscious experience, communication and processes (Langs, in press a).

This situation can be traced to Freud's (1900) abandonment of his *topographic (map) model of the mind* in which the term *unconscious* (UCS) referred to a system of the mind, and thus to the state of a particular set of mental contents and to a distinctive type of mental processes that he called the *primary processes*. This system was sharply distinguished from the other system of the mind, the *preconscious-conscious system* (PCS-CS) which had its own set of contents and mode of operation, which Freud called the *secondary processes*. These distinctions were based on the study of patients' communications in psychoanalysis, in which attention to symbolic unconscious expressions played a definitive role. Almost all of this was lost with Freud's (1923) adoption of his *structural approach*, in which the term *unconscious* no longer alluded to a system of the mind and its modes of communication and processing. Instead, the term referred to a quality of human experience and, thereby, soon became a secondary consideration in formulating material from patients and in intervening.

Of importance in this regard is the realization that Freud's models of the mind were grounded in a basically inner mental or intrapsychic focus, with minimum attention to coping with external realities – a position that is sustained to this very day by virtually all forms of psychotherapy. In contrast, the strong adaptive approach that informs this book is based on a view of emotional life and psychotherapy that is organized around the human need to adapt first and foremost to emotionally-charged external events and their meanings; inner mental issues are seen as a secondary concern. Because this adaptation-centred approach was developed as an extension and revision of mainstream psychoanalytic approaches, it shares features with Freud's and other present-day thinking, yet differs in significant ways as well – fundamentally, theoretically and clinically.

One difference of relevance to the present discussion is that, in being stimulus-oriented, the adaptive approach views unconscious communication as a means of conveying *encoded unconscious perceptions* rather than *encoded unconscious fantasies and memories* – although these may be encoded secondarily. And because unconscious

communications and processes are evoked and organized by events that can be specified, the strong adaptive approach has been able to define the unconscious realm in relatively specific terms. In addition, its focus on communication has led to an appreciation of the dramatic differences between *manifest (unencoded) or conscious* and *latent (encoded) or deep unconscious* modes of expression. This in turn has led to the development of a model of the emotion-processing mind that basically is a return to Freud's topographic model, albeit greatly modified – that is to a model of the mind with conscious and deep unconscious systems. And despite differences in attributes, the adaptive model shares with Freud's model a relative precision in defining for each system a set of clearly identified operations, moral values, mode of expression, degree of defensiveness, perceptive capabilities and adaptive intelligence.

The weak adaptive position

The proposition that adaptation is at the very centre of emotional life, as well as the psychotherapeutic process and the operations of the emotion-processing mind, is the basis for a classification of forms of psychotherapy into two basic groups – *the weak and strong adaptive approaches*. There's an in-built, natural tendency for us as humans and psychotherapists to adopt a mind-centred, weak adaptive position. By evolved design, the human mind tends to look away from external realities and to think of its troubles as its own. Emotional problems are then thought to arise when the mind thinks terrible or conflicted thoughts or has unfounded beliefs, or when it's learned poor ways of relating or has been conditioned to respond badly to certain kinds of situations. It's also believed that the mind's forbidden wishes and fantasies, and the conflicts that they cause both consciously and unconsciously, are the root causes of emotional ills. External realities are seen as a backdrop for the mind's struggles or as creating coincidental events that set off inner struggles and then fall by the wayside. Even in the case of extreme traumas, the focus is almost entirely on how the mind is affected by and handles these situations.

These are, then, *mind-centred approaches* which are exemplified by classical psychoanalysis and its off-shoots, self-psychology, relational and intersubjective theories and the like, which view inner mental conflicts, self-nurturing needs, and relational difficulties as the primary issues in emotional life (see for example, Freud, 1923; A. Freud, 1936; Greenson, 1967; Kohut, 1971; Kernberg, 1975; Atwood and

Stolorow, 1984; Stolorow *et al.*, 1987; Mitchell, 1988; Bacal and Newman, 1990; Orange *et al.*, 1997; Langs, 1998a, in press b). Also included here are behavioural and cognitive approaches to the human mind and its psychotherapy. Their basic principle when it comes to psychotherapy is: Heal the mind – train it to think more clearly, rid it of its bad habits and poor patterns of thinking, behaving and relating, and/or render its unconscious tendencies and conflicts conscious – and the patient's emotional problems will be solved. Healing is believed to stem from interpretations along these lines and from the patient's constructive identifications and interactional experiences with an assumed soundly functioning psychotherapist.

In respect to communication and listening, therapists who adopt these approaches work with manifest contents and the purported implications that can be extracted from these contents – an *extraction process* that is very different from the strong adaptive *trigger-decoding process* described below. When unconscious contents or processes are considered by weak adaptive therapists, if at all, it's done in three ways:

First, by defining unconscious expressions as previously unavailable or unmentioned mental images, thoughts, fantasies or memories that suddenly appear or break through into a patient's awareness. This phenomenon is understood to be the result of changes in intrapsychic defenses that allow previously repressed or unrealized mental contents to enter awareness.

Second, by classifying as unconscious expressions any implication of a manifest message of which the patient is unaware. Here, the focus is on meanings unrecognized by the patient that can be extracted from the surface contents of his or her free associations – that is, from the manifest contents of their messages.

Third, by viewing unconscious expressions as any behavioural tendency, pattern of behaviour or mode of relating that a therapist can deduce from a patient's behaviour in therapy or his or her self-descriptive free associations that the patient does not consciously acknowledge.

The study of these efforts from the vantage-point of the strong adaptive approach accepts the validity of some of these weak adaptive conceptualizations, but finds that they tend to pertain to emotional issues that have only minimal impact on the vicissitudes of emotional life and the psychotherapy experience. More tellingly, they appear to serve as ways of avoiding and defending against far more powerful, anxiety-provoking, emotionally-charged experiences and issues of a kind that serve as the deeper sources of both emotional health and

emotional suffering. These more compelling problems have been found to stem not so much from the inner mind as from the external world and life itself with its never-ending traumas, large and small, including the overwhelming prospect of personal demise.

The strong adaptive position

To the best of my knowledge, the strong adaptive approach is the only school of psychotherapy that has adopted a primarily adaptive viewpoint of emotional life and its vicissitudes (Langs, 1982, 1993, 1998a; Smith, 1991). As a result, as noted by Raney (1984), it is a new paradigm of psychoanalysis, one that illuminates all manner of therapeutic efforts. As noted above, its basic proposition is that the single most important function of the *emotion-processing mind* is that of adapting to external environmental challenges, which mainly take the form of blatant and more subtle traumas; adapting to inner mental processes and affects is seen as a secondary function. It also proposes that the emotion-processing mind adapts on two levels of emotional experience – *conscious and unconscious* – and that it's comprised of two relatively independent, distinctive processing systems – the *conscious system* and the *deep unconscious system*. Reality and the two-system emotion-processing mind are seen as equal partners in determining the course of our emotional lives.

As for the process of cure, the emphasis is on the healing qualities of the insights garnered through the interpretation of patients' unconscious perceptions as evoked by current or recent triggering events and their effects on the vicissitudes of patients' symptoms and resistances, as well as their unconscious links to responses to past traumas. Also salutary are a therapist's offer and maintenance of a secured setting and ideal set of ground rules for the treatment experience – a reflection of the healing powers of a soundly structured therapeutic space. And, finally, there are the curative effects of the positive unconscious identifications patients make with their psychotherapists when they function well and, in general, confine their therapeutic endeavours to unconsciously validated interventions – mainly trigger-decoded interpretations and efforts to keep the framework of a treatment well-secured.

These modes of insight and healing enable patients to modify their existing maladaptive behaviours and resolve their emotional symptoms, and to develop the ability to cope favourably with future emotionally-charged triggering events. By and large, this is a *reality-centred approach*

that views the mind's efforts to adapt to actual traumatic events and their multiple meanings as the primary issue in emotional life. It sees the mind as continuously activated by environmental events and rejects the idea that the mind is an isolated entity that goes off on its own to fight its own battles.

Communicatively, this approach is grounded in the understanding that messages from the deep unconscious system of the emotion-processing mind are *encoded* within the manifest contents of narrative vehicles such as dreams, conscious fantasies and daydreams, and stories that attract the interest of a patient. These messages reflect the deep unconscious experiences and adaptive processing efforts of this system, and they are determined by undoing their disguise in light of their evocative triggers. The means by which this so-called process of *trigger decoding* is carried out involves deciphering the encoded meanings of narrative themes in light of the unconsciously perceived triggering events that have prompted deep unconscious processing activities. In essence, then, trigger decoding entails using the trigger – the stimulus – for an encoded narrative message as the decoding key for undoing its camouflage or disguise. For example:

A male patient seeing a male psychologist in psychotherapy reports a dream of being examined by a male physician in front of a group of medical students. The doctor looks up at the students and announces that he's discovered evidence that the patient has syphilis. The patient tries to close the doctor's mouth so he'll stop talking.

Among the many possible meanings of this narrative, those that are relevant to and organized by the event that triggered these disguised themes are most pertinent to the patient's deep unconscious experiences and adaptive processing activities. In this case, the trigger was the therapist's request that the patient permit him to use his case material in a presentation that he was planning for his psychoanalytic society. The patient had agreed to the request and consciously stated that he felt pleased and flattered – little more. But in light of this trigger – which is a departure from the ideal, secured frame that guarantees the patient total privacy and confidentiality for his treatment experience – the dream trigger decodes as an indication that deep-unconsciously, the patient is experiencing the presentation as his therapist exposing his secrets to others. The syphilis encodes the fact that the patient is homosexual and is suffering from AIDS. The dream also decodes as indicating that while the patient consciously acceded to his therapist's request, deep-unconsciously he has the very opposite

wish – that the therapist not present his case and expose him and his secrets to others.

As can be seen, I have used the trigger to select the most likely meanings of the encoded dream and have transposed the themes in the dream into the therapy situation, thereby undoing their disguise. This process of decoding narrative themes in light of their unconsciously experienced triggers is distinctive to the adaptive approach and it accounts for its many unique findings and relevance to all emotion-related healing efforts – deep unconscious experiences affect all attempts at cure.

A clinical illustration

To illustrate the differences between the weak and strong adaptive approaches, let's consider the following psychotherapy session:

Mrs Hall, a depressed woman, begins the hour with her male therapist, Dr Benton, by talking about her fear of men. She ruminates a while and then decides that she must be afraid of men because all they want is to have sex with her. She recalls an incident in college when her psychology professor tried to seduce her during a visit to his office. When he got physical with her, she panicked and thought he was going to murder her. She reacted by pulling away from him and dropping the class. It was a disgusting, immoral thing for him to do.

Weak adaptive psychotherapists would propose a wide range of formulations based on the manifest contents of this material. In addition to simply addressing the evident surface messages, they would attempt to extract from these contents a variety of *unconscious implications* that pertain to the patient's behaviours, inner mental conflicts and state of mind. For example, the story could be seen to imply an undue, unconscious fear of men or as indicating that the client has unconsciously identified men in general with this seductive professor and therefore mistakenly mistrusts all men. Another reading of the story might lead to the proposal that the professor is a stand-in for the patient's father and that the incident with the professor represents a repressed, unconscious memory of seduction or harm at the hands of her parent. Projection of the patient's own repressed wishes to seduce men and/or of her murderous rage at them might also be considered, as might dysfunctional patterns of relating to or thinking about men. Also possible is the idea that the professor is a stand-in for the therapist and that, 'in the transference', the patient is entertaining the fantasy that he wants to seduce or murder her – a purported *unconscious*

misperception that might then be traced to a seductive experience that the patient had endured with her father in her childhood. On the other hand, the story might be thought of as a projection of the patient's own seductive and murderous wishes towards the therapist.

All of these formulations take the manifest contents of this material at face value and considers its themes in their own right. Adaptation is vaguely implied, but the main focus is on the inner mental world of the patient and how her thoughts, fantasies and behaviour patterns are disturbing her relationships with men. The search is made for possible meanings inherent to the tale; the main technique involves *extracting implications* from the surface story *per se* – that is, from the isolated narrative. No other information is needed. And there is, of course, a degree of logic and some likely elements of truth to these mind-centred, vaguely adaptive, arbitrarily extracted implications of this manifest tale. Why then is there a need for something more?

The answer lies with an event – *an adaptation-evoking, traumatic triggering event*, a trigger that is ignored in these formulations – something that happened in the therapy situation that calls for a very different line of reasoning and formulating. In escorting the patient into his consultation room, Dr Benton's arm inadvertently had brushed against Mrs Hall's arm.

While many therapists would think of this as an innocuous event, such an assessment reflects the naivety of, and proneness to the use of denial by, the conscious mind. Clinical observations made in the context of the strong adaptive approach indicate otherwise. A boundary violation of this kind, which is often disregarded consciously, is experienced deeply unconsciously as a highly traumatic intervention by the patient – and therapist as well. And the evidence that the patient had indeed unconsciously experienced and reacted to the physical contact with her therapist, which she ignored consciously, is found in *the encoded theme in the narrative images that bridges from the story to the trigger* – that of a professor who 'got physical' with her. This is how the deep unconscious system communicates with the conscious mind: by telling a story about someone else and some other event that is analogous and thematically similar to a disturbing event that has taken place elsewhere – for patients in psychotherapy, this other locale is almost always the treatment situation and the other person is the therapist.

It appears, then, that whatever her conscious intentions in telling this tale, Mrs Hall unconsciously chose to tell this story to convey her unconscious perceptions of the meanings of the physical contact that Dr Benton made with her arm. Thus, while the narrative reflects her

conscious attempt to understand her general problems with men, it also reflects her *unconscious* efforts to understand and adapt to the traumatic triggering event created by the therapist's lapse – the story is a two-tiered, two-meaning communication.

Once the trigger has been identified, it's no longer possible to be satisfied with mind-oriented, weak adaptive formulations of the story about the seductive professor. Instead, the unconscious meanings of the story must be formulated first and foremost in light of the trigger that evoked the recollection. But in order to do this, and to thereby discover the *encoded level of deep unconscious experience*, the therapist needs to have consciously noticed the physical contact with his patient and to have kept it in mind as he listened to her material. If the trigger goes unnoticed – as often is the case with disturbing interventional triggers – then weakly adaptive, intellectualized, intrapsychically-oriented but highly defensive formulations hold sway. But if the trigger is noticed – as it should be – then strong adaptive formulations are an utter necessity. The critical point is to appreciate that these manifest narratives contain two stories and two sets of messages – one consciously fashioned and stated directly, the other unconsciously honed, camouflaged or encoded, and indirectly stated.

To complete the picture, a strong adaptive psychotherapist would trigger-decode this narrative about the seductive mentor who made inappropriate physical contact with his student as conveying the patient's unconscious perception of her therapist's physical contact with her as being a seductive gesture on his part, and as something that was disgusting, immoral and murderously destructive. The incident was so damaging to the patient that she was thinking – again, quite unconsciously – of leaving treatment. All of this is logical and undistorted because the trigger, for which the therapist must bear full responsibility, is a violation of the ground rule that precludes physical contact between patients and their therapists. It is therefore correctly appraised deep-unconsciously by the patient, who has unconsciously chosen from among the many universal meanings of the event, those that are most relevant to her mental state and emotional history. *Selection rather than distortion* is the operative mechanism here.

Unconscious experience tends to be raw, undefended and very much to the point. For these reasons, the trigger-decoding of these manifest themes does not entail formulations that propose that the patient was making use of her imagination, engaged in expressing her fantasies or projections, or conveying disguised unconscious distortions or misperceptions of the therapist. Instead, the formulation is developed in terms

of valid unconscious perceptions, accurate readings of the actual meanings of the traumatic triggering event – meanings that the patient unconsciously and selectively experienced. Also included in this formulation are the patient's efforts to adapt to the incident by understanding its implications and responding accordingly. All of these cognitive processes took place outside of her awareness, as there is no sign of her conscious recognition of the physical contact with her therapist (nor was there any in the remainder of the session).

It's important to appreciate the extent to which the weak and strong adaptive interpretations of the *unconscious meanings* of this material are at odds with each other. These differences stem from the fact that weak adaptive approaches *extract implications from the story as such*, while the strong adaptive approach *decodes the themes of the story in light of their activating trigger*. In the first approach, the story is believed to be sufficiently revealing on its own that no additional information is needed. In the second approach, which is basically adaptive, the trigger for the story must be identified – without it, no active unconscious meaning can be assigned to the narrative. In addition, the various weak adaptive formulations of the patient's story are propositions about her inner mental psychopathology, while the strong adaptive formulation are propositions about her deep unconscious strengths. Put another way, one view reflects the belief that the material primarily reflects problems in the patient, while the other view sees the primary problem in the therapist and in his inadvertent boundary violation.

As for the genetic connections between this material and a likely seductive incident between the patient and her father, the weak adaptive position has it that the unconscious effects of the memory of that event prompts the patient to *mistakenly believe* that the counsellor is behaving seductively when he's not – the past is viewed as a source of present-day distortions. In contrast, the strong adaptive approach has it the other way around: the link to the past takes the form of an unconscious appreciation that the counsellor is *actually repeating* in some form the seductive behaviour of the patient's father – the past is actually being re-enacted in the present.

All in all, the weak adaptive line of thought is based on the premise that fantasy is stronger than reality, while the strong adaptive approach postulates (and has observed) that reality is stronger than fantasy. Furthermore, traumatic events do not fall to the wayside leaving the mind to fight its own battles – these events are as much a part of ongoing inner mental conflicts as the fantasies and memories that

they arouse. Residuals of traumatic events continue to be processed unconsciously – and more rarely consciously – for long periods of time, often for one’s entire life.

The following table summarizes the key differences between the weak and strong adaptive approaches:

	<i>Weak adaptive approaches</i>	<i>Strong adaptive approaches</i>
1	Emotional adaptation is a peripheral consideration	Emotional adaptation is the central thesis
2	Sees narratives and intellectualizations on an equal par	Distinguishes between intellectualizations and narratives
3	Extracts unconscious implications of manifest contents	Trigger-decodes narrative themes
4	Stresses fantasy and memory	Stresses unconscious perception
5	Focuses on the mind in isolation	Focuses on the mind as activated by traumatic events
6	Gives full credence to manifest contents and their implications	Acknowledges surface meanings, but works mainly by decoding encoded narratives
7	Models the ego, id and superego	Models the conscious and deep unconscious systems of the emotion-processing mind
8	Stresses individual differences	Stresses universals
9	Favours a subjective-relativistic view of reality	Favours an absolute view of reality
10	Unconscious realm ill-defined	Unconscious realm specifically defined
11	Accesses the superficial unconscious system of the conscious mind	Accesses the deep unconscious system of the emotion-processing mind
12	Focuses on relatively weak, intrapsychic issues: relating, interacting, imagining, fantasizing and remembering	Focuses on powerful environmental traumas such as illness, injury and death

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