Mental Health Resource and Education Network
MHREN, P. O. BOX 1082, Ashland, Oregon 97520 www.mhren.org

Winter 2007 Newsletter

New Year's Greetings to MHREN members and colleagues!

The winter newsletter is always exciting because we announce our lineup of workshops for the coming year. The slate we have prepared for you in 2007 is certainly our most ambitious and far-reaching in terms of the international caliber of the presenters and the variety of places from which they will be traveling (Boston, Seattle, San Francisco, Portland and Boulder) for these exclusive engagements. Please review our enclosed 2007 schedule and register early because all of these trainings are likely to fill up.

We also want to remind you that MHREN memberships are renewable each calendar year. Your continued and record-breaking levels of support have made these advanced level workshops of 2007 financially possible. As we keep this organization active and healthy, we guarantee that we will have quality trainings in our own backyard. You may renew or begin your membership by filling out the form on page 7.

Everyone on our mailing list will receive the 2007 Therapist Referral Book in January. If you know of doctors' offices, agencies, organizations that would like to have a copy, have them contact info@mhren.org

MHREN-sponsored Coming Attractions

February 2 - Collaborative Couple Counseling: Turning Arguments into Intimate Conversations
Daniel Wile, Ph.D., offers a one-day training on his work with couples developed over his 30 years in practice. He is the author of several books on the subject and is considered one of the top couple therapists in the nation. Marital researcher Dr. John Gottman considers Daniel Wile "a genius and the best living marital therapist." Please see the interview and enclosed flier. You may visit Dr. Wile's website at www.danwile.com

March 9- Modes of Therapeutic Action: Knowledge, Experience and Relationship
Martha Stark, M.D., Clinical Instructor in Psychiatry at Harvard Medical School comes to Medford for a special engagement to present her synthesis of therapeutic modes of action. She is a dynamic presenter and uses case examples and process recordings to demonstrate therapeutic change at work in a session and how the therapeutic influences and monitors what is occurring at any given moment. Her books have been highly acclaimed. Please see the interview and flier enclosed in newsletter.

June 1 – Trauma and the Body: The Theory and Practice of Sensorimotor Psychotherapy
Pat Ogden, Ph.D., leading expert in body-oriented psychotherapy, will present a workshop on integrating cognitive and somatic interventions in the treatment of trauma with an emphasis on body awareness. Her presentation will address interventions for all three phases of the phase-oriented treatment approach: stabilization and symptom reduction, work with traumatic memory, and re-integration.

Sept 28 - Clinical Approaches to Chronic Self-Injury, Self-Mutilation, and Self-Harm Syndromes
With David Calof, D.A.P.A. More information in the March newsletter

November 2 - Group Therapy: Process, Structure and Ethical Considerations
With Matt Modrcin, Ph.D., LCSW. More information in the March newsletter

Groups, Workshops, and Announcements

If you would like your announcement to be listed next time, please email information to info@mhren.org

Workshops and Classes:

The Soul's Orientation: Using the Enneagram to Know Oneself
The Enneagram combines ancient spiritual wisdom with modern psychological understanding to map out 9 different personality and motivational styles. This Foundational Training is an in depth study of the 9 points and the instinctual subtypes over a 3 year period. This ongoing training combines spiritual practice with psychological understanding with a focus on the belly, heart and mind centers. Taught by **ZM Suzanna Nadler, M.Ed., LPC & Rod Birney, MD, Dipl. ABPN 2007 Workshop: January 19-21, March 16-18, May 18-20**. Cost: $195. For info & registration please contact: Self & Soul Center 541.535.3338 or www.selfsoulcenter.org

Are you interested in hypnotherapy?
Ashland School of Hypnotherapy offers a 20 hour Introduction to Hypnotherapy for therapists, as well as a 10 hour Hypnotherapy for Health and Healing at Triune in Medford, and a 200 hour Professional Certification Training. All courses are eligible for CEUs for counselors, and offer national certification as a hypnotherapist with the National Board of Certified Clinical Hypnotherapists and the American Council of Certified Hypnotist Examiners. 541-488-3180. www.ashlandschoolofhypnotherapy.com.

Announcements:

Practice Management – Averill Consulting specializes in Practice Management for Mental Health Professionals. **We're offering a FREE one-hour consultation for MHREN members through February 2006 for new clients.** Don't settle with ordinary when you can experience the extraordinary practice! We can assist you in all of your Practice Management needs such as: Operational Development, Practice Analysis, Staff Training, Business Development, Hiring Assistance, Procedure Analysis & Creation, and much more. Averill Consulting is owned and operated by **Jessica Averill**. For more information, see www.purposedrivenpractice.com. Contact us today at (541) 261-9194 phone, (866) 862-0445 fax, or via e-mail at info@purposedrivenpractice.com.

Southern Oregon Child Study and Treatment Center has a full time job opening for a **Day Treatment therapist** in Ashland and a 20-hour position for a **School-based counselor** at Phoenix Elementary School. Contact **Leslie Kurlan, LCSW** at 482-5792.

Life Review services now being offered in my counseling practice. Life Review is a way for older adults to tell their life story, understand the meaning their lives have had and to pass on their history and values to their family. Sessions are videotaped and clients given a DVD to take home and share. **Carolyn Potts Metzker**, LPC 488-7957.

Looking to share Medford office - Looking to share one day (or part of a day) a week. Also willing to consider a swap, one day in my Ashland office for one day in your Medford office. Month to month lease. **Carolyn Potts Metzker, LPC** 488-7957

Roxanne Rae, LCSW, BCD is opening her clinical practice in Ashland. She specializes in the use of Sand Tray/Sandplay and other non-verbal techniques. Beginning in 2007, Roxanne will be offering a variety of workshops for C.E.U.s. Consultation is also available. She will continue to provide personal growth sessions. Inquiries: 541-292-9277 or roxannerae.com

Office available for part-time use in our pediatrics office at Ashland Pediatrics (251 Maple Street). Clinical psychologist Dr. Marilyn Thatcher will begin using it Jan 1st, but does not need it full time and would be willing to share the space if needed. Contact Debra Koutnik, M.D. at 482 8114 or koutnik@bisp.net

Groups:

We have two openings in our **Peer Supervision Group**. Issues addressed will be relevant to counselors and psychotherapists working with people recovering from the various disorders including: chemical and other dependencies, mental health disorders, and dual disorders. You'll discover that being in an active group of your peers will be an expansive and rewarding experience — in a word, *empowerment.* We'll provide you with emotional and psychological support, while exploring transference and countertransference dynamics, and personal and interpersonal styles of relating. And we do this in an atmosphere of trust, respect and camaraderie. The group meets on the 2nd and 4th Monday evenings, from 6:30 to 8:30pm. The current commitment will be for 6 months, from January 8 thru June 26, 2007. The fee for these 12 two-hour sessions is $420.00, with a pre-payment discount of $35.00 if paid on or before the second meeting; or pay $70.00 monthly. Insurance coverage will not apply. To join, or if you have questions contact **Joe Atkin**, (535.8885), e-mail (joeatkin@charter.net) or fax (535.8883).

Relapse Prevention education/process group
Addressing issues relevant to identifying and intervening on warning signs and symptoms leading to relapse of addictive behaviors. Group members will gain an understanding of relapse dynamics and develop a working relapse prevention plan. Meeting dates and times TBA. Contact **Cynthia Becker White CADCII** at the Counseling and Mediation Center (541) 776-9166, email cbeckerwhite@charter.net

Mixed Gender Process/Support Groups – A here and now group process working towards changing patterns that limit growth. We explore personal sensitivities, issues that are relevant to emotional and social well being, and self-empowerment. Issues may include depression, anxiety, compulsiveness, personality, relationships, intimacy, communication, assertiveness, stress and stress reduction.
Evening group is held on the 1st and 3rd Mondays monthly from 6:30 to 8:30 pm.
This group is open to new members in January 2007. **Afternoon group for the folks who work a swing shift is held on the 2nd and 4th Wednesdays monthly from 12 to 2 pm**.
If you are interested in joining a group or referring someone please contact **Cynthia Becker White** at (541) 776-9166 or email cbeckerwhite@charter.net

Legislative Action in Salem Affecting Therapists

Representative Peter Buckley Hears Us And Cares

By Mary Lou Brophy

About 30 therapists/counselors met with State Representative Peter Buckley on November 9 to provide input on CONSUMER MENTAL HEALTH LEGISLATION. Rep. Buckley is eager to get the draft to the legislative counsel for legal review prior to the beginning of the session, which begins in Salem on January 8, 2007, and was most grateful to the attendees for their comments and questions. One participant, Bryan Nilsen, drove from Eugene and will coordinate efforts in Lane County to pass this legislation.

Mary Lou Brophy, LPC, who authored the original "Consumer Protection and Consumer Choice" preparatory document for this legislation, facilitated the meeting. Gary Woodring, LMFT, and Jeff Borchers, Ph.D., both spoke of the history and rationale for furthering this legislation. Each continues to review and give input to the crafting of legislation. Julia Cooley, Executive Director of the Board of Licensed Professional Counselors, arrived late but was able to end the meeting by sharing some of her expertise.

Republican State Representative Sal Esquivel, who is very supportive of this legislation, had planned to attend but was called to Salem for organizational meetings, as were State Rep. Dennis Richardson and his staff.

To succeed in the protection of our clients or consumers of mental health services and to assure their right to choose the licensed psychotherapist of their choice, all of us will need to engage in action to get this legislation passed. If you want a copy of the "Action Steps" from the meeting, or have questions or comments, call Gary Woodring (541) 535-8542 or Mary Lou Brophy (541) 621-7390.

INTERVIEW WITH MARTHA STARK, M.D.

With Paul Giancarlo, LCSW

PG: First of all, I just want to say that we are really pleased to have you coming on March 9th.

MS: Oh, thank you. I am very excited about the prospect of being there. I'm really looking forward to it.

PG: *I was wondering if you would give us a background of your past, as far as becoming a psychiatrist, author, and teacher? It is probably a long road, but maybe a brief history?*

MS: Ok, a brief something? Well, I went to Harvard College undergrad and majored in mathematics, at that point thinking that I wanted to become a mathematician. Then near the end realized I am a very efficient kind of person and if I were to do mathematics, which I love, it would be so much removed from my life, at least as I was living it. So it seemed that maybe being a psychiatrist or working with people—that would enrich my life more and then living would enrich my life as a psychiatrist. Then if I were to become a psychoanalyst, I could then combine my left and right brain and work with people, but also get back to the analytic thinking that I loved in higher mathematics. So I decided to become pre-med, did that, went on to Harvard Medical School.

Anyway, so then I went on to do my psychiatric residency in adult work and then went on to do a 2-year child fellowship, as my adult psychiatry was done at the Cambridge Hospital, here in Massachusetts, and then I went on to Mass Mental Health Center, which is a another very fine public hospital, where I did my 2-year child fellowship. So, I came out then as an adult and child psychiatrist, then I went on to do my psychoanalytic training at the Boston Psychoanalytic Institute, which has an 8 or 10-year program and I got through that.

PG: *Congratulations!*

MS: Why, thank you, thank you. During my end of medical school, residency, and fellowship, I was in intensive psychotherapy with a female social worker whom I saw 3 times a week for 8+ years and then as part of my analytic training I needed to be in a training analysis with an analyst, so I chose then to be-- it ended up being about 4 years, not terribly long--, but 4 years, 4 times a week with a male MD psychoanalyst, and that was training analysis.

PG: *Boy, that's a long road.*

MS: It is a long road. I now have my office in my home but have stayed affiliated with the Harvard Medical School. I have been at Mass Mental Health Center, sort of stayed on there. I am teaching and very much involved in their continuing education department, and teaching on Cape Cod and at Esalen.

I have always done a great deal with supervising and love doing that, and I actually from early on, I used to be a psychopharmacology backup. That got me into doing consultations, working with patients stuck in their treatment. I would say, every year I do probably 50 or 100 consultations.

PG: *So, you are doing private practice, teaching, consulting and supervising primarily, and also writing.*

MS: Based on the consultations, I came to be interested in resistance--those forces within patients that get in the way of them moving forward in their lives. So then I wrote my psychoanalytic textbooks, 2 of them on resistance and then one on modes of therapeutic action. I do my teaching at the different psychoanalytic institutes and I do a lot of grand rounds at different teaching hospitals. I travel quite a bit to teach.

PG *You mentioned your book, <u>Modes of Therapeutic Action</u>, and that is one I am somewhat familiar with. You do such a wonderful job of synthesizing the essential ways that you can understand what is happening in the therapeutic relationship, and you talk about the 3 models, and I know this is going to be the focus of your Medford workshop. I am wondering if you could just give a short preview or synopsis to our readers so they have an idea of what to expect if they do attend.*

MS: Ok, it arose out of just extensive reading and just thinking about what is it really that gets people better? In the literature they talk a lot about the more "maternal" function on the one hand, which is more from corrective experience versus the more "paternal" on the other hand, (a little sexist the way it's described in the literature) meaning a little more intellectual insight and so on and so forth. I thought rather than the two-pronged approach, that it made more sense to me in terms of the three-pronged approach. Ultimately it took years to come up with these words in my classes that I taught and talking with my colleagues and my supervisees. I came up with the idea of Model 1 being more the classical psychology model, which is enhancement of knowledge within and so that is the insight model; Model 2 being provision of experience. The first one is a one-person model, Model 2 is a 1-1/2-person model, where the half-person is the therapist, the best person the therapist can be. The therapist beings herself as a good object, and as a good mother, as an empathic self object, the best of herself, so we will call that half—into the room with the

patient, a whole, so there is some form of correction provision or deficiency compensation. Model 2 is more about positive transference. It is about positive transference then disrupted. In other words, dis-illusionment, which if worked through provides the impetus for structural growth and the adding of do-good. Model 2 is a deficit model and it is about structural deficit or absence of good, or impaired capacity to be a good parent onto oneself. The therapist then participates as a good parent, as a good object; that is good, but then in those moments when there is the inevitable empathic failure, the therapist does not deliver, it is the work through of that rupture, that disillusionment, that provides the impetus for internalizing the good that had been there prior to the failure. And those externalized functions will become internal structure that enables the person to have capacity where they had deficit. So it is the filling in of deficit, it is a corrective provision model. It is the provision of experience for and working through disruptive positive transference.

PG: *Providing a new experience that they can carry with them after therapy.*

MS: That is right, by way of working through the disappointment that inevitably follows. Exactly. As in Model 3, it is the more contemporary relational prospective. So Model 2 is more self-psychology and those object relation theories that, like self-psychology, focus in on the good that did not happen--the absence of good. Model 3 is more about the bad that did happen, i.e., the internalized trauma, the contemporary relational perspective. It is about internal presence of bad and it is about engagement in relationship with. So, this would be a 2-person psychology and is about 2 authentic subjects in relationship and engaged, and going at it--so, at the intimate edge, and negotiating at that intimate edge, and working that stuff through. Whereas Model 2 is about positive transference and then positive transference disrupted, Model 3 is more about negative transference, where the patient experiences their world through the filters of these internal bad objects or these pathogenic introjects. This is presence of bad that they got inside of them because of traumatic interactions early on, a single one or the cumulative impact over time of bad. That gets internalized in the form of these paired internal bad objects, one or the other pole of which can be projected onto the therapist. When the patient acts in such a fashion as to get the therapist to accept the projection, which makes it then a projective identification, we talk about mutual enactment. We talk about the two of them now as authentic subjects in negotiating at the intimate edge, trying to get a better resolution this time than the earlier traumatic failure situations had been. So the patient, under the sway of repetition compulsion re-creates in the here and now, the early-on traumatic failure situation in the hopes that this time there will be a better outcome.

PG: *And in this model, Model 3, the therapist or analyst is bringing herself to the relationship in an authentic way by talking about her own counter-transferential experiences or her own feelings in the moment, a here-and-now kind of approach.*

MS: That is exactly right but with a slight little refinement. The therapist uses herself but I would want to say I make a distinction in my own mind, and as I teach it, between what I think of the therapist as being sort of moment-by-moment positioned in a certain way in relation to the client. As the therapist or the analyst (or the psychodynamically oriented therapist) there is both afferent and efferent (terms derived from neurology) information coming to the therapist and then some leaving the therapist. So the therapist listens and comes to understand and comes to know by way of being present in the moment and using herself to come to a better understanding of what might well be going on in the client and in the relationship between the two of them. She uses herself and uses her counter-transference to understand. She has not necessarily said anything yet. So half of it is about afferent (what comes to her) and the other would have to do with efferent (how she then intervenes) and what she then does with what she has come to know. She might well then, indeed, as you suggested, share some aspect of her own experience of being in the room here and now with the client in the hopes that that will enable the two of them to get to the deeper and better connection or understanding about relational dynamics that both, especially the patient, are playing out.

PG: *That helps. I also wonder if the information that the therapist is receiving and feeling within herself would be the determining factor as to which model with which to intervene, Model 1, Model 2, or Model 3.*

MS: That is a very nice way to put it. Yeah, I like that. That's right. That what she comes to know is on three levels. One, she steps away from the interactive field in Model 1 and "strokes her beard," and is an objective sort of neutral object, observing and noting with her observing ego. In Model 2, she is an empathic selfobject, decenters from her subjectivity and her objectivity and joins alongside the client and entering the client's experience, taking it all in as if it were her own, but it never really becomes her own. So she comes to know all sorts of stuff by assuming a position alongside the client. Then in Model 3 she takes on the client's experience as her own, using the counter-transference now in a relational sense to come to understand deeply important stuff about the patient's internal and relational dynamics.

PG: *It is such an elegant way of synthesizing all the different phases that the client might be in when in therapy and I was curious if*

the three models of therapeutic action roughly correspond to a particular stage of therapy.

MS: I would say no. That is the question most often asked. It occurs to me that I probably – should have made my book a little clearer about that and I will make sure I am clear about that when I teach it. I believe, though, you could say you have got your Model 2 to get the client comfortable and relaxed-- in your Model 1 you do some interpretive stuff and, finally you can negotiate at the intimate edge in Model 3. Oh, the other question that goes along with that is, "Are there certain diagnoses that you tend to do certain models with?" To some extent there is a little truth in that but it is only a moment-by-moment thing.

PG: I do want to say that you did talk about that in your book, how it is a fluid process. It is not a staged process, in the sense of sequentially or chronologically. It is an active weaving of three approaches throughout the therapy. There was a question that came up for me, whether there was a particular leaning toward one or the other, but that clarifies that.

I have lots of questions, but I know we have limited time. One of them is about how you teach this stuff. Before we go to that, I was just so curious about the idea of relentless hope. That is your upcoming book, Relentless Hope: Failure to Grieve, I believe. You talk about relentless hope, or how we can hold onto the expectation or wish for someone to change or become whom we need them to be. In doing so we continue to bring ourselves suffering. If I understand you correctly, your belief is that if we can comes to terms with the grief of not getting what we wanted and accepting that we never will get it from that person, that we can become free to begin to see a person for who they really are and then participate in more authentic relationships.

MS: Let me just say that it is so perfect I have nothing further to add. That is absolutely exactly perfectly it.

PG: So, would you say that this is one of the essential tasks of a successful therapeutic process?

MS: That is interesting. I think that I would have put it this way: I do not, myself, tend—the way my mind works, because I am such an integrative thinker, I do not tend to say anything necessarily will happen. Now with that proviso, quite frankly, deep in my heart, I have found that in almost every single really good therapeutic experience that I have tried to facilitate, that *did* happen. So, I am kind of playing with words a little bit, but I do not quite feel I want to say it has got to happen, I would say quite frankly it probably just about has to happen.

PG: Right, well there are a lot of other things that happen around it, but it seems like at the core that is what I have found. It is so freeing to be able to not have to walk around with all these projections and expectations on people and to be able to just accept who they are. You end up having better relationships.

MS: Yes, yes, yes. I was going to add one word. Projections *and* displacements. I have a big thing about that.

PG: Yes, talk to us about that.

MS: Well, displacement feels to me more like—and this is something that, quite frankly, in the literature has not been carefully explained. People forget about displacement. Displacement is like—I think that is what gives rise to positive transference. Sort of "love me and only me," you know, some oedipal stuff, and then I get into my analysis and guess what, I wanted my analysts to love me and only me. The name of that transference, while I was thinking and hoping that maybe my analyst did--a positive transference because I was feeling good about it and feeling kind of charged--but the way that I got that need delivered into my relationship with my analyst was by way of displacement, where the target shifts but nothing was projected. My need is inside of me. I used to experience it in relation to my daddy and then I displaced the target and then I needed it in relation to my analyst. So that is displacement, it is positive transference. Where I used to need my mommy to mirror my grandness when I was a little one and had healthy developmental narcissism as a little girl, and to the extent that was not fully worked through, etc., etc., as an adult I went into my analysis and wanted my analyst to mirror my grandness. That is displacement--it is not projection.

PG: So, is displacement the same as transference?

MS: It is the same as positive transference. Negative transference is more about projection. Let's say I was criticized. The cumulative impact of traumatic criticism as a kid—I internalize the presence of the bad, criticiz-*er*—criticiz-*ee* as my introjective pair. I then project one or the other of those poles off the analyst and then play that out with my analyst and that is projection, projective identification, and negative transference. So, transference can involve displacement or projection, or both.

PG: Well, that is good, that helps clarify that.

MS: So with relentless hope, I walk around and have all these filters that I experience my objects through- either I am busy needing them to be a certain something by way of displacement, or I am busy needing them to be something else by way of projection. That is just a little point there—because I think the way we work through positive transference disrupted is very different than the way we work through negative transference. I think that positive transference disrupted, which is more the province of Model 2, as you know and as I said earlier as well, is more about the grieving; i.e., the experience of good become bad and grieving that. Model 3 is more about the experience of

bad become good and so having a new – by way of negotiating the intimate edge, having a different outcome this time. It is not as specifically about grieving as it is about having the experience of old bad. Then the therapist blends aspects of her own capacity and ability to the processing of negative-charged topics, and her ability to de-toxify it such that what then gets re-introjected by the client is slightly detoxified, modified. By way of these ongoing projections, introjections, and this and that, you gradually detoxify the internal presence of bad. Though grieving may well be involved, it is not as much specifically about grieving.

PG: What you are talking about seems so complex to me that I look forward to reading this interview so I can study it a little bit!

MS: Let me just say, and this is totally true— When I listen to people and I feel their energy, and I feel their receptivity or not, it draws out certain things in me. I feel from you such openness, and you so clearly, so absolutely mastered so much of what I believe and write about, and will be teaching. That is such a thrill for me that it stimulated me to be more articulate.

PG: Thank you for that.

MS: This is co-created. What I said to you, the way I said it to you- I have never quite said it this way.

PG: It is synergy—co-creation. Essentially, that is what you have talked about too, that the therapeutic process is a co-creation and it is never going to be the same with any two people.

MS: Thank you, that is right. Furthermore, what I say to my patients, I do not ever, every want to have a patient say to me either—I knew you would say that, or yeah, yeah, that could be but I do not really feel it as such. You know, you should never be so glib or you are getting predictable and are not fresh and in the moment.

PG: Martha, would you just say a little bit about the workshop the last minute or two—What kind of format you have. I know that you are going to use some vignettes. Do you use videotapes? How do you do your daylong workshops?

MS: I don't use videotapes. If I needed to, which I won't need to—but if I needed to I could stand up there and simply—but this is not the way I will be doing it—I could stand up there and teach for 40 hours straight.

PG: I'll bet.

MS: That is not what I am going to be doing, but I could if I needed to. I will be there for 6 hours. I will have a lot of material prepared that will be a distillate of the essence of what I see as being the therapeutic action and what is involved in our helping our clients to get better. I will elaborate on the three different models. I will use also little vignettes, and also little clinical pearls I hope, little hot tips. I will present at greater length more extended sort of vignettes, demonstrating the three different models. If there seems to be the desire, I am willing to suggest and review some sort of prototypical interventions that can be used for different situations, like in working with a patient's narcissistic entitlement or their hope, or statements that facilitate the grieving, or use of the self Model 3 statements that are efforts to share selectively aspects of your own experience to advance the therapeutic endeavor. I am very open to questions from people. I will probably want to have the first part of the day be a little more my input, but if questions are particularly relevant to what I am saying at the moment, I will be open to those. In the afternoon, I will be open to brief little vignettes, if people want to present that, or I will present my own, or if people will leap out of chairs asking questions. That is fine.

Basically, I am going to be very responsive to what people seem to be interested in and in the afternoon I will probably talk a little bit more about the relentless hope. People just love that. That is meant to be relevant to all of us in our own work as therapists, as clients, in our relationships with our loved ones. It is meant to be, and it is. It's a continuum and we all have it. When you are caught up in needing and wanting both other people in our world and ourselves to be a certain way, we are confining ourselves to chronic frustration, disappointment, and heartache, because the world will never be all of what we would have wanted it to be. I have a new piece here about relentless hope that has to do with when it gets played out not just in relationships but internally, where you have cycles of self-indulgence, alternating with self-destructive and self-sabotage.

PG: Yes, I can also see it playing out in terms of the broader culture and the broader global situation to play out in that way as well, so the whole circle.

So, Martha, we need to go. I just want to thank you so much for taking the time to do this. It feels like it has been an education in and of itself, and I really look forward to March in meeting you and spending more time with you.

MS: Well, thank you so much. It has absolutely been my pleasure.

Note: Martha Stark, M.D. will be in Medford on Friday, March 9th. See enclosed flier. Her three books, Working with Resistance, A Primer on Working with Resistance, and Modes of Therapeutic Action have earned the top rating of 5 stars on amazon.com

The following two pieces were written by **Daniel Wile, Ph.D**. who will present a MHREN workshop on his Collaborative Couple Therapy on February 2, 2007. The first piece contains excerpts from a chapter he wrote in the textbook *Clinical Handbook of Couple Therapy* 3rd *Edition.* To read the entire chapter, go to http://danwile.com/2002chapter_final.doc

COLLABORATIVE COUPLE THERAPY

Collaborative couple therapy (CCT) focuses on the intrinsic difficulty of being in a relationship: the inevitability of slipping repeatedly into withdrawn and adversarial cycles. How partners cope with these cycles determines the quality of life in the relationship and, indeed, whether the relationship lasts. Gottman (1999) can watch newlyweds discuss a disagreement for 3 minutes and predict whether they will stay together. What he is observing is how they relate when in an adversarial cycle.

In CCT, the therapist shows the partners how, by discovering and confiding the "leading-edge" thought or feeling of the moment, they can shift out of their withdrawn or adversarial cycle and into a collaborative one. The goal is to increase their ability to make such a shift themselves.

A defining feature of this approach is an appreciation of how, as therapists, we grapple with the same problems the partners do: being pulled into adversarial states, where we lose the ability to appreciate each partner's point of view, and into withdrawn states, where we lose the ability to engage at all. Partners become dysfunctional, and we, their therapists, do so too. In the course of a session, we keep losing and regaining our ability to do therapy.

CCT is "collaborative" both in the stance the therapist tries to adopt toward the partners and the relationship the therapist tries to establish between them. CCT emerges out of the realization that the inner atmosphere of a relationship is continually changing, and that it is possible at any moment to capture an intimacy intrinsic to that moment and to create a collaborative (empathic) cycle. The terms "collaborative cycle" and "empathic cycle" are used interchangeably, since each term highlights an important aspect of the idea.

A relationship is essentially a shifting among empathic, withdrawn, and adversarial cycles (Wile, 1999). Partners are either confiding what is on their minds, which means that they are in an empathic (collaborative) cycle, or they are not confiding, which means that they are in a withdrawn cycle, unless there is blaming going on, in which case they are in an adversarial cycle. Every couple spends time in each of these three cycles, although couples differ in the time spent in each and the form each takes. For some couples, being in an adversarial cycle means an out-and-out battle; for others, it may be a simple exchange of looks.

CCT results from replacing resistance (and defensiveness) with loss of voice as the core psychodynamic concept. My viewing this client as defensive says more about me – about my frame of mind and the angle at which I am looking at things at the moment – than it does about her. It is my clue that I am out of position to do therapy: I am reacting to her behavior rather than seeing through to the inner struggle. I have stopped too soon in the causal chain. I am thinking, "She's defensive; that's the problem. She's a defensive person." Were I to continue to the next step in the causal chain, I would think, "She is defensive because of the threat she feels – which is what I need to be focusing on."

The crucial problem from a CCT point of view is not the one the partners are arguing over, but their inability to recruit each other as resources in dealing with it. To me, that is the real problem – how partners relate to each other about the issue at hand. It is how partners relate about whatever is going on that creates the inner atmosphere and quality of life within the relationship.

It is an advantage not to have to solve the couple's problems, since many of these problems are unsolvable (Gottman, 1999; Jacobson & Christensen, 1996; Wile, 1981). Gottman calls them "perpetual problems." Every couple has their own set of perpetual problems that they are going to be wrestling with

throughout the relationship. The goal is to build the relationship out of the manner in which they relate to each other about these problems, turning moment-to-moment manifestations of them into moments of intimacy. To the extent that partners are able to recruit each other as resources, they will find themselves automatically coming up with whatever concrete solutions and compromises are possible.

Is such "solving the moment" rather than "solving the problem" possible with partners with character pathology, such as those diagnosed with narcissistic or borderline personality disorder? The challenge with such people, as it is with everyone else, is for the therapist to make the shift from disapproval to empathy – from viewing such people from an adversarial perspective to viewing them from an empathic one. I ask myself, "What is this person experiencing? What is the inner struggle that, were she able to confide it, would get me, the partner, and the person herself all on her side?"

The CCT idea of "inner struggle" is similar to the cognitive therapy idea of "self-talk" and the narrative therapy idea of "self conversation." All are ways of referring to the ongoing conversation or debate that people hold with themselves. They engage in such inner conversation even if they are unaware of it, just as people dream each night even if they cannot remember doing so. This inner struggle, self-talk, or self-conversation is the plane on which life is experienced. It is the immediate "who I am" that the intimate moment needs to be about.

CCT emerges out of the recognition that at any given moment there is something a partner can say, and a conversation the couple can have, that can reassemble the relationship on a higher level and create a collaborative cycle. Therapists who think in these terms will find themselves automatically trying to come up with this conversation.

OPENING UP A SECOND LEVEL IN THE RELATIONSHIP

(Originally published in the *Los Angeles Psychologist*, a publication of the Los Angeles County Psychological Association, Nov/Dec 2000 By Daniel Wile)

A relationship is like the weather -- continuously changing. At any moment, you can confide your concerns and turn your partner into an ally, avoid them and turn your partner into a stranger, or attack and turn your partner into an enemy. You'd be turning your partner into an ally were you to say, "I've been feeling lonely all day at work." You'd be turning your partner into an enemy were you to say, instead, "You'd never think to call me, would you?" You'd be turning your partner into a stranger were you to say nothing about what you're feeling and ask, simply, "Anything good on TV tonight?"

What you want to do, of course, is to turn your partner into an ally -- and just keep him or her there. But let's say your partner (you're a wife talking to her husband) is taking too long to get to the point, you're finding yourself getting impatient, and you can't think of how to tell him that without hurting his feelings, starting a fight, and ruining the evening? So, you keep your mouth shut, but that turns him into a stranger, and a still-nattering one at that. Eventually you blurt out, "Can you get to the point some time in this century!" which turns him into an enemy, hurts his feelings, starts a fight, and ruins the evening. There was relief in getting that out, but you were surprised yourself at how harsh it sounded.

The quality of life in the relationship depends on how you deal with this enemy (or stranger) you repeatedly turn your partner into. What you'd like to be able to do is immediately turn him into an ally, by telling him, "I can't believe I said that," or "I think I just crossed the line, or "I'm shocked myself at how harshly that came out," or "There was a point I was trying to make but I don't think that was the way to do it." You'd be taking him into your confidence about your distress over what you just said. You'd be turning him into an ally in the manner by which you'd be acknowledging having just turned him into an enemy. You'd be opening up a second level in the relationship.

This is the capability I want to talk about here -- the capability of solving the problem you just created by re-assembling the relationship on the next higher level. You'd be creating a second tier in the relationship, an observation post, a process relationship, a joint platform, an observing couple ego.

Unfortunately, it's hard to imagine anyone having the presence of mind to come up with such a perfect conciliatory gesture. To start with, you don't feel conciliatory. You're angry at him. Later, in the shower, you're

still angry. You tell yourself: "What a bore he is. And if he knew me at all -- and he *should* after all these years -- he'd know I'm the last person on earth to care about all those details." But, having gotten that out of your system, you're calm enough to think, "He really did look stricken when I snapped at him like that. Poor guy!" And who says I'm so easy to live with? In fact, I've got the opposite problem. I worry so about boring people that I don't give them enough information to know what I'm feeling. Who's to say which is worse?"

You stepped into the shower commiserating with yourself; you stepped out of it commiserating with him -- which puts you in position to turn him into an ally. You go to him and say, "I feel bad about snapping at you earlier." You hope he'll say, "Well, I appreciate your saying that." But no such luck. "Yes," he says, "why do you always have to do that!?!" This immediately makes you sorry you said anything at all. You're obviously his enemy now, which makes you want to return the favor. You open your mouth to tell him, "Here, I'm trying to be an adult and what do you do: you use it against me. You're acting like a baby. The hell with you!"

But before you can get that you, you tell yourself, "Of course, my original comment was pretty harsh -- *I* was acting like a baby -- so I can't expect him to come around right away. He needs a little time to get over it. His rejecting of your peace offering turned you into his enemy; your inner re-analysis of it turned you back into his ally. You tell him, "Yes, well, I'm not *proud* of it." Your soft response when he was expecting another retaliatory sally -- he was actually wincing in anticipation of it -- completely turns him around. He says, "Well, I'm not proud of taking so long to get to the point. I know I do that a lot -- sort of get lost in minor details -- in fact I've been doing that with people all day and no one's been listening to me." He's looking at things from your point of view in response to your having just done so from his. He's sympathizing with you for having a partner who doesn't get to the point, in response to your having just sympathized with him for having one who snaps at you when you don't. The two of you are standing back looking at your earlier fight, but now each of you is viewing the other person's position compassionately. This is the definition of shifting to the second level.

What everyone wants to do, of course, is to make such a compassionate second level an increasingly more prominent part of the relationship. Every couple has its own set of unsolvable problems that they'll be grappling with throughout the relationship. Establishing such a second level is an ideal grappling tool.

The difficult-to-achieve goal, although you hope over the years to approximate it, is to turn the unsolvable problems (e.g., your getting impatient when your partner takes too long to get to the point), as well as any moment-to-moment problems, into usable clues for navigating the relationship. Imagine being able to tell your partner, "I hate to tell you this, but I'm starting to tap my foot," and -- here's the important part -- *knowing* that he will welcome your saying it. You'll know he'll see you as making a contribution to the relationship, as rescuing the two of you from the morale-sapping exchange in which you are pretending to be interested and he is pretending not to notice that you aren't -- which, when one of you stops pretending, will lead to a fight.

Imagine further his telling you -- which he very well might do, since he'd be taking what you said as information rather than as criticism -- "Yes, I didn't realize it until what you just said, but something's troubling me that I've been circling around because I don't know what it is." You, then, are able to say, "Well, maybe it's what you just said: that no one's been listening to you all day?" You'd have avoided becoming part of the problem -- another person who wasn't listening to him -- and, instead, had become part of the solution: someone who finally *was*. You would have turned this ongoing issue in the relationship -- this unsolvable problem -- into an opportunity for intimacy.

Here is the theory of relationships implied in this example:

1. You repeatedly find yourself in the unmanageable situation of having feelings about your partner that, if you express them, lead to one set of problems, and, if you don't express them, lead to another.
2. A good way to deal with this unmanageable situation is to open up a second level in the relationship. But you can do so only when you find yourself looking at things from your partner's point of view. Everything depends on how you feel when you get out of the shower.
3. Even then, you can't expect your partner to come around right away. Much depends on how well the conversation you have with yourself guides you through the shoals of the one you have with your partner.
4. The ultimate goal is to turn the problems of the relationship into opportunities for intimacy.

Daniel Wile will present a MHREN workshop in Medford on February 2, 2007 at the Smullin Center. Please see the flier enclosed.

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