Text of the Question and Answer Portion of the Webinar Sponsored by the Intrapsychic Humanism Society

October 16, 2021[1]

This is the William J. Pieper memorial lecture.

It is fitting that it is I who is giving the William J. Pieper memorial lecture, since William Pieper was my co-author and husband. He was passionate about ideas and would have loved nothing more than to be here with me to answer these questions. He also loved his clinical work and approached it with utter commitment and dedication. Neither he nor I could have developed Intrapsychic Humanism alone – it was a meeting of the minds that brimmed with excitement and creativity and, finally, fulfillment. I can only imagine the satisfaction he would take from this gathering and your interest in learning more about the theory of Intrapsychic Humanism.

Introduction: A few key ideas from Intrapsychic Humanism that will be referred to when I answer questions.

1. Intrapsychic Consciousness

[1] The On Demand Webinar will be available on the Intrapsychic Humanism website (www.intrapsychichumanism.org). For professionals 3 CE's and CEU's will be offered for the 3 hour webinar, which will include the in-depth clinical consultation. For non-professionals, the video of the question and answer period will be available but not the in-depth clinical consultation.

i) Intrapsychic consciousness has never been recognized before but it is the key to understanding human nature. Intrapsychic consciousness generates motives for personal meaning which must be gratified for life to continue. I don't have time to give you all the supporting evidence for the claims I will make in the Introduction, but they are laid out in *Intrapsychic Humanism: An Introduction to a Comprehensive Psychology and Philosophy of Mind (Falcon II Press, 1990).*

ii) Motives for personal meaning are gratified by a perceptual identity process in which a precept or ideal must be signified as being matched by a percept, or experience. That match produces the meaning of agency. To repeat, a perceptual identity process produces meaning when a percept, or registered experience, is signified as matching a precept, or ideal. Motives can be defined as the need for perceptual identity. Meaning is the gratification produced by the completed process of perceptual identity. Experientially, then, motives generate meaning

(1) On the intrapsychic level, the precept or ideal has to do with loving one's caregiver and being convinced that one causes the caregiver to want to give and actually to give ideal care. I use the word caregiver to refer to the primary adults in an infant's life whether that be a parent, a relative, or a non-related person. The word is

singular in infancy because at that point even though more than one person can have intrapsychic meaning for the infant, intrapsychic meaning is the same for all primary caregivers. In infancy, any and all experiences with significant caregivers have the meaning of matching the intrapsychic precept or ideal and producing the meaning of having an agent self with the power to cause the love one needs.

iii) The problem is that the ideal of causing caregiving love with which every child is born can be modified if the actual caregiving she receives is not accurate. In other words, all infants attach the meaning of causing accurate caregiving love to whatever kind of care they get. Every child goes through a phase in which her conviction of causing the caregiver's love is illusional. This illusional phase protects the child from three potentially destructive realities: (1) the fact that every caregiver has personal motives and, therefore, may not always be available to the infant to provide veridical intrapsychic motive gratification; (2) the fact that caregivers may have psychopathology that structurally prevents them, despite the best intentions, from having the conflict-free capacity to subordinate their personal motives to motives for caregiving pleasure; and (3) the fact that the caregiver's ability to respond to the child may be structurally interfered with by health issues, systemic racism, other forms of prejudice, socio-

economic inequalities, or other detrimental environmental realities.

iv) This illusional phase is obviously adaptive in that if infants could recognize and reject inaccurate caregiving, it is very likely that their caregivers would reject them or worse. So infants will adore their caregivers regardless of the kind of care they get. If the care is not accurate, their ideal of caregiving will be modified so that the inaccurate care signifies a match of the ideal. Inaccurate care causes unhappiness, which then acquires the meaning of receiving ideal love. This is the basis for psychopathology, that is, of an unrecognized addiction to unhappiness. This modification of the inborn precept or ideal occurs in the animal kingdom as well. If a gosling only meets a human, it will follow that human in preference to the mother goose when the goose is later introduced. So the gosling's ideal of caregiving has been modified and it has developed intrapsychic psychopathology, which results in choosing the human over the goose in spite of the fact that the human is not as good a caregiver as the mother goose.

v) If caregiving is veridical, that is, accurate, the inborn, accurate ideal of causing the caregiver's love will be matched by experience and the child will grow into an adult with a secure, stable, inner well-being that will not be affected by the inevitable losses in life. Losses may make this person sad or

angry, but because her inner well-being is stable, that is, is based on the accurate certainty that she caused the caregiver's caregiving love, these losses will not cause her to turn on herself or innocent others. She may feel badly, but she will not feel like a bad person. Moreover, this person will make good choices, choose good relationships, work without conflict, etc.

2. Interpersonal Consciousness
   i) Without exception, clients who come for psychotherapy suffer from the unrecognized misidentification of non-veridical care with ideal care, that is, from an unrecognized addiction to unhappiness that occurs preverbally on the intrapsychic level. This plays out on the interpersonal level of consciousness, which is the only consciousness recognized in other psychologies. Interpersonal consciousness consists of social, cognitive, and physiological motives, both conscious and unconscious, and is the soil which produces the broad range of symptomatology we see in our practices. But at bottom, symptoms are a manifestation of intrapsychic psychopathology, which as I described, is a perceptual identity process that produces personal meaning that includes a motive for unhappiness that has been misidentified as happiness.
   ii) When caregiving is accurate, children will have their own internal source of inner well being and will not

use interpersonal experience for inner well being. For example, their inner well being will not depend on the gratification of interpersonal motives such as to win a game or get a promotion, or on false meanings of self, for example identifying with a sports team or one's school.

iii) However, in psychopathology, because inner, that is, intrapsychic, well-being is not stable and includes unrecognized motives for unhappiness, all interpersonal experience is used for inner well-being.

(1) But interpersonal gratification is never stable. A person may get ill or lose a game or a job, so interpersonal gratification cannot be a stable source of inner well being. Moreover, sometimes interpersonal loss is sought as a way of gratifying the addiction to unhappiness. One of the most striking examples is teens who cut themselves.

(2) You can see that in all psychopathology there is a balance between self-experience composed of motives for pleasure, even though that pleasure may have aspects of unpleasure ie. addictions, and between self experiences composed of motives for actual unpleasure, ie. masochism. We call these two interpersonal selves the pathological pleasurable self and the dysphoric self.

iv) This understanding of normal and psychopathological development also explains why

we need an enlightened and just society so that all parents will have the opportunity to provide the kind of care that will allow children to develop stable inner well-being. Unfortunately, this country lags way behind most others in ensuring parental leave and the other parental benefits which make it possible for infants to have the benefit of the one-on-one experience that is so important to them.

3. I know this introduction is very condensed, but it forms a framework for the answers I will give to the questions I received, and I think and hope that as I apply these principles in answering the questions, these concepts will become much clearer. So let me now turn to the questions. I thank all of those who sent in questions, and they were all good ones. Time constraints caused me to choose ones I felt would be of the most general interest to this audience. So the first question is:

2) **How does Intrapsychic Humanism posit that psychopathology develops preverbally in infancy.**

1. To answer this, I refer back to the introduction and probably a little repetition won't hurt here. Intrapsychic psychopathology develops preverbally, whereas interpersonal psychopathology develops later.

2. As I said in the Introduction, babies wouldn't survive if they could evaluate the quality of the care they get and reject any and all non-veridical caregiving. Babies are born with an ideal of a caregiving relationship that signifies loving and being loved and having the

agency to cause the loving care they need. However, that precept can be modified to accept any care they get as ideal and as matching that precept. So if babies are made unnecessarily unhappy, they will misidentify that unhappiness as the happiness that results from ideal caregiving and develop an appetite for it, which is why the self-help book I wrote is entitled *Addicted to Unhappiness*: *How Hidden Motives for Unhappiness Keep You from Creating the Life You Truly Want, and What You Can Do* (Second Edition, Smart Love Press, 2019). This intrapsychic psychopathology develops before language, and the pre-verbal nature of it means that while people can deduce that they have it, they can't experience it and change it outside of a psychotherapy relationship. In other words, intrapsychic psychopathology is invisible because it is the unknowing, preverbal misidentification of unhappiness (caused by non-veridical caregiving) with happiness.

3. What we call interpersonal psychopathology is the only type of psychopathology recognized by other psychologies and usually presents as symptoms. Interpersonal psychopathology most commonly appears along with or after the acquisition of language, and is the result of many factors including: identifications with important others; negative and positive life experiences; just or unjust social conditions (ie. racism, economic inequality, classism); the health and availability of primary caregivers, and so on. Interpersonal symptoms can be worsened or alleviated by various factors and are the focus of all

other psychological treatments. The problem of course is that all interpersonal symptoms are underlain by intrapsychic psychopathology, which means that even if one symptom is relieved the addiction to unhappiness will result in some other type of dysphoria.

3) **Please explain how Intrapsychic Humanism views the Intrapsychic No vs. the Interpersonal No in development and how this is unique to the theory.**

1. The intrapsychic no is a developmental achievement not recognized in any other psychology. It occurs in paradigmatic development some time after a year of age. The child no longer accepts the caregiver's mere presence as gratifying the precept of ideal caregiving, but realizes that the pleasure of interacting in a positive way with the caregiver is the highest kind of relationship pleasure. As a result, when the caregiver's personal motives require her to stop playing with the child, the child says "No" to the inferior pleasure of the caregiver's mere presence. This is not an angry or paranoid "no" but rather an optimistic belief that the caregiver, too, would prefer that pleasure. For example, if the caregiver has to take a work call and can't play with the child, the child will respond with the intrapsychic no, meaning that it's not good enough just to be in the caregiver's presence. The caregiver smiles at the child and agrees that there is a loss at the moment which the caregiver will rectify as soon as she can get off the phone. When the caregiver endorses the child's intrapsychic no even at times when the caregiver

cannot immediately resume playing, the child comes to realize that s/he always has access to and can engage the caregiver's caregiving motives. That recognition results in a part of the child that has an unshakable, permanent sense of loving and being loved. It will take all of development for that to regulate the whole child, but this is the beginning of that process. So the intrapsychic no is a key element in paradigmatic development. Unfortunately, other psychologies misunderstand the child's protests in this stage and conclude the child is "spoiled," "willful," too "dependent" etc. and suggest that parents respond with deprivation rather than positivity to the child's request for their engagement, which of course is exactly the wrong response. In psychopathology, the intrapsychic no does not result in stable inner well-being because, for whatever combination of individual and environmental reasons, the caregiver is unable consistently to put personal motives aside (personal motives include feeling irritated by the child's demands, having to work so many hours that the caregiver is exhausted and lacks the energy to give the child what she needs, or the caregiver has health problems that make her unavailable etc.). So this caregiver cannot give the child a consistently positive response to the request for involvement.

2. The interpersonal no is entirely different. The interpersonal no marks the onset of interpersonal agency, which consists of social-interpersonal, physiological, and cognitive motives, that is, of the everyday behaviors we feel and see in others. The

interpersonal no is the child's negation of the caregiver's interference with a specific interpersonal motive the child is pursuing as well as with the all-powerful self's belief that it can choose to pursue and gratify any motive it wishes. The all-powerful self is a normal part of child development in which children's experience of their own agency is that they can be and do anything. This is why children can assert they are more powerful than superman and smarter than Mommy and Daddy. They also feel they know everything and don't need to be told what to do. In normal development the all-powerful self is ultimately replaced by a verdical interpersonal self that gets its gratification from the inner well-being of the intrapsychic self and the gratification of appropriate interpersonal motives. In psychopathology, the all-powerful self continues into adulthood, and we see examples in people who can't tolerate not getting their way, who overlook signals of job problems or illness, who have no sense of their limitations, etc.

i) An example of the interpersonal no is when the child is playing and the caregiver says it is time for bed and the child shakes her head or says no. Hopefully the caregiver only interferes with the child's interpersonal motives because the motive entails danger for the child or someone else, conflicts with what the child needs (ie. to sleep), or conflicts with a personal motive the caregiver must pursue. And when the caregiver does have to interfere it is with great diplomacy. The notion in some psychologies that frustration is inherently

good for the child is entirely wrongheaded, and will result in a child who is either very inhibited or intolerant of loss.

4) **What does Intrapsychic Humanism tell us about the differences between imitating a caregiver's behavior and copying what the child understands to be a caregiver's caregiving intentions?**

1. Imitating a caregiver's behavior is a form of identification and it occurs on the level of interpersonal consciousness. It may be conscious or unconscious. That is, an adult may think, "I am compulsively on time just like my mother". Or in spite of herself, an adult may find herself yelling at her children just like her father yelled at her.

2. The most important meaning of copying a caregiver's intentions is that this process occurs on the level of intrapsychic consciousness, It is preverbal and not introspectable. As I said earlier, infants cannot evaluate the quality of the caregiving they receive – which is the only reason many children survive childhood. So infants believe that whatever care they receive is both ideal and intended and they develop an appetite for it. If the care is veridical, that is, accurate, children's conviction that the happiness they feel is intended by their caregiver will be genuine and they will grow up with a stable inner well-being and the ability to make good choices for themselves and to pursue them effectively. If the care they receive is inaccurate and causes infants unhappiness, children will unknowingly attach the meaning of intentionality and ideal relationship pleasure to that unhappiness

and they will develop an appetite for that unhappiness, which has been misidentified as happiness.

5) **Explain why Intrapsychic Humanism does not blame parents when parents are the cause of intrapsychic and interpersonal psychopathology.**
   1. Cause and blame are not the same. If you are unaware that you are coming down with the flu and you pass it on to others you are the cause, but you are not to blame. All parents want to do the best for their children. When they are unable to give veridical care it is because they had inaccurate models for parenting; unenlightened social policies such as too short parental leave make it difficult for them to parent as well as they otherwise could; health issues prevent them from being as available as possible; racism and other systemic ills affect them emotionally, economically and in myriad other ways; they are given bad advice by “experts;” etc.
   2. For whatever reasons, the general problem is that parents pursue personal motives they mistake for caregiving motives. Examples are being angry at children for acting like children; having to work so many hours that their energy for parenting is diminished; believing that young children should have the social graces of adults, and so on. Interestingly, the evolution of cognition and symbolic thought in the human race has created many diversions and distractions (sports, theater, TV, books, the internet, work) that compete with caregiving commitments to children. In many other animals parenting is a long

and simpler process in which one or both parents remain available to their children for long periods of time without distraction.

6) **I know Intrapsychic Humanism doesn't use the DSM diagnostic categories – what is your nosology and how do you apply it?**

1. Our nosology is unitary, namely intrapsychic psychopathology, that is, an inner well being that includes both innately based motives for veridical inner well-being, but also the preverbal, unrecognized misidentification of unhappiness with happiness. So our diagnostic criterion is based on treatability not interpersonal symptoms (that is, not on the quality of interpersonal functioning). The degree to which a client can tolerate and value the intimacy of the intrapsychic caregiving offered by the therapist without having severely self-destructive or anti-social reactions is the basis of our diagnostic evaluation. This is why we ask all the therapists in the Smart Love Services Clinic to write the process for the first and second sessions with a client. These sessions give us a window into how severely clients will react to the pleasure of the caregiving they get in therapy. If the reaction is too severe, ie. the client becomes actively suicidal, then we know that that client is probably not treatable as an outpatient. In addition, for therapy to go well, clients need to have a reasonably stable motive to feel less dysphoria and more pleasure. Eventually that evolves into the wish for genuine as opposed to psychopathological pleasure.

2. Interpersonal symptoms are protean and range widely in severity, but they are not themselves the fundamental cause of psychopathology, which is intrapsychic. In other words, we do not use the DSM categories.

7) **How does recent thinking about critical race theory, which is also now expanding into critical mental health theory, fit with the emphasis in Intrapsychic Humanism on an individual's psychological health and psychopathology.**

1. Systemic racism and other systemic forms of prejudice, such as misogyny, along with the unfair distribution of wealth and opportunities, strengthen the addiction to unhappiness and weaken constructive motives, making people who have intrapsychic psychopathology more unhappy than they would be in a just, non-racist, non-classist society. That is, in a just society without racism, classism, and where all workers were given a living wage and children had the benefit of good educations and parental leave, even individuals with psychopathology as I define it, that is, intrapsychic psychopathology, would find greater support for constructive motives and little or no support for symptoms that cause unhappiness. So social justice is not only important from a human rights perspective, but also from a psychological standpoint. Intrapsychic Humanism and the effort to eradicate racism and other forms of socially constructed unfair treatment of

individuals are not just compatible but synergistic. And just as important, someone who has genuine intrapsychic inner well-being is still made unhappy about living in an unjust society – that unhappiness just does not become self-rage or rage at innocent others.

2. So there is value in critical mental health theory (which posits that injustices in society contribute to mental illness), just as there is in critical race theory (which posits that racism is embedded in our social structures and not solely an individual problem). Injustices that are society wide are not only morally repugnant, but also have a demonstrable impact on mental illness by strengthening the addiction to unhappiness and making it harder to follow constructive motives.
3. Another reason we need to redress social, economic, class, and race discrimination and deprivation is that the effects of these injustices often prevent caregivers from giving the accurate care necessary for optimal mental health and from offering positive interpersonal models for children's positive identifications.

8) **Is Intrapsychic Humanism anti-racist?**

1. My understanding of anti-racism is that it mandates an active and critical response when one hears racist remarks or sees racist behavior. On a personal and social level, I am an anti-racist. However, I believe that as an Inner Humanism therapist anti-racism is

counter-therapeutic and counter-productive. Why? Because

i) Therapy does not work as persuasion – that is, telling clients that what they are doing is wrong is anti-therapeutic, even when the perception that what they are doing wrong is correct – i.e. the client holds racist views, stays in an abusive relationship, drinks too much. Communicating disapproval in therapy is not effective in changing behavior. All that happens if the therapist is confrontational is that the client either gets angry, hides the behavior from the therapist and then feels like a failure, complies but is resentful and feels alienated, may leave therapy, and in any event as soon as therapy ends most likely will reconnect with the disparaged behaviors.

ii) More effective than direct confrontation is to help clients discover and experience parts of themselves that are more reflective. For example, a client who expressed racist opinions in her therapy suddenly found herself with an African American boss. She thought of quitting her job, but also liked the job and was afraid she wouldn't find one as good. Her therapist, who had previously not commented on the racist views the client had expressed took this opportunity to build on the client's motive not to quit her job by suggesting that there was a part of the client thinking it would be in her interest to stay in her job and give her boss a chance rather than go

with the part of her that felt globally negative about African Americans. The client provisionally decided to stay and discovered to her surprise that she quite liked the boss and wanted to keep her job. As a result, she stopped making sweeping racist statements and began the process of assessing people of color individually. Because the therapist waited until the client expressed a motive to modify her racist views in the interest of keeping her job, the client was able to view as her choice the modification of these views and to maintain the therapeutic alliance.

iii) Moreover, when the therapist does not respond to racist statements by being judgmental or critical but demonstrates her commitment to helping clients whose views the therapist doesn't agree with, the client's constructive motives will be strengthened and she may well copy the compassion she receives and become less judgmental and so less racist. The need to feel superior to others can diminish in response to the genuine care the client gets from the therapist.

iv) Also, clients usually assume that by definition therapists are broad minded and not racist, and that unstated assumption can be influential if the client admires and respects the therapist. One client made prejudiced remarks and immediately said, "I can guess that you don't agree with me and you probably dislike me for what I think." The therapist

said, “I am here to help you, not judge you, but it’s possible there is a part of you that questions the validity of your hostility toward all people of color and feels badly about feeling that way and is experiencing that critical reaction as coming from me. Something we can think about together.”

v) Importantly, in our teaching, webinars, and writings, Smart Love Clinical Services and individual practitioners of Inner Humanism psychotherapy are anti-racist in that on a social and personal level we always explicitly oppose racism and other forms of prejudice, and we promote programs such as It Takes a Village that are specifically targeted to help African American families.

vi) I know that some time ago we had a presentation in which it was suggested that therapists should be anti-racist, that is, confrontational, with clients and I am disagreeing with that approach and offering an alternative based on both my theoretical orientation and on many years of practice that have shown that confronting clients with their dysfunctional symptoms is anti-therapeutic. In no way should this be taken as endorsing any type of prejudice, but rather as advancing what I am convinced is the most effective way to change client’s prejudiced views.

9) What does it mean to have a therapeutic relationship in Inner Humanism psychotherapy?

And how does this differ from other theoretical approaches?

1. There isn't time to consider all other approaches in detail, but I can say that no other approach views the therapeutic relationship as we do: for example, cognitive behavioral approaches assume that the therapist is there to help the client with maladaptive behaviors that were learned and can be unlearned. So the therapist is in effect a teacher who focuses on correcting symptoms and often gives "homework." Other approaches see the relationship as a playing out of transference so that the therapist is to be quite abstinent so as to create a "blank screen" on which the transference feelings can be projected; still other approaches see the therapist as a friendly guide or peer who accompanies the client and helps her embrace happier feelings etc.
2. None of these approaches has the relationship that is created in Inner Humanism therapy because no other approach understands the opposing motives every client brings to therapy. Clients come to therapy wanting help with the pain of their dysphoric self, which represents the addiction to unhappiness, (which as I described earlier is the unrecognized, preverbal, misidentification of unhappiness with happiness). The therapist makes herself available to help with the client's desire to feel less unhappy while also recognizing that the client will have aversive reactions to this help. Aversive reactions to pleasure occur to everyone with intrapsychic psychopathology. Whenever these individuals experiences genuine

pleasure, their addiction to unhappiness, the motive for unhappiness misidentified as happiness, is deprived of gratification and finds some way to create unhappiness. Once you know to look for it, the aversive reaction to pleasure can be seen all around us – for example it is the only reasonable explanation why so many sports and entertainment figures reach tremendous success and then undo it with addictions and other self-destructive behaviors. In therapy the aversive reaction to pleasure often takes the form of the client's conviction the therapist doesn't understand or isn't helping her, missing sessions, etc. So because the Inner Humanism therapist understands the inevitability of aversive reactions to pleasure, she won't personalize those reactions: ie. she won't accuse the client of resistance, give up on the client, or make the client responsible for her own personal feelings of irritation or boredom. The Inner Humanism therapist also understands that as the client is able to shift toward more pleasurable ways of being, her job is to help the client choose constructive pleasure over fixated and self-defeating pleasure. Examples of self-defeating pleasure are eating too much or too little or choosing friends that are difficult to get along with. The Inner Humanism therapist creates a relationship in which she is not unduly withholding from the client and thereby gratifies dysphoric self motives, but also is not unreflectively gratifying the pathological pleasurable self out of a need to have the client like her.

10) **What are the qualities of a therapist that will facilitate or inhibit a client's progress.**

1. Most important is the therapist's ability to gratify the non-fixated, that is, the developmental, portion of the client's positive motives without unreflectively giving pain-relief. Pain relief means gratifying fixated positive motives, which always contain an element of unpleasantness ie. overexercising, sexual addictions, etc.). The Inner Humanism therapist is also not unnecessarily withholding, because that unnatural abstinence gratifies the dysphoric self motives. The ability to respond developmentally requires that the therapist be able to separate personal and caregiving motives.
   i) The ability to distinguish between personal and caregiving motives is an essential skill for all therapists. Caregiving motives are accurate motives to help the client develop an appetite for following constructive motives and losing interest in motives that gratify the addiction to unhappiness. The therapist's personal motives are all other motives, which may include the wish to be liked or, even, disliked by the client; the desire to be entertained, which can lead to irritation and boredom if not gratified; and therapeutic ambition – the desire for the patient to progress faster than is genuine progress.
   ii) The ability to recognize non-fixated, that is, developmental, motives is probably the most

sophisticated aspect of Inner Humanism therapy. There is no rule of thumb because it varies with every client. For example, a client who entered treatment unable to tolerate angry feelings manifested a non-fixated motive when she was able to tell the therapist that she was upset with her for being late. But another client, who reacted to the care offered by the therapist by consistently doubting the therapist's motives and compassion, manifested a non-fixated motive when instead of responding to the therapist being a few minutes late with accusations that the therapist probably didn't want to see her, she actually said, "I don't like it when you are late, but I know you will make up the time and that it probably had nothing to do with me." So in one client an angry response and in another a positive response to the same stimulus, represented the non-fixated motive.

2. When the therapist is having trouble finding a way to help a client, the problem is usually that her personal motives often override her caregiving motives - usually for one of three reasons:
   i) The therapist herself may have aversive reactions to intimacy. She may say and do things that provoke distance, alienation, or anger in the client in response to the client's feelings of closeness. An example is the therapist whose client shared a painful memory about her childhood in which she was told by a parent that she was too fat and

needed to lose weight. The therapist responded by sharing her own memory of being told the same thing by a teacher and how badly she had felt. The therapist consciously thought the similarity would create a bond, but the client felt competed with, ignored, and alienated. So the therapist's aversive reaction to the pleasure of the intimacy the client was creating caused the client to feel alienated.

ii) Another common problem when treatment is not going well is that the therapist needs clients to feel positively about her, so she can't help clients who can't recognize or admit negative feelings about the relationship. This is probably the most invisible and common problem that therapists have, and it is subtly harmful to the client. The therapist seems very kind and supportive, but when this is in the service of feeling liked by the client, there is no room for hostile feelings. For example, following a productive session, one client came in late and looking dejected. The therapist enthusiastically said, "I was thinking what a good session that was yesterday – you did a lot of good work!" The client was having an aversive reaction to the pleasure of the previous session, which caused her to be late and to feel she didn't want to come, but the therapist's positive response effectively blocked that part of the client from getting into the relationship. A therapist without the need to be liked by the client might have responded to the client's

negative vibes by saying neutrally, “How are you today?”

iii) The third most common way in which a therapist’s personal motives may gain hegemony over her caregiving motives is therapeutic ambition. The therapist needs the client to make progress and communicates that wish in various ways, which include being overly enthusiastic about any sign of progress, ignoring aversive reactions to pleasure, and making suggestions about how clients could improve in areas in which they are struggling when clients are not ready to make that effort.

11) **What are signs of progress the Inner Humanism therapist looks for - both interpersonal and intrapsychic - in supportive therapy.**

1. On the interpersonal level the therapist looks for a change in the balance between dysphoric and pathological pleasurable selves so the pathological pleasurable self becomes more influential and then evolves into a stable preference for constructive pleasure.
   i) For example, rather than choosing to stay in a conflictual relationship with a friend, one client left that relationship and chose friends with whom she could have a smoother, more pleasurable relationship
   ii) Or a client who had difficulty committing to caring for herself sought out and began a sensible exercise program.

iii) Clients will increasingly lose interest in their dysphoric motives and motives for a pathological type of pleasure that had always seemed attractive. One client who had always struggled with her weight said that she no longer found attractive the idea of ordering and eating an entire pizza and that in fact it was hard for her to understand why that had seemed so compelling.

iv) Equally important, aversive reactions to caregetting pleasure in therapy will start to feel like a loss. For example,after a good session, clients will not want to come late or miss altogether.

12) **What is the Inner Humanism therapy approach to responding therapeutically to children or adults who experienced traumatic events prior to coming to therapy?**

1. Underneath the trauma that children and adults who come for treatment are aware of is an underlying trauma that is not experienced – that trauma is the result of inaccurate intrapsychic caregiving, which caused the client as an infant to misidentify the unhappiness which resulted from the nonveridical caregiving with happiness and develop an addiction to unhappiness. The trauma that is currently the focus of a lot of psychotherapy is exclusively interpersonal, ie. sexual, physical, emotional abuse; being a person of color in a racist society; having parents who are addicted, ill, or otherwise unavailable; or being involved in a traumatic incident such as a fire or car

crash. These are real traumas and causes of real unhappiness. But the addiction to unhappiness (intrapsychic psychopathology) is what makes it impossible to mourn the traumatic event because the pain is being used to gratify the dysphoric self. A person with stable intrapsychic well-being would mourn the trauma – that is, she might feel angry, sad, frightened or anxious -- but she would not turn on herself or innocent others, that is, she would not feel like a bad person or blame uninvolved others, and she would not develop phobias or disabling panic attacks. Those reactions occur because the trauma is being used to gratify the dysphoric self – as a result, the trauma results in self-rage (self-harm, ongoing depression, inhibitions etc.) or rage at others who don't deserve it (ie. conflict in or withdrawal from close relationships).

i) An example is a couple in couples therapy whose child had developed and was being treated for leukemia. They came in because they had become angry at and alienated from each other. The couple's therapist helped them to see that they were turning on each other in response to the trauma they were experiencing with their child and helped them to reject this way of responding to the trauma and rather to view each other as a source of support and sustenance. *So the focus of treatment for trauma is not on reliving or becoming desensitized to the trauma. Rather the focus is on*

separating the genuine pain caused by the trauma from the gratuitous unhappiness in reaction to the trauma that serves to gratify the addiction to unhappiness.

2. **If the therapist knows about the trauma prior to starting therapy (e.g., through an intake process), should therapists bring up this topic in the first 1-2 sessions? If so, how?**

   (1) In general if you know about the trauma, it's a good idea to let clients know you know about it, especially because they may suspect you have been told by the intake worker, a parent, etc. However, that is different from pushing the client to "deal with it," that is, to talk about it, recall it, relive it etc. The principle is to let the client share her feelings about the trauma when she feels enough comfort in the therapy and trust in the therapist. This is the same principle in all of Inner Humanism therapy -- wait for the non-fixated motive to show itself and then encourage it, but don't pressure the client to share or consider more than she is ready for because of therapeutic ambition or a misguided notion that ripping off emotional scabs is good for clients. If the client feels she is in control of what is being shared she will feel trust and relaxation rather than defensiveness and tension.

3. **How can therapists listen for and respond to indirect communications from the client that**

suggest that the client is thinking about the traumatic event in some way?

i) This is always the goal in therapy, namely to listen and, when it fits, to make connections between what the client is saying and deeper concerns, such as a trauma, or, of course between the content being talked about and the process meanings about the therapeutic relationship. For example, an adult who was adopted as a four year old because of her single mom's addiction to cocaine had many reactions to her therapist's vacation, which included missing sessions beforehand, regressing to self-defeating behaviors she had given up previously, and talking about leaving therapy. The therapist gently made the connection that because of the earlier trauma of losing her mother, the client might be experiencing the therapist's vacation as an absolute loss rather than a temporary interruption and might be reacting by trying to protect herself by withdrawing ahead of the vacation, by missing sessions, and also by soothing herself in old ways. The therapist went on to show the client she understood the depth of the client's reliving of the trauma by offering to connect with the client by phone or text during the vacation. The connection the therapist provided during the interruption helped the client respond to the interruption in her sessions by staying connected to the therapeutic relationship rather than by falling back on old, dysphoric ways of handling relationship losses.

4. **What concerns do you have, from an Intrapsychic Humanism perspective, about therapists focusing on trying to get patients to talk about the trauma more?**
   - **i)** This is a throwback to old theories about the value of abreaction and catharis, ie. that the trauma is like a poison that needs to be regurgitated. Various permutations of this thinking are desensitization, hitting a pillow, role playing etc.
   - **ii)** The problem is that when trauma continues to have a destructive hold on clients, it is because the client has an addiction to unhappiness that makes that dysphoria soothing in an unrecognized way. The irony is that causing clients to relive the trauma may gratify that addiction to unhappiness and do nothing to make the trauma less compelling. When the client is allowed to bring up the trauma on her own time-table, she will bring it up because she wants help to make it a less central part of her emotional landscape, that is, it will come from the non-fixated part of the client.

13) **What are some general rules of thumb regarding couple's treatment**

1. Couples come in with both an addiction to unhappiness and also motives for constructive pleasure, so the goal is to help them respond to each other more frequently with motives for constructive pleasure
2. The first step is to help couples recognize both sets of motives and to recognize the role that the addiction to unhappiness is playing in their relationship.

i) One common example is provoking conflict to gratify the dysphoric self. For example, couples who have been together for a while know where the hot buttons are – ie. leaving clothes on the floor for the other to pick up, being chronically late.

3. Once the couple recognizes the operation of both sets of motives – positive and negative – they can be helped to see that they have the power to make the better choice of motives to gratify and that they will be much happier if they choose the motives for constructive pleasure. One couple was consistently irritated with each other over relatively small things: for example, the wife was angry because her husband left his dirty dishes for her to clean and put in the dishwasher, the husband because the wife never looked at the gas gauge in the car so that he nearly ran out of gas on the way to work. Once they understood that their conflict was gratifying their addictions to unhappiness, they were able to see that both the provocation and the irritation were less important in the scheme of things than the fundamental pleasure that was available in the relationship. This progress, however, hinges on the therapist helping the couple accept that they have motives for unhappiness as well as happiness so that they cease to attribute all the problems to the other person.
4. The therapist needs to avoid the trap of identifying an aggressor and a victim (excluding of course actual sexual or emotional abuse). That is, if one partner is dominant and one is more submissive that doesn't

make either one bad or good – it's something to work on. Too often therapists go with their personal motives (often based in their own childhood experiences) and think of one partner as the good guy and one the bad guy with the result that the "bad guy" often feels dissatisfied and leaves and the "good guy" never sees the part they are playing in the dysfunctional dynamic.

5. Another question I received was about family therapy and the same principles apply except that where the therapist may allow couples in couple's therapy to express anger and negativity for a while before commenting, when children are involved in a family therapy session, the therapist should step in immediately if adults are being critical toward children. One parent said, "Bobby is totally unmotivated – he would never pick up his room or do his homework if there weren't consequences." The therapist responded, "Bobby is in therapy because he often feels depressed, which can make it hard to have the energy necessary for homework or cleaning his room. As the therapy helps him, energy will be more available to him. So the important thing is to give him time and understanding." This swift intervention protected Bobby from the parents' negativity and showed him and them another way to think about the behavior he was being blamed for.

14) **Can you talk about differences and/or similarities in working with a parent for individual therapy who asks for parenting advice versus a parent you are working with for parenting guidance?**

1. Yes, there is a big difference. When working with a parent in individual therapy who is asking for parenting advice, the therapist has to be very careful not to just focus on giving advice but must take all parts of the client into account and must understand what is behind the request. For example, one client asked for advice in order to use the answer to rage at herself for not being a good enough parent; another asked in order to feel alienated from the therapist, who she felt looked down on her for doing the wrong thing. In other words, before giving any parenting advice to a client in individual therapy, the therapist must ascertain whether on balance the client will use the answer to feel more distant and alienated from the therapeutic relationship or will feel understood, helped and more trusting of the therapist. Even in the latter case, the therapist must then be on the lookout for the client's aversive reactions to the pleasure of being able to turn to the therapist for help with parenting.
2. When working with parents in parent guidance, while you will give advice much more freely then with a parent in individual treatment, it is important not to use parents instrumentally, that is, just as a vehicle to fix the problems with the child. Rather it is important to show parents your respect and recognition that they made a good decision to come for help and that you know it may be difficult to hear that changes are necessary.

15) **Clients come in because they are being made unhappy by symptoms – how and how much do you focus on them? How does Inner Humanism therapy**

differ from cognitive behavioral therapy and its variants.

1. Clients come to therapy because symptoms are making them unhappy, but the symptoms are also gratifying the addiction to unhappiness, so when CBT (used generically, that is, in all of its various permutations) treats symptoms as learned cognitive problems, the therapist misses the nature and strength of the addiction to unhappiness. As a result, giving the client homework, suggesting coping strategies, using desensitization, and other, similar, interventions does not solve the problem. Inside, the client actually feels worse – more of a failure now because she has let the therapist down, with the result that the addiction to unhappiness is gratified by that and made stronger. The client may comply, dissemble, or leave treatment, but not get genuinely better. CBT is really a form of persuasion/therapeutic ambition rather than respect for the client's own process.
2. Inner Humanism therapy focuses instead on being available to the entire range of feelings the client brings including the addiction to unhappiness. So when the client expresses a motive to try to resolve the symptom, the therapist allows for aversive reactions to that pleasure. For example, when one client said, "I am not going to binge when I get home tonight," the therapist endorsed that non-fixated motive, saying, "That sounds like a plan that would make you feel good," but she also left room for an aversive reaction to that pleasure, so that the client

wouldn't feel shame if she binged in spite of her resolve. The therapist added, "But we know that there is a part of you that may react to that resolution by undoing it - if that happens, you can bring that reaction to our relationship".

3. As a result, the client in Inner Humanism therapy feels increasingly cared for by the therapist, who she knows both wants to help her improve her life but is understanding and accepting of the motives that oppose that goal.

16) **How does Intrapsychic Humanism define character structure and how does it shift in treatment.**

i) The character structure is a feature of psychopathology and does not occur after a paradigmatic development. It is a synthesis of: (1) the motives of the pathological pleasurable self (that is, the nonveridical interpersonal agent self that seeks pleasure) and the dysphoric self (the nonveridical interpersonal agent self that seeks unhappiness) and (2) negative and positive identifications with the caregivers and other significant people, (3) positive environmental messages (getting awards for being good at sports) or negative environmental messages and experiences, including racism, classism, and ethnic discrimination. The child with a character structure acquires her repertoire of interpersonal motive experience in large part by: (1) copying the manifest behavior of her caregivers, (2) complying with the fantasies of her caregivers (ie. that the child is destined for greatness), (3) developing

those innately given endowments of which the caregivers approve (ie. being a competitive tennis player), (4) assimilating social and cultural values, both positive and negative (ie. adopting racist views or working for social justice), and (5) responding to her own conflicting motives for pain and for pleasure. Interpersonal identifications based on caregivers' socially adaptive or maladaptive characteristics constitute an important part of a person's character structure. For example one client whose father had been fired from a series of jobs came for help because he was heading down the same path.

ii) In a paradigmatic self system, there is neither a character structure nor a character self, rather the interpersonal agent self seeks only constructive pleasure. Although only an individual with psychopathology develops a character structure and a character self, this individual's conscious self-experience need not be painful. The character structure can be the basis for a character self that is "sunny" and socially adaptive. Even in the best case, however, the individual with intrapsychic psychopathology and a sunny disposition will have reactive motives for dysphoria that she may not recognize. For example, when a college student with intrapsychic psychopathology but excellent interpersonal functioning attained her dream of being accepted to veterinary school, she wore her ear buds into the shower and ruined them. She did not connect the loss of her ear buds with the good

news of her acceptance until she entered Inner Humanism treatment many years later.

17) **What has been the most pleasurable part of being the author of Intrapsychic Humanism and the consultant to other therapists studying the theory? What has surprised you in your work?**

1. First, the most gratifying aspect of practicing and teaching Inner Humanism psychotherapy is to see how the broadest possible range of clients thrive and improve – "untreatable" adolescents; infants, young children and teens; children on the autism spectrum; adults with a wide variety of presenting problems, couples, parents in parent counseling, and clients who are racially and ethnically diverse, etc.
2. Second is to see how effectively Inner Humanism can be practiced by therapists of different disciplines (psychologists, social workers, psychiatrists, counseling therapists) and of varying levels of experience, including recent graduates. Even though as learners therapists new to this approach may make mistakes, just understanding the conflict in the client between constructive motives and unrecognized motives for unhappiness, along with the therapist's commitment to trying to distinguish personal and caregiving motives (plus the wonderful training provided by the Smart Love Clinic director and supervisors) has a positive impact on clients who visibly improve and benefit from their therapy.
3. Also gratifying is witnessing the positive impact practicing Inner Humanism has on therapists themselves. Because they have a genuine

understanding of their clients and know to expect aversive reactions (backsliding) in response to progress, our therapists not only don't burn out but as their skills improve they feel increasingly fulfilled and positive about their work. The understanding of the theory necessary to practice effectively also impacts and improves therapists' own self-experience and relationships.

4. Truthfully what has most surprised me is that I believe Intrapsychic Humanism is so logical, conforms so well to observations of human nature, is supported by child development research findings, never resorts to metaphysics, and is demonstrably so helpful in a myriad of settings and for all clients as well as for parents and teachers, that I am amazed it is not more widely known and taught, especially as genetics and neuroscience have proved to be dead ends: As Thomas Insel, former NIMH director, is quoted as concluding, "[after] 13 years at NIMH pushing on the neuroscience and genetics of mental disorders … I succeeded at getting lots of really cool papers published by cool scientists at fairly high costs – I think $20 billion – I don't think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness." In contrast, Inner Humanism therapy has a terrific track record in treating clients who span the mental health spectrum and come from all ethnic, racial, economic, and social groups. So it never fails to surprise me that it isn't more widely known. If I'm candid, I have to say that the density and challenge of

reading *Intrapsychic Humanism* itself no doubt contributes to this problem, but nonetheless the theory is available in other presentations and publications. I can only hope that one day Intrapsychic Humanism will be universally recognized for its powerful explanatory power and efficacy.

5. Now I would like to hear from you – I covered a lot of territory and I'm sure there are questions and things you would like clarified.