THE CLIENT AS SUPERVISOR: The Approach of Robert Langs

by
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Robert Langs' "interactional" approach to psychotherapy is one of the most recent American offshoots of psychoanalytic therapy. Highly original and controversial, Langs' work contains ideas which I believe will be of use to therapists of many philosophical persuasions.

The fundamental theme of Langs' work may be summed up in the statement that the client unconsciously perceives the therapist's countertransference and feeds this back in a disguised or encoded form. To put it more tersely: the unconscious of the client is the therapist's supervisor.

It is perhaps appropriate to pause at this point and consider the term "countertransference" for the benefit of those not versed in the psychoanalytic jargon. Countertransference is that within the therapist which interferes with his or her professional functioning. Countertransference can be either chronic - based on deep-seated characteroligical factors - or transient. It can be discharge orientated (based on some drive or impulse stirred up within the therapist) or defensive (geared towards keeping such impulses unconscious).

Langs postulates that any communication from the client can be understood in three possible ways, referred to as three "modes of relatedness". In the **manifest** mode of relatedness no unconscious meaning is attributed to the communication, ie. in Freud's words "Sometimes a cigar is only a cigar!" Listening in the manifest mode of relatedness when the client talks about a cigar he or she means nothing more and nothing less than a cigar. The second mode or relatedness involves the assumption that the client's communication is a covert expression of an unconscious preoccupation, ie. a cigar is not just a cigar; it is a breast, a penis, an umbilical cord, etc. Langs calls this the "type one derivative" mode of relatedness. The third mode of relatedness is referred to as the "type two derivative" mode. It involves the assumption that what the client says is an expression of unconscious **perceptions** (as opposed to fantasies) of the therapist, ie. a reference to being unable to give up

cigars might refer to the therapist's dependency needs interfering with his functioning.

Listening to clients in the type two derivative mode has convinced me beyond a shadow of a doubt that clients are unconsciously extremely perceptive of the therapist's difficulties and are able, in an encoded way, to diagnose them quite accurately. The unconscious of the client is one's most brilliant and confronting supervisor.

First Example

During the second year of the therapy of a female teacher I found myself in the grip of a strong countertransference reaction which prevented me from making effective interventions. As is typical for most therapists in such circumstances I was not fully aware of what was occurring and was inclined to attribute the difficulties to the client's resistance. This teacher worked with highly disturbed adolescents. On one occasion she described an interaction with a pupil who had difficulty mastering mathematics in the following terms: "I don't understand what's wrong with Nigel. I know that he's intelligent but he just won't **think**. He seems to pull answers out of the air instead of working them out . . . I get the feeling that he does this just to frustrate me!"

Unfortunately I was not very well acquainted with the interactional approach at the time. In retrospect, her remark can be seen as a thinly disguised and highly perceptive diagnosis of my countertransference. Indeed I was not thinking and working out what was going on: I was pulling interventions out of the air. Her conclusion - which was quite correct - was that I (unconsciously) did this to frustrate her, ie. my professional functioning was blocked by unconscious competitive urges stemming ultimately from my childhood. Incidently, nobody with whom I discussed the case at the time was able to lead me to the insight so succinctly and accurately offered by my client's unconscious.

Second Example

A thirty-five year old homosexual male arranged an initial diagnostic interview with me. As it happened, this was the only appointment that I was to conduct on that particular evening.

Richard arrived for his interview fifteen minutes early and rang the doorbell. Thinking in passing that it would give me more time with my family that evening, I decided to see him then. The interview proceeded uneventfully and we agreed that he should begin once a week psychotherapy as soon as possible.

As might have been expected, Richard arrived for his first psychotherapy session fifteen minutes early. I greeted him at the door, explained to him that he was fifteen minutes early, and asked him to take a seat in the porch-cum-waiting room until the appointed

time. He agreed to this in a calm, easy manner.

At seven o'clock I showed him into the consulting room. He began almost immediately to recount a tale of having gotten involved with a rather narcissistic, exploitative and seductive man who used him and then abandoned him. After having been very warm and inviting - although somewhat mystifying - at first, he later refused to see Richard or even respond to his letters. Fortunately, I was sufficiently aware to listen and respond to my unconscious supervisor in Richard. I interpreted that it sounded like Richard was talking about his perceptions of me as well as a hurtful event which occurred in his life. It sounded, I said, like he perceived my seeing him early on the initial interview and my making him wait for the present interview as a seduction followed by an abandonment. He was perhaps deep down afraid that I was selfish, exploitative and dangerously inconsistant like his ex-lover.

This intervention provoked considerable validation and proved to be of considerable importance during the first phase of Richard's therapy, which revolved around his fear of trusting his own perceptions and inner wisdom.

Conclusion

Langs' interactional model proposes that the client is able to perceive and accurately diagnose the therapist's countertransference; ie., the unconscious of the client supervises the therapist. This model, which is much more subtle than could be explained in such an abbreviated account, is at great value in both the process of self-monitoring and the process of supervision. As a supervisor using this approach I can base my interventions largely on the counsel of the client's "unconscious supervisor" to elucidate my supervisee's countertransference difficulties.

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