Introduction

I am not interested in converting anyone to Freudianism or glorifying Freud as a genius. As the title of this book suggests, my aim is to make psychoanalysis—Freud's ideas and clinical practices, along with later developments by those who followed in his footsteps—useful for counselors and counselors-in-training. Freud and his followers for counselors, not counselors for—or against—Freud. When we take a fresh look at Freud, a look predicated on the idea that Freud should be studied not simply for historical or polemical interest but for use and applicability, we find that we can construct broad themes, identify recurring clinical issues, and gain a larger perspective both on Freud's work and on contemporary clinical practice. Approached in this fashion, we can increase our clinical knowledge and avoid becoming overwhelmed with the complexity of his ideas or the daunting scholarship on Freud and psychoanalysis that has accumulated over the years.

In *Psychoanalytic Approaches for Counselors*, we begin by taking a brief look at Freud's life and historical context. We then consider the therapeutic themes that Freud inaugurated and review his achievements in light of the common factors hypothesis. In Chapter 1, The Talking Cure, we see that from the very beginning, the psychoanalytic relationship focused on the client. We find that this relationship is not just the container for therapeutic interventions, it is the most potent treatment intervention itself. In Chapter 2, Basic Psychoanalytic Concepts, we look at how Freud thought of our mental life as continuous struggle; in his view, the rational Ego attempts to mediate between unacceptable wishes and urges, internalized parental voices, and real-life demands of the external world. In Chapter 3, The Evolution of Psychoanalysis, we see that psychoanalysis continued to grow and evolve beyond Freud. Psychoanalysis moved from an internal, one-person drive model to a two- and more-person relational model and has integrated neuroscientific findings into its clinical theory and practice. In Chapter 4, Multiculturalism, we address three major multicultural categories, (1) race/ethnicity, (2) social class, and (3) sex/gender, and find that multicultural considerations have informed counseling from its inception

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in anti-Semitic Europe during Freud's life. We find that psychoanalysis, derided by some as a treatment only for the wealthy, in fact contains relational resources for work with all clients. In Chapter 5, A Case Illustration of Contemporary Psychoanalytic Counseling, we examine the fictitious case example of Jennie Lin. This case example illustrates some of the twists and turns that might occur in contemporary psychoanalytical practice as clients are encouraged to access insights that are dynamic and that can be rationally acted on. In Chapter 6, Conclusion, we summarize the major points of the book in service of the overarching aim of the *Theories for Counselors* series, which is to help us understand the contributions of each major theorist from a common factors perspective.

Who Was Sigmund Freud?

Freud was born on May 6, 1856, to a Jewish merchant, Jacob Freud, and his wife, Amalia, in what is now the Czech Republic town of Příbor (Freiberg). His family moved to Vienna in March of 1860, when Freud was nearing 4 years of age. Freud lived in Vienna most of his life, studying and working in a European city that was cosmopolitan and sophisticated yet deeply riven by racist attitudes. While there were promising strains of liberalization in culture and in politics, there were other more threatening tones and undertones in the political and social discourse in which Freud grew up and lived. As Gay (2006) demonstrates, the 19th century in Europe and in Vienna was "an uneasy interlude between the old anti-Semitism and the new" (p. 20). While there was much more opportunity available to Freud, scholastically and career-wise, there were also continued hints and threats of posts and advancement denied because of anti-Semitism.

Freud thus grew up in a complex social environment, an environment that promised shining advancement and murky threat. His family was also complex. Freud was the eldest of Jacob and Amalia's seven children; in addition to his siblings, Freud also had a number of half-siblings, since his father had two wives before he married Freud's mother. Freud's father was 20 years older than his mother, which was a puzzle to Freud as a child—why was his young and beautiful mother married to such an old fellow? The two sons from Jacob's first marriage lived nearby; one of Freud's nephew's was older than Freud was, and his half-brother Philipp seemed to be a much better romantic fit, age-wise, with his mother. It was all very confusing for Freud, and we might suspect that some of his early bemusement played a powerful role in his subsequent theorizing about mothers, fathers, and boys.

Throughout his academic career, Freud was a hardworking and gifted student. He enrolled in medicine at Vienna University and graduated with his

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medical degree in 1881. He met and fell in love with his future wife, Martha Bernays, in April of 1882 when he was in his mid-twenties; they were too poor to marry immediately. In 1885, Freud studied in Paris under the famous Jean-Martin Charcot and soon thereafter opened his private practice and married. Of particular note throughout the 1880s and 1890s were Freud's connections with Wilhelm Fliess and Josef Breuer, two colleagues with whom he shared intense personal and professional relationships.

With *The Interpretation of Dreams* (it came out in November of 1899 but bore the date of 1900), Freud published the first major text of psychoanalysis. While Freud used the word *psychoanalysis* earlier in 1896 in French and German (Gay, 2006), and had developed his theory before its publication, *The Interpretation of Dreams* began an avalanche of lectures, papers, and books in which Freud articulated his mature views. In text after text on sexuality, on therapeutic technique, and on psychology and metapsychology, Freud provided the world with intriguing evidence that "the mind, however disheveled it might appear, is governed by firm rules" (Gay, 1989a, p. xvi). Freud was a tireless worker and advocate for psychoanalysis, presiding over meetings, writing letters, maintaining professional relationships, and indefatigably advancing the cause of psychoanalysis until his death on September 23, 1939, shortly after France and Britain declared war on Germany.

In considering Freud's life, it is important to keep in mind Gay's (2006) reminder that while he entertained the most scandalous of ideas, he was a proper bourgeois, regulated by work and by the clock. Freud would rise in the morning at seven, seeing clients from eight to twelve. Dinner, with the full household assembled, took place at one, followed by a walk. Consultations began at three, followed by more patients. Supper might take place as late as nine, followed by cards, or a walk or trip to a café; following this, he would read, write, and edit articles. At the end of this long day, he would go to bed at one in the morning. He was also devoted to his family, spending time with them at meals and during their summer family vacations. His devotion was poignantly illustrated in the grief and sorrow he felt over the losses suffered by his family (such as the death of his daughter, Sophie, and his grandson, Heinz); Freud, who came to see life as a war between the forces of life—Eros—and death—Thanatos—was a human being who deeply experienced both in his long life.

The Relevance of Psychoanalysis

This brief synopsis introduces us to the historical Freud, but it nowhere addresses his relevance. It is my contention that textbooks and classes on Freud often do a relatively good job of describing Freud's historical

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significance and the architecture of his system—as if it were some interesting cathedral wherein esoteric and sometimes cruel rites were once carried out—but a relatively poor job of describing his contemporary significance. Through my own experience working with clients, talking with colleagues, and teaching graduate counselors-in-training, I've developed an instructional strategy that presents Freud in a clinically relevant fashion. I think students are open to exploring his relevance, even if they have had less-than-ideal past instruction in this regard. And it has also been my experience that when I talk with professional colleagues, those who are "in the trenches" seeing clients every day, many are enthusiastic about reassessing Freud in terms of contemporary clinical significance. Regardless of theoretical orientation, many are open to the idea that Freud remains relevant, though perhaps not in the ways that have been traditionally articulated. Moreover, an assessment of Freud's relevance is an ongoing question of practice. Clinicians-in-training and clinicians can and should evaluate Freud's ideas in light of their experiences in their clinical training and in their subsequent careers, asking themselves: Does Freud still matter, from a contemporary clinical perspective?

Inauguration: To Mark the Beginning of a New Period, Style, or Activity

To do so most effectively, they may need to be offered some assistance in how to structure an understanding of his life and work. I suggest that we think of Freud as someone who inaugurated important therapeutic concerns that continue to have clinical utility. I use the term *inaugurate* carefully; in using this term, I am more interested in these two definitions of the word—"to put something into use or action officially" and "to mark the beginning of a new period, style or activity"; I am thinking less of this definition of the word, "to put someone into an official position with a ceremony" (Walter, 2008).

In other words, I'm not interested in crowning Freud the first King of Counseling; I am interested in describing how he marked a new style, a new way of doing, a new systematizing of practices. It is important to keep in mind that Freud, while he did have flashes of originality and new insight, generally did not come up with totally new ideas or come up with radically different theories and therapeutic interventions. As Ellenberger (1970) says in his comprehensive work on the origins of dynamic psychotherapy, "much of what is credited to Freud was diffuse current lore, and his role was to crystallize these ideas and give them an original shape" (p. 548). This is an important point to keep in mind when referring to Freud's ideas. Freud's thinking was sometimes original but more often *synthetic*.

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I acknowledge that considerable work has gone into my reconstruction of Freud in order to make him useful for clinicians today. I also acknowledge that I depart at times from opinions that Freud held about his own work, let alone what other critics have said. For example, he said at one point that "the theory of repression is the corner-stone on which the whole structure of psycho-analysis rests" (Freud, 1914/1957, p. 16). I disagree. The cornerstone of psychoanalysis, considered as a clinical undertaking, is the talking cure. While repression is certainly a major theoretical component of psychoanalysis, it takes a backseat to the central importance of the client and the relationship.

Starting With the Two Most Important Common Factors: The Client and the Counseling Relationship

Thus we begin with the two therapeutic concerns that have been shown by contemporary research to have the largest influence on therapeutic change, the client and the therapeutic relationship. It may seem anachronistic (to judge someone or something in the past according to our present knowledge) to present Freud in terms of this contemporary research, which has been termed the *common factors hypothesis*. But as we shall see, these two factors can be understood to be the primary building blocks of psychoanalysis itself, factors that Freud knew to be of utmost importance to the therapeutic enterprise.

Freud clearly understood the power of the therapeutic relationship and spoke about it repeatedly and in terms that asserted its primary importance, as we will see. And Freud concentrated his energy on working with and describing unique individuals in that therapeutic relationship: Dora, the Wolf Man, Schreber, the Rat Man, Little Hans. Some were his metaphorical companions for years; Anna O.—her real name was Bertha Pappenheim—remained of interest all his life, even though he never personally treated her. He knew—though he could seem to forget—that the patient was of primary importance. Freud becomes least useful when he distances himself from his patients, mostly notably when he follows twisting and winding interpretations that stray farther and farther from the patient's experience, until the patient and Freud are seemingly miles apart, shouting at one another.

Freud Versus Freud: What Did He Actually Do?

Freud's interpretive excesses have long been noted by his critics, and they must still be acknowledged (his treatment of Dora, one of his early patients,

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is particularly noxious). However, they are not of foundational importance to understanding the *utility* of psychoanalysis. In fact, they show Freud's frequent misunderstanding of the results of his own clinical work; his blunders show that he was relatively unsuccessful when he lost focus on the client and most successful when he demonstrated the qualities that outcome researchers have identified over the years as leading to positive therapeutic change, "factors such as therapist credibility, skill, empathic understanding, and affirmation of the patient, along with the ability to engage the patient, to focus on the patient's problems, and to direct the patient's attention to affective experience" (Lambert & Barley, 2001, p. 358). Freud possessed these qualities and often showed them to patients. And his patients, as patients are wont to do, probably didn't really care much about his esoteric interpretations, but instead remembered the small kindnesses and humanity that he displayed. Freud could be empathic, affirming, and engaging; these qualities have been recorded in stories by and about his patients (Doolittle, 1956; Lohser & Newton, 1996; Ruitenbeek, 1973), and these qualities remain essential—primary—in therapeutic treatment.

Quick Clinical Vignette

The Importance of Being Human

The vital importance of empathically understanding and responding to clients was illustrated to me with the case of Teddy. Teddy was a twenty-one-year-old male who struggled with major depression. We met for about a year, discussing the neglect that had characterized his childhood, his struggles with depression, weight, and keeping in good physical shape, and his attempts to find employment.

As is often the case, there was a negative interaction among his issues—his depression, and the medications that he took for it, led to weight gain, which made him further depressed, which led to more weight gain, which caused him to be more sedentary—all of which impacted his employment negatively. His weight gain caused serious knee and joint problems, making it difficult for him to stand for long periods. Since he couldn't stand, many jobs were ruled out. His overall poor health and fitness ruled still more jobs out, and as a consequence of his depression, he tended to have problems with sleep, either sleeping too much (and missing work) or sleeping too little (and falling asleep at work).

Despite all this, Teddy did improve, and at termination was working steadily part-time. He told me that I had helped him. I asked him how. He said that when he told me about a successful job interview, I had literally jumped up and down with excitement. (I recalled the incident—I had rocketed to my feet and yelled with glee.) He said that no one had ever been excited by anything he had ever done—I was the first person to express joy for him. The takeaway? Even Freud, who advocated restraint and objectivity, was human and real with his clients. If a client tells you something that makes you want to jump up and down with joy, you might consider doing it.

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It needs to be said that only certain of Freud's pronouncements were enshrined while others were neglected so that key attitudes such as tact and empathy that Freud himself emphasized in his clinical practice were systematically ignored (Thompson, 1994). Freud was clear that there were very few hard and fast rules that governed the clinical encounter. One was abstinence—refraining from the easy gratification of a patient's wishes, sexual and otherwise. Another was that the patient should say everything that came to mind—particularly those things that he or she might not want to say. But aside from a few of these firm guidelines, much of what goes on is up to the analyst and the patient to figure out together.

Over the years, supposed unbreakable rules were developed about what psychoanalysis was or wasn't; if one reads accounts by Freud of his work, and accounts written by people that he treated, Freud broke most of those rules, including rules that he himself seemed at times to be putting forth in his own writing. He never broke the rule on sexual abstinence, which is one of the few rules that has survived to the present day and upon which all therapeutic codes of ethics agree—no sex with clients! But other than that, Freud's actual clinical practice was much warmer, and much richer, than the picture that is often imagined of the silent and opaque figure who would break his silence with occasional cryptic remarks.

However, we shouldn't try to make Freud warm and fuzzy and cuddly, or to present him as better than he was. Though he appears no better or worse than most of us regarding his family life and his friendships, he was no paragon of professional virtue. As his critics have shown, notably Crews (1986, 1995) and Masson (1984, 1992), Freud acted in ways that were, in our present understanding, self-promoting, defensive, and even unethical. Freud took liberties with his presentation of his case histories (Sulloway, 1991), and everywhere seemed to feel that the most important measure of his actions was whether it advanced the cause of psychoanalysis, even as some of those very actions ultimately caused many who came after to reject both the man and the theory. It is important to recognize the fact that Freud himself was highly neurotic (a fact that he was very aware of) and in thrall to a mystical vision of sex as God and himself as High Priest, as Jung (1961) so ably described. It is important as well to note that there have been questions about the possibility that he was sexualized at a young age (Vitz, 1988) and that this may have played an important part in his obsessive concern with sexuality. (Analyzing someone's ideas according to their sexual biography was inaugurated by Freud, by the way.)

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Freud's Goody-Goods: The Necessity of Collaboration

I am sympathetic to the idea that "the first practitioners of psychoanalysis were making it up as they went along" (Phillips, 1993, p. 2). In some ways, this had to be the case, since what they were doing was new and could only be accomplished with a certain degree of trial-and-error. However, Freud's biggest downfall was his inability to truly engage talented colleagues such as Jung and Adler on equal terms, which would have perhaps created a real community (not the society of followers that he did in fact create) that could have corrected many of his excesses and helped him avoid the dead ends that his obsessive focus on sexuality led him into. In this, an inquiry into Freud's life and work yet again anticipates a major, ongoing clinical issue—*the absolute necessity of collaboration with one's peers*. We must use Freud as an example of the need for counselors to be humble and to be wary of the potential harm they can do if they try to operate without the correcting influence of colleagues. Freud himself realized that he had created no real, vibrant community of psychoanalytic scholars and researchers, but instead had driven away his brightest colleagues, saying once, "the goody-goods are no good" while the "naughty ones go away" (Sulloway, 1979, p. 482).

Thus, he was left on his own, and though he attempted to surmount it through his self-analysis—psychoanalysis began as a result of Freud's (1900/1953a, 1900/1953b) analysis of his own dreams—Freud was a creature of his own time and place. Freud, who was born in 1856 and died in 1939, was influenced by the Victorian Era, his upbringing and Jewish heritage, the powerful reductionism of his mind, and his authoritarian, rigid tendencies that warred with his kindness and tact and empathy. Again, our understanding of how his life and work was influenced by forces and motivations that were often out of his conscious thought is a classically Freudian thing to do. It is also classically Freudian to understand that there exists a need for help in understanding oneself, whether it be the client who needs help from a counselor in unearthing and interpreting hidden psychic material, or the counselor who needs help from colleagues and supervisors to understand how her own hidden psychic material is impacting clinical work with clients. Freud's example encourages us to be self-reflective and concerned with insights into our own condition (one therapeutic theme) but Freud illustrates the pitfalls that even the most self-reflective clinician might succumb to without the benefit of colleagues whom one listens to and trusts (another therapeutic theme). It was emphasized in my clinical training: *consult with colleagues, consult with colleagues, consult with colleagues,* and I hope this has been emphasized in your clinical training as well.

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Constructing a Counselor-Friendly Freud

Thus, there are minor and major adjustments that need to be made for Freud to “work” for contemporary usage. I acknowledge that the end result will be a Freud that is different than the one who critics and admirers construct, different to some degree than the one who Freud understood himself to be. The Freud who is ultimately created in *Psychoanalytic Approaches for Counselors* is, I hope, a counselor-friendly Freud, and again this means substantial revision and updating of his ideas. For example, contemporary research appears to cast doubt on the traditional psychoanalytic view of repression. I am comfortable with a revised view of repression, wherein Freud’s particulars are corrected, yet the basic idea—that we hide things from ourselves, and these things retain potency in our life—is retained. This would drive some critics of Freud crazy. In their view, this is a typical Freudian apologist strategy—grant that Freud was often wrong about the particulars, but mostly right about the big picture and still highly relevant, which is in fact the basic position I hold on most of Freud’s ideas. (I should again be clear that I’m speaking not about his overall contributions to the field of psychology or more broadly his philosophical contributions, but more narrowly to his ongoing clinical relevance.)

Thus I agree with the conclusions from one recent attempt to update repression, in which the author said that “it does not matter from a scientific standpoint if we label the process ‘repression,’ ‘suppression,’ ‘retrieval inhibition,’ ‘dissociation,’ ‘cognitive avoidance’” (Erdelyi, 2006, p. 511)—the latter terms being used in modern-day empirical research. This, as I’ve said, drives rabid Freud critics absolutely bananas. They dismiss it as simply repackaging truisms as Freudian insights. As one critic fulminates, “Freud did not earn his reputation as a bold and original thinker by blandly affirming that people sometimes try not to think about unpleasant things. He earned it by making all kinds of wild claims about what gets repressed, such as the desire of every little boy to murder his father and have sex with his mother” (McNally, 2006).

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Quick Clinical Vignette

The Boy Who Wanted to Marry His Mother

It might seem unlikely that you might see an actual case of a boy expressing a wish to marry his mother, but it happens oftener than you might think. (If you are a parent, you might even have an example of your son or daughter expressing this wish to you.) A clinician whom I supervised shared a case

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(Continued)

with me of a seven-year-old boy who was very adamant that he was going to marry his mother. His biological father was long out of the picture, and the boy and his mother lived together. The boy would frequently ask the clinician to pretend to be his mother and to dress up in white so they could get married.

The clinician was a particularly sensitive and creative person who was able to empathically enter her little client's world. I remember being in awe of the elaborate play counseling that she engaged in with the client around this theme, and I looked forward to hearing the next installment on their marvelous psychodrama in our supervision together. Following the best developmental principles, she worked with the boy to express in play how he felt as well as to work through in play to achieve mastery (Erikson, 1963). In their work together, the clinician worked with the many imaginative variants of the boy's marital fantasies, examining not only how the boy felt but also how the various participants in the wedding might feel, and I have no doubt that "deep" work was accomplished. The takeaway? Children can sometimes directly and strikingly address things that adults have learned to hide—from themselves and from others—including direct expressions of erotic interest in their parents.

I admire the wittiness of this remark against Freud (Freud seems to frequently inspire this kind of scathingly witty critique; what could that possibly mean?), but it goes against the grain of what I am doing in *Psychoanalytic Approaches for Counselors*. I am interested in bland affirmations, in particular those that we have come to find are clinically relevant and useful, like, "The client is the most important person in the therapy room," and "A pact between counselor and client is vital," and "People often come to therapy not knowing exactly why they are doing the things they are doing." The origins of these affirmations can be traced to the work that Freud did. Ultimately, so many of the issues that Freud thought about and wrestled with remain of continuing interest to the work that clinicians do and to the clients that they see. Counselors-in-training need to start with Freud, and practicing counselors should continue to read him because his life and work embodies key themes that organize the helping professions, themes that practitioners and theorists keep returning to, themes that *they can't help returning to* because they constitute the therapeutic enterprise itself. (Yes, the idea that we can't help returning to things—because they keep returning to us—is a Freudian one. It is the idea of "the return of the repressed" [Freud, 1896/1962b, p. 170]). These themes return to us, and we to them, in our clinical work.

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THEMES INAUGURATED BY FREUD

- Importance of client
- Importance of therapeutic relationship—transference and countertransference
- The role of unconscious processes
- Repression of important psychic material
- Resistance to uncovering and acknowledging important psychic material
- Interpretation of dreams
- Role of reason and rationality in therapeutic change
- Sexual drive/Sexual motivation
- Childhood determinants of personality
- Multicultural considerations
- Feminism
- Etiology (origin/cause) of mental illness
- Hypnotherapy
- Electrotherapy
- Psychopharmacology (use of psychiatric drugs)
- Diagnostic classification of mental illness
- Child sexual abuse
- The necessity of counselor self-awareness and self-insight
- The ongoing necessity of clinical supervision and collaboration

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The Cause(s) of Mental Illness

An important example is the etiology (origins or cause) of mental illness. In the 1880s, scientific theories of the mind were "in essence barely disguised physiological theories" (Gay, 1989a, p. xiii) that held that organic issues such as brain lesions were responsible for abnormal thoughts and behavior. Patients might be summoned to display their bizarre symptoms in amphitheaters before medical students or the interested public, but in the scientific community at that time it generally wasn't thought useful to listen to them and take seriously what they said. The focus was on determining how organic problems such as brain lesions or tumors produced abnormal behavior. Freud instead began to suggest that there were psychological factors that could produce these behaviors, and his entire project was aimed at finding out their underlying root causes.

Yet the debate between the biological versus psychological origins of mental illness was not thus laid to rest. Freud, who himself began his career in scientific, applied research, never fully abandoned his hopes for a biochemical explanation of brain and behavior. Moreover, the method introduced by Freud's contemporary, Jean-Martin Charcot, involving the

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"systematic clinical correlation of compromised mental functions with anatomical damage to particular areas of the brain . . . has been the central method in neuropsychology for many years" (Turnbull & Solms, 2004, p. 574). Resurgent research interest in this arena was officially recognized when Congress declared the 1990s the "Decade of the Brain," and there has been a roaring return to inquiry into the relationship between brain structure and functioning and mental health and mental illness.

Transference and Countertransference

As another example, transference (feelings of client toward counselor) and countertransference (feelings of counselor for client) continue to be useful because they illuminate otherwise incomprehensible reactions on the part of clients and equally incomprehensible (and sometimes unethical) reactions on the part of counselors. Helping professionals are less likely to be blindsided if they are well-versed in Freud's views on the therapeutic relationship. There is a story about a counselor who, confronted with the fact that he had sex with a client, was asked, "Didn't you consider the possibility of transference and countertransference?" He replied, "I don't believe in all that Freudian stuff." There may be plenty of "Freudian stuff" that a clinician can safely regard as optional, but the potency of the therapeutic relationship isn't one of them. Freud remains important because of the fact that many of *his* clinical preoccupations remain *our* clinical preoccupations; the questions raised by *his* theory and practice are the questions raised in *our* contemporary clinical practices. His answers are not always our answers (and they may need significant revision to remain useful to us), but many of his questions retain crucial significance for every therapeutic encounter and we ignore them at our—and our clients'—peril.

Further Developments

And as we shall see, psychoanalysis did not end with Freud. There have been a number of crucial developments in the field. There has been an important transition from a classical model that stresses internal, instinctual drives to an interpersonal model, in which our relationships with other people are not incidental to our development, but in fact fundamentally constitute our growth as human beings (Greenberg & Mitchell, 1983). There has also been a growing concern with multiculturalism and how psychoanalysis can be practiced from a diversity competent and multiculturally aware perspective (e.g., Altman, 2010). There has been important work

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that aims to integrate neuroscientific findings and psychoanalytic theory (Schore, 1994, 2003, 2011). These important new findings—patches that update the basic program, to adopt a computer metaphor—further support the idea shown that psychoanalysis isn't simply of historical interest, but continues to be highly relevant and a useful model for the contemporary clinician.

Not only highly relevant and useful, but supported by empirical research as well. Shedler (2010) reviews the literature and concludes that the evidence shows that psychodynamic (he uses this term interchangeably with psychoanalytic) approaches are just as efficacious (working in clinical trials) and effective (working in more natural settings) as other psychotherapies. He says there have been chronic misconceptions of what constitutes contemporary psychoanalytic practice, as well as a lack of awareness of the research studies that support its effectiveness. In fact, research supports the use of psychodynamic/psychoanalytic approaches and finds that it is just as effective as other approaches; this equivalence should sound familiar, because it points us back in the direction of the common factors hypothesis that states that different psychotherapeutic approaches are equivalent in their treatment outcomes.

Summary

- Freud's life and work remains clinically relevant for counselors and can be most usefully understood from a common factors perspective that emphasizes the importance of the client and the counseling relationship.
- Freud, when he was most successful with his clients, displayed the care and attentiveness that we now know to be essential for positive treatment outcomes.
- Freud serves as an example of the necessity for counselors to gain insight into their own thoughts and behaviors; he serves as an example to avoid through his inability to collaborate with his peers.
- Freud inaugurated key themes that the field returns to, themes such as the cause(s) of mental illness and the status of unconscious processes; these themes fundamentally define the counseling enterprise.
- Important revisions have been made to Freud's theory. The most important ones are a movement toward an interpersonal model, a concern with multicultural practice, and integration of neuroscientific findings, which all are examined in detail in this book.

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