***Editor's Note**: Many analysts—Freud, most famously—have had dogs in their consulting rooms. Yet none to our knowledge have described the psychodynamic role of dogs or other pets that may be present during the treatment process. At the Journal's request, the author of the following article agreed to briefly explore this matter. Responsible correspondence concerning this article and the topic is welcome. –DHI*

The Dog's Role in the Analyst's Consulting Room

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Joe, a Labrador retriever, has accompanied an analyst in the consulting room since the dog was age three. Patients uniformly find him soothing and reassuring. In this capacity, he facilitates the therapeutic alliance and the holding environment. In addition, he often functions as a transitional object and transference displacement. Patients frequently use him as an introject for certain qualities they desire, such as security, strength, and confidence. Sometimes he promotes enactments between the patient and the analyst. At other times, he functions as a countertransference displacement for the analyst. On occasion, he is incorporated into the patient's defensive maneuvers and resistance. In each of these roles, he facilitates key elements of the therapeutic process, including exploration, understanding, interpretation, and working–through. Perhaps his most important role is that of a nonjudgmental, supportive, loyal cotherapist. Case illustrations highlight Joe's various functions in the analyst's consulting room.

Predictably, Freud, the preeminent groundbreaker in our field, was the first analyst to have a dog in the consulting room (Gay, 1988). As a consequence, he may have also been the father of "Animal Assisted Therapy" (AAT). The latter is a rapidly developing field centered on the use of domesticated animals (usually dogs) for the purpose of aiding and healing those who are ill, elderly, or alone (Lipton, 2001). Studies have demonstrated that AAT helps decrease anxiety, depression, anger, and aggression. It also increases social interaction and encourages patients to discuss painful material by reducing the threat of the treatment setting (Barker, 1999). The first published report of a psychiatrist using a dog in therapy sessions was by Levinson (1962). He reported that the dog facilitated communication and provided a sense of security to his child patients. Freud was given his first dog, a German shepherd, by his daughter, Anna, in 1928. Later he had several chows, the best known of whom was Jo–Fi. The traditional 50–minute hour is allegedly attributed to Jo–Fi, who used to get up at ten minutes to the hour, thereby allowing Freud to end the ses-

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sion in order to let her out. Freud believed that dogs possess qualities that humans often lack; they express their feelings directly, are incapable of deception, and remain fiercely loyal (Roazen, 1975).

Since Freud, many analysts have had dogs in their consulting room, but none have written explicitly about the role of the dog in the analytic setting. Although I have owned several dogs, I never had one stay with me in the consulting room until I moved my office adjacent to my house. When my Labrador retriever, Joe, was about age 3, he began accompanying me into my office. Patients did not seem to mind having him sleep quietly through sessions (better him than me), and his presence became habitual. Joe possesses the ideal nonverbal qualities of a good therapist. He is even–tempered, nonjudgmental, empathic, friendly, and not easily provoked. Confidentiality is his forte, and I have never known him to betray a secret.

I always ask new patients if they mind having a dog in the consulting room before I allow him to be present. The majority of them do not object; in fact, they express eagerness for his company. The few who decline or express reservations about his presence usually reveal a pathological source. They are phobic of dogs, allergic, or narcissistically resent having someone else in the same room who might demand my attention. After greeting each patient with a wag of his tail and a cursory identifying sniff, Joe usually lies down somewhere between the patient and me. Joe invariably sleeps during the session and is awakened only if a voice is raised or if he becomes aware of intense emotion (e.g., crying, laughing). If a patient exhibits emotional distress, Joe often goes over and offers a paw or whimpers in an empathetic tone. Otherwise, he is respectful of boundaries and is never intrusive unless the patient asks him to come over for some reason. The only exception is when he hears an extraneous noise outside the office that disturbs him. On those occasions, he might go toward the door and bark. However, he will quickly stop on my command unless I cannot control the outside disturbance (e.g., a delivery person knocking at the door).

On the whole, patients find Joe soothing and comforting. They often pet him when they first enter the room as a way of calming and reassuring themselves. In that sense, he facilitates the holding environment and is a positive influence on the therapeutic alliance. In effect, he promotes the patient's feelings of safety and security in a potentially threatening situation. He also functions as a transitional object and a transference displacement. Patients often feel less threatened communicating disturbed feelings and fantasies to him rather than directly to me. For example, a patient may begin the session by saying, "Oh, Joe, it's been a tough day," or "I'm an unhappy camper today, Joe." By the same token, they are frequently less inhibited about expressing both positive and nega-

tive transference feelings to him instead of toward me. Examples are: "You're such a good boy, Joe"; "I love you, Joe"; "bad boy, Joe"; or "mean dog." Generally speaking, he functions as an available, benign object for the projection of threatening and nonthreatening feelings. Evidence of this is the following: "Joe looks mad today"; "Joe acts bored"; "Joe seems happy"; or "Joe's relaxed and peaceful." On the other hand, he also functions as an introject of qualities and feelings that patients desire. He is looked at, spoken to, or touched for solace, affection, reassurance, strength, confidence, and protection. For example, patients say, "I'd love to have Joe's peace of mind" or "I wish I had Joe's determination."

Either as an object for projection or as an introject, Joe frequently serves as a displacement of me that patients find more tolerable and less threatening. Sometimes he becomes an unwitting ally in the patient's defensive or resistance maneuvers. For example, talking and playing with him may divert patients from focusing on themselves. Silence and withdrawal are more easily camouflaged when the time is spent petting Joe. He may also act as a facilitator of enactments between patients and me. For example, a patient may point out a sore on his body that has escaped my notice. In turn, I become involved in examining it and discussing possible remedies. The entire interaction between patient, dog, and me may be a repetition of the physical or emotional neglect the patient experienced with her parents. Simultaneously, it may be a transference displacement signifying the patient's dissatisfaction with my therapeutic efforts.

Joe occasionally functions as a countertransference displacement for my feelings. I sometimes stroke him for reassurance and support when I am attacked or devalued by a patient. When I feel uncertain or discouraged, his soulful eyes will often communicate an understanding of my discomfort and affirm my purpose as a therapist. At times, I project my frustration and anger onto him with a curt command such as "lie down" or "stop doing that." At other times, I can be affectionate and playful with him in a manner that would be totally inappropriate with a patient. As an object for transference and countertransference displacement, he is also helpful in maintaining boundaries while simultaneously promoting continuity and spontaneity.

The following clinical vignettes may serve to illustrate Joe's functions in the treatment situation:

I

A divorced woman was in treatment for recurrent depression, depersonalization, self–mutilation, and suicidal behavior. She was sexually

and physically abused by her father from age 6 to 13. Her ex–husband, an alcoholic, was verbally and physically abusive. Her mother, who failed to protect her from her father, nevertheless loved and cared for her. Following an initial idealizing transference, she began to view me as abusive (e.g., insensitive and indifferent). On the other hand, she perceived Joe as friendly and affectionate. She often brought him biscuits and petted him during sessions. As this split transference evolved, she withheld critical information from me, but confided in Joe. She would frequently arrive early and ask if Joe could stay with her in the waiting room. While alone with Joe, she often whispered to him her urges to cut or kill herself. When I became aware of this, I would ask Joe in a play–acting mode whether she was feeling self–destructive. Sometimes it took an entire session before she begrudgingly acknowledged that she had told Joe about cutting herself, or that she was planning to overdose on medication. Once, she reported that she was feeling suicidal at home and was about to cut herself when she noticed a photo of Joe that I had previously given her at her request. She began stroking it, soothing herself until her self–destructive urge subsided. In that instance, she stated that Joe "saved my life." While critical of me during sessions, she would sometimes motion to the dog and say, "He would never hurt me." Over a period of time, I interpreted to her how she perceived Joe as the good, loving father she wished for, while selectively focusing on my shortcomings. Ever so gradually, she began to express negative feelings for Joe (e.g., "he's not friendly today"; "he almost bit me when I fed him a biscuit"). Paradoxically, I became the recipient of more positive feelings (e.g., " I can always rely on you"; "I believe you really do care about me"). Increasingly, she began telling me directly about her feelings and fantasies rather than communicating them through Joe. It became clear that her self–mutilating behavior was connected to intense guilt and anger over her incestuous relationship with her father. Cutting herself was also a way to acquire feelings, albeit painful ones, in order to overcome the inner numbness of her depersonalization. Over the course of treatment, she has become much less self–destructive and sees both Joe and me more realistically (although she still maintains a special affection for the dog). In my opinion, Joe served as a benign, transitional object for her that she could trust, and in whom she was able to confide. He became the recipient of a displaced positive transference while I was the object of her negative transference. As treatment progressed, she introjected the positive aspects of her relationship with Joe (trust, safety, affection) while simultaneously identifying them with me. For example, her capacity to control her suicidal impulses when she looked at Joe's photo represented an internalization of my self–regulatory function. Gradually, her relationship with me was transformed and internalized from an abusing

one into a protective, caring one. Correspondingly, the guilt and anger connected to her father diminished. Although all of these changes would most likely have occurred without the dog's presence, I believe that he facilitated and perhaps even accelerated them.

II

A young man entered treatment for impulsive, acting–out behavior, temper outbursts, and disturbed interpersonal relationships. He frequently lost jobs because of quarrels with fellow employees and supervisors. On several occasions, he was arrested by the police for using abusive language after being stopped for traffic violations. He also had a dog and initially behaved toward Joe as if he owned him. For example, he would command Joe to "sit down" or to "come over to me," as though I were not in the room. As I explored this interaction with the dog, his sense of entitlement and grandiosity became apparent. Born into a wealthy family, his parents failed to set limits for him and catered to his every demand. During sessions, he often became enraged, yelled, used profanity, and became agitated as he reported an encounter with someone who disturbed him. When these episodes occurred, Joe would become startled, get up, and follow him around the room. Finally noticing the dog, he would begin petting him, calm down, and lower his voice. This allowed me the opportunity to explore the particular interaction he was describing in a more rational way. With his rage and aggression contained by his physical contact with Joe, we were able to examine the situation in question from different perspectives. Sometimes he was able to realize how his actions had been irrational and provoked the other person. Although it was relatively easy for him to openly express his hostility and aggression, he was only able to communicate his tender, loving feelings to Joe (e.g., "I love you, Joe; "I'll take good care of you, boy"). Negative transference was the hallmark of a substantial part of therapy, and the following statements were typical: "You're just like the cops"; "I don't care what you think." Conversely, his positive transference was displaced onto Joe by bringing him biscuits, or comments such as "you're a good boy, Joe." His pattern of interpersonal boundary violations was manifested within our relationship when he would sometimes insist that he take Joe home with him for a weekend. On another occasion, he announced that he was bringing me a puppy so that Joe would have company. These occurrences provided me with an opportunity to explore the origins of his fantasies, and to point out how his statements and behavior could be threatening to others. We gradually discovered that a good deal of his anger and sense of entitlement were connected to

his inner feelings of inadequacy and failure. His educational history revealed ample evidence of a learning disability and attention-deficit disorder. With appropriate medication and therapy, his anger and aggressive behavior diminished. However, it was Joe's presence that soothed and helped him to contain his rage, permitting me to engage him in a rational, calmer exploration of his behavior.

III

A divorced woman entered treatment for depression, social isolation, and paranoid ideation. Since her divorce, she totally avoided relationships with men. She lived alone with two cats, and rarely socialized. Her mother was physically and verbally abusive toward her, while her father was remote and indifferent. At the beginning of therapy, she was wary of Joe and avoided petting him. Curiously, he positioned himself at her feet as though he were protecting her, forming a barrier between her and the outside world. Slowly and hesitantly, she told me about her profound distrust of others, including me. Her mother, who made her feel unwanted and useless, was the target of enormous rage. Her ex–husband, similar to her father, was inattentive and enmeshed within his own family. Therapy was punctuated by long periods of silence, during which she would look away from me and stare at Joe. Gradually, she began petting him, simultaneously telling me how sad, frightened, and lonely she felt. As she petted Joe, she began making references to him (e.g., "he's always here for me"; "there's not a mean bone in his body"). At the same time, she expressed her distrust of me. In particular, she was afraid that I might betray her by revealing a confidence to someone else (as she believed a previous therapist had), or that I might abandon her. Her split transference continued for several years, complicated by medication noncompliance and several attempts to end treatment. In the meantime, her father died, she changed jobs several times, and she sustained a fractured wrist and leg in separate falls. Throughout each of these events, Joe remained steadfastly beside her, and I maintained my empathic stance. Ever so gradually, she began commenting on my availability and reliability. Eventually, she revealed that in spite of herself, she was feeling affectionate toward me. However, she acknowledged that any romantic or sexual fantasies about me would be too frightening and inappropriate. Nevertheless, she allowed herself to begin imagining the possibility of an intimate relationship with another man again. Her social life gradually expanded, and she finally began a relationship with a man she met at work. In this case, Joe served as a soothing, protective transitional object. He was also a transference displacement, facilitating

a gradual shift in the patient's feelings of distrust and fear to affection and trust toward me.

In each of these clinical examples, Joe was available to the patient as a soothing introject. In this capacity, he facilitated the therapeutic alliance and helped the patient feel less threatened in the treatment setting. Moreover, he fostered transference displacement, particularly positive transference, thereby allowing negative feelings to be more easily directed toward me. Over the course of treatment, he often became the foil for negative transference when patients shifted their positive feelings more consciously toward me. As a nonthreatening object, he also served as a repository for painful feelings and fantasies. He was frequently a patient's initial confidant for feelings of sadness, loneliness, and despair. On more than one occasion, it was communication through Joe that alerted me to self–destructive and suicidal fantasies. By the same token, it was easier for patients to project positive feelings and fantasies onto him rather than me (e.g., affection, love, trust). As an object of displacement, Joe helped me to make transference interpretations more understandable and acceptable. Enactments and boundary violations were more effectively managed and interpreted with Joe playing the role of intermediary. Because he was a convenient displacement of me, he helped to reinforce patients' identification and internalization of my healing qualities, including constancy, containment, and affirmation. In particular, I believe that the bond of mutual love and loyalty that patients observed between Joe and me encouraged them to replicate it in their relationships with significant others (at the very least, with their pets). Moreover, his presence encouraged patients to express themselves more spontaneously and playfully inside and outside the treatment setting.

Lastly, and perhaps most importantly, Joe provided me with a companion who was always available for self–soothing and narcissistic reinforcement. The work of therapy can be demanding, frustrating, and emotionally depleting. A nonjudgmental, loyal co–therapist is a reassuring source of support. Furthermore, an idealizing, loving dog is an additional bonus that makes up for the many hours that often go unrewarded during the therapeutic journey. Some might argue that a dog's presence in therapy is more of a distraction and a potential source of resistance than it is beneficial. This may be true in certain instances, but more often than not, I have found that Joe's usefulness in the therapeutic process outweighs his liabilities. Perhaps the outcome of each treatment I have described would have been the same without Joe's presence. And there is no doubt that I have engaged in a certain degree of idealization and projection regarding Joe's role in therapy. However, keeping in mind that a dog is known to be man's best friend, I would emphatically add

that a dog can also function as both a therapist's and a patient's best friend in the consulting room.

References

Barker, S. B. (1999). Therapeutic aspects of the human–companion animal interaction. *Psychiatric Times, 16*(2), 43–45.
Gay, P. (1988). *Freud: A life for our time*. New York: Norton.
Levinson, B.M. (1962). The dog as co–therapist. *Mental Hygiene, 46*, 59–65.
Lipton, L. (2001). Some patients petting their way toward improved mental health. *Psychiatric News, 36*(3), 17.
Roazen, P. (1975). *Freud and his followers.* New York: Knopf.

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