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Introduction to a Conversation

Helping patients begin psychoanalysis

A recent book by the social essayist, Stephen Miller, is titled *Conversation: A History of a Declining Art*. As we know from personal experience, good conversation is rare, but exhilarating when it occurs. Since the eighteenth century philosophers and scholars have talked about the importance of good conversation, and the impediments to it. For me, in its simplest terms, *a good conversation is about creating further conversation*. It's about engaging others in furthering along thinking by careful listening, reflection, and considering one's inner life. This is also a pretty good approximation of what we hope occurs in the analytic conversation. For the patient, we hope to create an atmosphere where an inner conversation that has been disrupted can be resumed with the help of the analyst.

We all know what it's like to be with someone who *wants* to be in a conversation. Some are good listeners and reflect on the conversation. It can stimulate us to think more about what we've said. On the other hand there are those who can't wait to interject their own thoughts. As analysts we struggle with these issues, and it can be a central issue in whether we help a patient into or out of psychoanalysis.

As indicated earlier, it is helpful to think of two types of conversation patients bring to treatment. The first is the ability to use associations to tell a story that is not

conscious, but preconscious. A second conversation we hear in treatment occurs in language action, where the words are meant to *do something*. Then there are times when it seems a conversation has come to a halt, or the patient looks to the analyst to lead the conversation. In all these conversations the analyst is trying to understand what leads the patient to this particular type of conversation taking place. In this I'm focusing not only on the content, but also on the form of the conversation. As if things aren't complicated enough, we also need to pay attention to the underlying affect in a conversation. The greeting, "Hello," can be said jovially, in a friendly way, seductively, hissed, spit out, whispered or yelled. Thus we need to listen to the music as well as the words in our patients' conversation.

However, we soon come upon an important question: Why do we want to help further the patient's conversation? – especially with regard to its sub-text. I would
answer that a basic tenet of psychoanalytic thinking is that what leads people to our offices revolves around their inability to feel or think something, or else being stuck in repetitive thoughts and feelings. *That is, our patients suffer from interrupted or unproductive conversations with themselves*. This was Freud's monumental discovery.

The increasing capacity of patients to know of and *own* their inner conversations is central to their developing a *psychoanalytic mind*. It is the basis of an exhilarating freedom of the mind. In contrast, it is the inhibited, restricted, interior conversations, which leaves them

feeling depleted, confused, and unappreciated. We have to help them understand the fears that led to them falling internally silent, so they can pick up again the thread of these conversations. In short, I find the metaphor of interior conversations useful, as it captures a way of thinking about the therapeutic process, especially the analyst's role in aiding or interfering with the patient's conversations.

A supervisee recently told me of the following clinical moment.

P: I was angry when I left here yesterday … it's hard to remember what happened.

A: Something makes it difficult to remember *that* you were angry at me. Do you have a sense of discomfort and want to move away from your angry feelings?

P: No … I'll get back to it … other things are on my mind.

Here we have the patient barely getting started in her conversation, a conversation about why it might be hard to have a conversation, when the analyst steers the conversation to what she's interested in (the transference). It is also striking that in steering the conversation the analyst changes the nature of the patient's conversation. That is, the patient says, "*I was angry*. It's hard to remember what happened." The analyst says, "Something makes it difficult to remember that *you were angry*."

As analysts we have always struggled with sifting the patient's conversation from our own. I believe it is

important to highlight this struggle, because the analyst's intrusion into the patient's conversation, as well-intentioned as it may be, is a problem across the theoretical spectrum.

In fact, if we allow it, patients will converse with us in words and actions, their negations, denials, and intellectualizations, in their telling of dreams, or not, in their expression of intense feelings, or not, and the multitudinous forms of communication available. In these conversations we will find the why of our patients coming to us, and the road to their leaving. In between they will tell us why they shouldn't have conversations with us, and vehemently deny there is any conversation going on in their mind. At other points patients will be happy to have a conversation with us, but will be uncomfortable with owning their side of the conversation.

The first interview

There are multiple goals in any first interview. We all have to make some type of evaluation of the person's readiness for psychoanalysis, and whether psychoanalysis will be useful to the prospective patient. In the vast majority of people I see in consultation, I haven't felt the need to make a diagnosis, and thus feel freer to convey to my patients that *I can best help them through understanding their own mind*. I don't say anything about this, but hope they experience this in the way I work. For those patients who are capable of becoming intrigued by this way of working, it can be an eye opening and emotional experience. Below is a vignette where it worked out well.

A vignette from a first interview

Sarah came to her first interview because of feeling unhappy and unfulfilled. In a plaintive voice she launched into multiple complaints about her husband, who she felt was selfish and not giving.

In my musings I wondered how she thought I could help her, but recognized in her voice the cry of someone who feels she has no power to change anything.

Sarah continued in this same vein for quite a while, including now her adolescent children in the mix. She then said, "You probably want to know about my growing up," and launched into a story about her mother, and how controlling she was of everyone. Her mother cowed her father, who Sarah saw as a kind and gentle man. Her older brother lived across the street from her parents, and never married. Sarah felt that sometimes she thinks she got married to get away from her mother's influence.

F.B.: After connecting your unhappiness to your husband's selfishness, your thoughts turn to how no one in your family seemed able to stand up to your mother. I wonder if one reason you're seeking treatment is *to find your own voice so you can speak up for yourself*.

In this I am integrating her associations to her early history with the plaintive tone in her voice indicating, to me, she felt she had no voice. While her husband may, indeed, have been selfish, I saw finding her own voice as a way of helping her understand more about the dynamic between the two of them.

Sarah: I know my father secretly agreed with my complaints about my mother, but he always took her side. I'll always remember the one time he stood up for me. I wanted to go to the movies with my friends, and my mother started saying nasty things to me, making suggestions I was up to no good. My father finally told her to "stop," and amazingly she did. I felt so good after that, but that was it. He probably got hell from her after I left [tears come to her eyes].

Sarah returned a few days later. After a brief period of therapy she entered analysis.

In what I say to Sarah, I am trying to convey that treatment is about listening carefully to what comes to her mind, and in what way. By listening in this way, and communicating how I listen, I convey that her voice is worth listening to. Being able to listen to *her own voice* becomes a central part of the treatment. I saw her tears and association to the experience with her father as an indication of her capacity to work in this way. She appreciated the analyst–father standing up for her, but was appropriately cautious in hoping it might happen more than once.

Betty

In another example from an interview by an experienced psychoanalyst, the conversation deepens through the analyst's interventions, and it also results in this patient entering analysis. The analyst learned later that the patient immediately felt comfortable with her, sensing the analyst was attempting to understand her in a

complex way, and this allowed her to open up in ways that surprised her. I will look at the analyst's interventions only from the perspective *of how to invite a patient into an analytic conversation*.

The patient, Betty, is a woman who is about 45, and the psychoanalyst is also a woman. The patient begins the session by talking briefly about being nervous, and looks at the analyst in an inquiring way.

This is a pattern that continues throughout the interview, and it becomes clear later on that it has particular dynamic significance.

The analyst encourages Betty to continue, and Betty comes right to the point. She and her husband no longer have sex, and she is both afraid the relationship will end and she feels the urge to run away. Again Betty stops and looks inquiringly at the analyst who asks the patient if she can say more. The patient says it has always been like this. When she had a sexual relationship it would be good at first and then she would withdraw.

So far we are hearing a number of conversations. There is the conversation of the patient telling the analyst what brings her for help (i.e., her confusion, the sexual problems in her relationship with her husband). The second, underlying conversation, is Betty demonstrating, in action, exactly what she's talking about,

i.e., she tells us that in sexual relationships things start out well and then she withdraws. This is what happens every time she starts to talk to the analyst. She begins strongly, and suddenly pulls back. In this sense the interrupted conversation becomes what this conversation

is about. The analyst senses this and tries to encourage the patient to continue the conversation. I think this is what most of us would do in this situation. It is much to early to help Betty see the repetition that's occurring, especially since she's relating it to sexual relationships at this point. To do so would likely make her more anxious. So we listen.

The analyst then asks Betty if she has any idea how this came about.

I see this as the analyst's attempt to see what Betty's private theory might be about what happened, which of course is a crucial issue. However, as noted earlier in the chapter on asking questions, it can also give the patient the impression that if she asks the right questions, and thinks real hard about something, she will find the answer to what is troubling her. This question, like many others, merely turns the mind to what is already known. In short, such questions often call for an answer already consciously available, rather than leaving an empty space for the patient to search for ways to communicate what is emerging into the preconscious via free association.

Betty responds to the analyst's question by telling of a party where everyone was pretty drunk, and her husband flirted with, and started kissing another woman at the party. He then fell asleep with the woman curled in his arms. It didn't go beyond that, but Betty couldn't get over it. She saw that her husband wanted to talk about it, but she didn't want to and realized she was withdrawing from him more and more.

At this point the analyst suggested there might have been something before this that led to this difficulty.

Here the analyst tries to broaden the conversation to the history of Betty's relationship with her husband. Again, something we might all do. However, I think Betty may be attempting to convey something deeper, i.e., what happened at the event seemed to be traumatic for her, and she hasn't been able to recover. "Somehow I couldn't get over it," she says. With her "somehow" Betty is conveying the possibility that it is this "not being able to get over it," not just the experience itself, that is part of the problem. She's also saying it isn't the history with her husband that's so important here, but her own feelings. This can be defensive, masochistic, or wanting to help the analyst see she recognizes something in herself that's a problem.

Betty associates to how sometimes she feels constricted by her marriage, and that she has wanted to go out with colleagues so she can feel closer to them. However, she notes again that she has problems in relationships. The more she likes people the more she withdraws from them. Betty *then withdraws into silence*.

Here I might say something about what's being expressed in the withdrawals, as it is now about colleagues and liking someone, and not sex. I might say something like, "I wonder if you've noticed in talking with me you often start out talking in a strong voice, and then suddenly stop … like a withdrawal. I wonder if you can go back in your mind's eye and try and capture what your feeling or thinking was at the moment you withdrew." What I would be attempting to demonstrate

is that what happens in our conversation will mirror and help us understand the problems the patient is bringing. This can be a very powerful demonstration of the usefulness of the talking (and not talking) cure. Further, by bringing Betty back to the moment before the withdrawal we are conveying that if we look very closely at what happens in our conversation, we can tell a lot about the problems that brought her to the analyst. It is an emphasis on analysis as a
special kind of conversation where we can learn about the nature of the patient's problems. It's not about the analyst's special powers of insight or empathy, which can often skew an analysis from the very beginning. Rather it's an attempt to help the patient by indicating in our way of working – I can help you by listening to your conversation with me. By emphasizing it is about the patient's conversation we convey our interest in her. For Betty, who didn't feel there was anyone around who treated her as special (as we will see later on), this in itself could have a powerful effect.

In thinking about withdrawing from colleagues, Betty was surprised to realize she feels she isn't interesting enough, and that she's felt this way since she was young. She then started talking about her childhood, saying at first, there was always a parent home. However, as she continued talking it turned out that her mother was a teacher who devoted long hours to her work, and the children in her classes. Most days Betty went to her mother's school after her classes were finished, but she portrayed her mother as so busy that she hardly noticed her. Betty then said, "Now I sometimes wonder …" and then interrupted this wondering.

There are many issues one could pick up on in this increasingly rich conversation. What I would pick up on is when Betty starts an internal conversation, and then has to stop it. That is when she starts to wonder about this after-school arrangement, and then interrupts herself. At this moment we see a conflict in action about a thought or feeling that stops the conversation. It is at this moment we have the best chance to help the patient see that, in their mind, they suddenly turned away from an idea because there was something disturbing about it. It is a window into many issues the patient has raised. She seems to be on the verge of asking some question about why her mother took a greater interest in these other children, and how this relates to her never feeling interesting, but then stops herself. It raises questions as to whether the traumatic nature of what her husband did with this other woman was a repetition of the cumulative trauma from childhood of not being found interesting enough. All of these considerations seem plausible, but we find a window into these issues primarily via her interrupted chain of thoughts. That is, until we can help the patient understand the interruption of wondering, wondering isn't possible.

The secondary, but equally important issue of technique, is that via the method I'm describing the focus is on the patient's mind. We are conveying our interest in what is happening for the patient in the interrupted conversation, i.e., the moment when Betty began to wonder and then had to withdraw. In this way we don't repeat the trauma of primarily talking about what we find interesting in what Betty tells us. If we were to suggest to Betty that "maybe her mother's interest in

teaching these other children made her feel less interesting," we would ignore something very basic to Betty, her tendency to withdraw what she's interested in … a primary symptom.

While recounting her story, Betty began to cry. She noted again how surprised she was by all this coming out, and then dismissed her concerns as "stupid."

Again we see her defending against the possibility that her story may not be interesting to the analyst.

The analyst then suggests that maybe Betty wondered if she wasn't interesting enough for her mother to be with her.

This raises an interesting question about empathy. Often we feel we are being empathic when we help our patients understand how certain parenting caused them to feel a particular way. Many times this is true. However, we rarely consider that appreciating and exploring the patient's wishes to not know is being empathic. However, I would say it is exactly the opposite. Helping a patient understand why she feels a particular way when she's still debating whether she wants to know about it might not be experienced as empathic.

I have tried to highlight in this vignette a method of introducing patients to the psychoanalytic method by exploring the *interruptions of the conversations* that go on in in Betty's mind. It is exactly where these interior conversations are interrupted that we see a defense against something threatening, that inevitably leads a patient to repeated acting out. My method is a particular way of working where I hope to intrigue a prospective

patient with what is going on in her mind, rather than giving answers to question, or feel I have to be a particular way.

I once used the metaphor of "telling stories" to capture the analytic work. I suggested that the capacity of patients to tell and own their stories is central to their developing a sense of well being from analysis. I think patients come to us because they are inhibited from living out their own stories. They live out somebody else's story instead, or they are afraid to see the story they're living, or they cannot bear the consequences of the story they've constructed. They feel the pain of an unlived life, and they want to know whose life they've been leading and how they can learn to lead their own. It is the fostering of this view that I hope to further with my method.

Of course, not every prospective analytic patient is like Betty, ready for a conversation. Some are so overwhelmed by external circumstances they can't talk about anything else. Some can't talk about anything. With each type of patient we might sometimes need to ask lots of questions or keep silent. Figuring out what type of conversation each of these different types of patient can tolerate is difficult, but necessary. In fact it is important to remember that Betty told the analyst a lot in this first interview, much of which was surprising to her, and that indeed she became an analytic patient.

As I noted earlier, we have sometimes tended to focus on *the analyst's way of being to create safety, sometimes to the exclusion of the analyst's ways of analyzing*. In this chapter I've tried to bring forth some methods of

working analytically that I think are useful in helping patients into an analytic treatment. I don't mean to suggest it is the only part of an invitation, but I think a part worth highlighting.