DISCUSSION 2

For this discussion, the patient for whom you wrote your transcript in the Week One Initial Call discussion has come to your office for a 15-minute initial assessment. As part of the intake process, you have asked the patient to fill out a biographical form that contains the same information included in the case study. Based on this information, propose three questions you would ask the patient to determine a diagnosis and treatment plan.

Provide a transcript of this brief initial session including your three questions and the answers you would expect the prospective patient to give. Beneath the transcript, provide a rationale for each of the three questions you proposed. Include the case study title you chose for your Week One Initial Call discussion post.

**Guided Response:** Review several of your colleagues' posts, and respond to at least two of your peers by 11:59 p.m. on Day 7 of the week. You are encouraged to post your required replies earlier in the week to promote more meaningful interactive discourse in this discussion.

Examine your colleague's transcript, and write an evaluation of the prospective patient's apparent symptoms and presenting problem(s) within the context of a theoretical orientation. Theoretical orientations are based on the personality theories you learned about in PSY615, and are referred to as "approaches" in *Abnormal and Clinical Psychology: An Introductory Textbook*.

Remember that symptoms may not be explicitly mentioned by the patient, but they may be inferred by the patient's presenting problem(s). Summarize views of these symptoms from at least two historical perspectives. For instance, how have these symptoms have been conceptualized and understood, historically? Finally, suggest diagnostic manuals and handbooks besides the *DSM-5* that might be used to assess this patient.

PLEASE USE FRED IN THIS DISCUSSION & NOT THE WIFE

FRED IS THE PATIENT →

# CASE 19

## You Decide: The Case of Fred

This case is presented in the voices of Fred and his wife, Margaret. Throughout the case, you are asked to consider a number of issues and to arrive at various decisions, including diagnostic and treatment decisions. You can find Fred's probable diagnosis, the DSM-5 criteria, clinical information, and possible treatment directions in Appendix B.

### **Margaret** "My Husband's Brain Stopped Working Properly"

About 8 years ago, my life changed completely. The reason? My husband's brain stopped working properly. We had been married 34 years and Fred was 67 years old. He had worked for the same construction company in New Jersey for 32 years, first as a laborer, then as a security supervisor and union leader. He was a big strong man, a good husband, and a good father to our son, Mark. Together, we had managed to make a decent living with him in construction and me an actress in television commercials—the original Odd Couple, our friends would call us. Life was good. And then Fred's brain went downhill, taking the whole family down with it.

The problems seemed small at first, hardly noticeable really. Sometimes, when telling me about his day at work, Fred would talk about the foreman, Jimmy, driving a "tractor" when he meant "bulldozer," or he'd say that he had made a "revision" instead of "decision." Little stuff. And he'd catch himself. I didn't worry too much about it, but it was odd. It doesn't sound like much, but it wasn't like him. I even thought, "Oh, well, the old boy's slipping," and would laugh to myself. But when he forgot the anniversary of our first date, well. . . I knew something was wrong. I gave him all kinds of hell for that—I accused him of having an affair, I cried, I really let him have it. But I was also scared. I mean, maybe an anniversary like that doesn't mean much to other people, but for us—well, over the years, he'd taken me to Atlantic City for shows and to dinners in expensive restaurants. Once, after Mark was grown, he even got us a hotel room in the Catskills for a weekend. There was always some sort of surprise. So, 8 years ago, in anticipation of a special evening, I got all dressed up. When he got home from work that night and sat down on the sofa, I knew he'd forgotten; and when he saw the disappointment in my eyes, he realized the same thing pretty quickly. In fact, he felt terrible about it, and took me out to a very fancy Italian restaurant after I calmed down. But it was a bad sign. That year turned out to be a rough one.





Forgetfulness is universal, and increases in forgetfulness are a normal part of aging. How might we distinguish normal forgetting or normal aging from the symptoms of a clinical disorder?

It wasn't as if he suddenly forgot everything, but it seemed like he was forgetting a bunch of things that he'd never forgotten before. I had always been the one with my head in the clouds, forgetting dates and losing car keys. Fred would be the one telling me, "Maggie, you've got to stay more on the ball. If you forget to pay the bills, they're gonna shut off our electricity." Or he'd chew me out about forgetting to make a doctor's appointment for Mark. Of course, I'd joke, "Why don't we switch jobs and you'll see who's got it tougher," but he definitely had a sharper head, no denying that. Now, suddenly, he was losing his wallet and we'd find it later in the study, where he'd sworn he hadn't been in days. Or he would leave half-full glasses

of juice on the floor of the living room, and when I'd chide him about it he'd say, "Oh, I'm sorry," and change the subject. This was Mr. Neat Freak who, in the past, couldn't stand it if a dirty dish sat on the kitchen table more than a half hour after dinner.

What might be the most difficult aspects of observing a spouse, parent, or other close relative gradually lose their memory or other cognitive faculties?

He also had little accidents, spilling food on himself, or knocking over a pile of papers or the jar of pencils from the counter. Then he started asking me to drive him to work all the time. He said that he'd caught himself veering off the road a few times and had just barely avoided an accident. "It's all the stress," he'd tell me. "We've got a new contract coming up and I don't think it's gonna go our way. I've just got too much on my mind."

As the forgetfulness and unusual behavior mounted, it couldn't be ignored any more. Yet somehow I found a way to do just that. I wanted to believe that he was fine. Then, one day, he missed a meeting with an important contractor—just didn't show up. Instead, he went to his office like it was any other day. The company lost the contract and a lot of money, and it also was bad for their image. Actually, by that point in time, I wasn't all that surprised by his error. This strong and organized man, who had taken care of everything for so many years, was by then becoming a different person, and I was now taking care of him. That's when I told him that he must see a doctor. And Fred did something I'd never seen him do: He burst into tears.

Despite his emotional outpouring that evening, Fred managed to put off medical treatment for nearly a year. Eventually, however, the incidents caught up with him—for example, leaving his glasses in the mailbox or mowing only half the lawn—and he went for a neuropsychological exam. The results of a battery of tests revealed some significant problems, and the neuropsychologist, Dr. Schoenfeld, broke the news to us that he was suffering from a neurocognitive disorder. He explained to us that we would be facing a very difficult battle—that Fred would become less and less able to take care of himself. He also told us that very little could be done to stem the progress of Fred's condition. Fred was going to have to rely on the support of his loved ones, particularly me, to see him through this.

Neurocognitive disorders include a group of organic syndromes, marked by major problems in cognitive functioning, such as memory and learning, attention, visual perception, planning and decision making, language ability, or social awareness. Based on your reading of either the DSM-5 or your textbook, what form of neurocognitive disorder might Fred be displaying? Which of his symptoms suggest this diagnosis?

p. 293

Fred had already planned to retire, as his position in the company had been scaled down drastically after the contract debacle. The doctor's diagnosis simply made it official in our minds. Within 3 months, he was thrown a retirement party by his coworkers, many of whom he had mentored. By then he was having trouble remembering people's names, but that party meant a lot to him. He knew just how lucky he was to have so many caring friends and colleagues. He was still embarrassed about having lost that contract, but everybody tried their best to show him that they had nothing but gratitude for his years of service. He wasn't walking too well by then, either, so I helped him to a chair, where he sat for most of the party, sometimes crying quietly to himself because he no longer had full control of his emotions. I think that was really his last great experience, the last time he had a really special night out.

At the party, Fred gave a short talk to his coworkers, thanking them for the event. He had been worried about this speech for days. He feared attempting to reminisce or trying to be too specific, because he'd been having so much trouble remembering things. But he didn't want to read a written speech, so he just kept it short. It broke my heart when I heard him say, "This is really a special night. I want to thank you all for this and for helping me out the way you've done the last few months. I'm not the kinda guy who talks a lot and makes big speeches to his friends. And that's what you are—my friends. That's why I've had a great time all these years. That's why I've loved my job, and going to work in the morning. We've had a lot of good times, and I'll miss you, my friends."

In 2012, more than 15 million family members and friends volunteered 17.5 billion hours to care for individuals with dementia, which can lead to a range of psychological problems for caregivers. What kinds of problems would you expect caregivers to develop?

It was more than a retirement speech; it was a farewell speech. But, as painful as that was, the impromptu speech that he gave to me alone just 2 days later hurt even more. He was lucid that day. He was clear and organized and sharp as a tack, just like the old Fred. And he was hurting.

## Fred "Preparing for a Trip to Nowhere"

I'm mad, I'm frustrated, I'm everything in between. It sure is embarrassing, Maggie, it sure is. Can you imagine what it's like to have to think for 2 whole minutes before remembering our own grandchild's name? A child I held in my arms when he was born, and said, "This boy is a perfect child." I watched him grow and played ball with him, and I can see his face in front of me as if he was in the room with me, but when I reach for his name, there's nothing there. Blank. How do I convince an 8-year-old child that his grandpa loves him and cares about him when I can't even be bothered to know his name?

I spend my whole life trying to be sharp, but I end up a failure. I'm a 69-year-old man who needs a woman to take care of him like he's 90. What use am I? I provided for my family. I earned money. I did my job to help keep Wellstone Construction running. And now that's all gone. All gone. I can't do any of it anymore. Lying in bed or sitting in a chair all day. My wife and son provide for me. The company takes care of me. I'm a drain. No one will ever again think of trusting me with anything. Anything. "No, it would be too taxing for the poor guy." That's what they'll say, but what they'll mean is, "He'll just screw it up, like he screws everything up."



Consider Case 5, Major Depressive Disorder. Did Fred show any symptoms of clinical depression as his disorder unfolded? Did Margaret? Would any of the treatment techniques described in Case 5 be helpful to either of them?

Sometimes, all of a sudden, I don't know what time of day it is, or even what day of the week it is. I don't even know what I had for breakfast this morning. If I want to go over there to pick up that book off that table, I have to ask you if you can help me walk. I can't walk without leaning on someone. Otherwise, I'll fall or have to stop and sit down.

Why should I even want to get up in the morning? Being up isn't all that different from being asleep, only a bit more confusing. Nothing in the world is more infuriating than knowing that you know the thing you can't remember. Knowing that you're not stupid, but that everything you once knew is being stripped away from you, little by little. God knows how long I'll even know who you are, Maggie. How long will it be before it's all just shapes and colors? How long before everyone else is making plans for me. Putting me in a home, putting me out to pasture, putting me to sleep. I feel like I'm preparing for a trip to nowhere.

If you were to lose your memory and cognitive faculties, bit by bit, how would you feel? What fears and worries do you think you would experience?

I don't even know if I'll mind that so much. When I don't remember anything, it won't be so hard. Probably then I won't feel so stupid. I won't realize how much I am forgetting. That's what gets me—the forgetting. It gets me mad, but it gets me scared, too. I reach for a pen that I thought I was just writing with and I realize that it's not there. I look for it and then I realize that I'm not writing anything. Now I can't find the pen, and I don't even remember why I'm looking for it, and nothing makes any damned sense. It's like this dream that's real upsetting because I don't know what's going on, but I know I should know. Oh, God!

When this all started, you know, I didn't believe it. A man can get used to a lot if he can convince himself that nothing is wrong. Every time I'd forget something, or lose something, or drive off the road, it bothered me for exactly 5 minutes. I'd be scared for 5 minutes and I'd admit to myself for those 5 minutes that there was a serious problem—that these things were happening more and more and that something was very wrong and that I should get this taken care of somehow. But after those 5 minutes, I would laugh it off and decide that everything was fine—everyone forgets things, everyone loses concentration driving, everyone misplaces things—and I'd be fine. I'd come home, and I wouldn't think about it until the next thing happened. Then I'd be upset for another 5 minutes.

Why would Fred and Margaret have tried to overlook his symptoms, even as they were worsening?

I want you to put me away, Maggie—you know what I mean—let me go, if I ever don't remember who

you are. I don't want to forget my beautiful wife, and if I don't know who you are anymore, have them just inject me or give me whatever is necessary in order to get this life over with. Don't worry about whether it's the right thing, because it is. I'm afraid that you won't do this, that you'll let me go on when I'm not myself anymore. I don't want you to have to see me and not know that I love you and need you with me. I don't want you to doubt my love for you because of this damned disease. Please, Maggie, don't let that happen. Please promise me.

## **Margaret** "A Long Goodbye"

Unlike most of the other disorders in this casebook, Fred's problem was organic, progressive, and largely irreversible. What role might psychological treatments play in disorders of this kind?

I heard that speech from Fred several other times during the next 2 years. But of course I couldn't make that promise. Eventually, he became less clear and less interested, and less able, and he stopped saying those things. The last 4 years really have been a long goodbye for us. As the years have passed, Fred has been less and less able to do for himself. He has been increasingly unsteady on his feet. Furthermore, he lost control of his motor functions and is now unable to feed or clothe himself, or to use the bathroom on his own. At first, this was very upsetting to Fred; he was still aware enough to feel that his incapacitation made him ridiculous in some way, and he often lashed out at me in anger—even accusing me at times of trying to drug him so that he couldn't take care of himself. Later, he would tearfully apologize after these outbursts.

About 4 years ago, I bought him a walker to make it easier for him to get around. But a year later, he fell while trying to walk across the hall to take a bath. He broke his hip and couldn't leave his bed for 4 months. Fred became more and more depressed and began spending days staring at the wall or the bed sheets, refusing to talk even when I tried to speak to him. After his hip had healed, he still remained in bed, refusing to try to walk. He even began hearing voices and seeing people who weren't really in the room. Sometimes he would believe that long-gone relatives were in front of him and talking to him. Eventually, it seemed like it was just too taxing for him to try to distinguish the real from the imagined, and Fred began to treat everyone and everything around him with indifference or doubt. He treated real people who were talking to him as though they might be figments of his imagination and just turned away.

What role might psychotherapists play in helping close relatives cope with the deterioration of a loved one? What therapy approaches described throughout this casebook might be particularly helpful to such relatives?

Our son, Mark, visited regularly, at least once every other weekend, from his New Hampshire home. Even so, Mark was always surprised by the speed of his deterioration. After breaking his hip, Fred, who had always looked so forward to Mark's visits, often failed to get out of bed to greet our son, sometimes sleeping through the entire visit. Mark noticed that his father appeared to get less pleasure from the visits. He tried to prepare himself for the ravages of Fred's condition, but as his father deteriorated more and more, he became very shaken.

During one visit, Fred looked Mark in the eye, then turned to me and asked, "Who is this, Maggie? Who's he? Is that your brother Jimmy? What's he doin' here?" Mark faced his father and said in a quiet voice, "Dad, it's me. Your son, Mark. And I love you." As he said this, however, Fred fell asleep, and Mark left the room feeling dejected. Later, after Mark and I ate lunch, Fred awoke again, and called out. When Mark entered the room and stood over his father's bed, Fred touched his hand to Mark's face and after a minute said, quietly and hoarsely, "Son . . ." And they held hands without saying a word for an hour. I almost couldn't bear it.

Also, about 3 years ago, Fred started having violent nightmares, and he would sometimes wake me with his screaming. During and after some of the nightmares, he seemed like a completely different person, with a crazed passion behind his frightened eyes. He was growing more and more convinced that I was plotting against him. During one of our visits to the neuropsychologist, he complained, "She's stealing things from me. She steals my clothes so that she can make me feel foolish when I can't find them. I was eating a banana, and she wanted the banana. I put it down and turned my back for a minute, and that banana was gone. She's taking my food. This is all her fault. I know it is."

People with a disorder such as Fred's often become angry, suspicious, and accusatory. What are some of the potential

People with a disorder such as Fred's often become angry, suspicious, and accusatory. What are some of the potential reasons for such reactions and personality changes?

It's now been 8 years of taking care of him. At this point, I have to feed him and help him use the bathroom. I bathe him and I take him to the doctor. Thanks to his retirement package, we're okay financially. Still, I need to spend every penny we have on Fred's care. I can't work myself, since I have to be with him. The worst part is when he looks at me and I know he doesn't know who I am, yells at me as if I'm an enemy, and accuses me of stealing his things. At other times, however, he looks at me and his eyes say, "Thanks, Maggie," and I know he hasn't forgotten—even if he's remembering for only a moment.

Fred's decline seemed to reach a new level beginning around 6 months ago. Since then, he has been completely incontinent and barely able to speak. He has also been unable to leave our bedroom. He hasn't shown any recognition of Mark during his visits, and has barely even acknowledged me. About 3 weeks ago, he developed a cold that would not go away, and last week I took him to the hospital. He's still there, with a respiratory infection, using a ventilator to breathe. He is in such a weakened condition that doctors are not sure that he will live out the week.

I suspect that Mark and I each privately hope that the doctors' prognoses are accurate and Fred will die within the week. Neither of us has dared express this to the other, but I think we will both be relieved when Fred is gone—that is, the bedridden Fred whose true spirit has already left us. When he is gone, we will all finally be delivered from this long ordeal. And Mark and I will be able to remember our beloved Fred again as he once was—strong of mind and body.

After a long ordeal such as Fred's, it is common for close relatives to find themselves almost wishing for or looking forward to the person's death. What factors might explain such feelings and reactions?

# Appendix B
# You Decide: The Case of Fred

The individual in *Case 19: The Case of Fred* would receive a diagnosis of major neurocognitive disorder, probable Alzheimer disease.

**Dx Checklist**

**Major Neurocognitive Disorder Due to Alzheimer Disease**

1. Individual displays substantial and gradual decline and impairment in memory and learning and at least 1 other area of cognitive function as well, such as attention, planning and decision-making, perceptual-motor skills, language ability, and social awareness.
2. Cognitive deficits interfere with individual's everyday independence.
3. Genetic indications or family history of Alzheimer disease underscore diagnosis, but are not essential to diagnosis.
4. Symptoms are not due to other types of disorders or medical problems.

(Based on APA, 2013.)

## Clinical Information

1. Alzheimer disease is the most common form of dementia, accounting for approximately two-thirds of all cases of dementia (Burke, 2011).
2. The disease sometimes appears in middle age, but most often occurs after the age of 65, particularly among people in their late 70s and early 80s.
3. After its onset, the disease progresses gradually, ranging in duration from 2 years to as many as 20 years with most people surviving only 10 years after diagnosis (APA, 2013; Soukup, 2006).
4. Patients with Alzheimer disease may at first deny that they have a problem, but may soon become anxious or depressed; many also become agitated.
5. Approximately 1 percent to 2 percent of the world's adult population suffer from some form of dementia, including up to 80 percent of all people older than 85 (APA, 2013).
6. Structural changes in the brains of people with Alzheimer disease include an excessive number of neurofibrillary tangles (twisted protein fibers found within the cells of the hippocampus and certain other brain areas) and of senile plaques (deposits of a small molecule known as the beta-amyloid protein that form between cells in the hippocampus, cerebral cortex, and certain other brain regions) (Fandrich, Schmidt, & Grigorieff, 2011; Selkoe, 2011).
7. The disease often has a genetic basis (Hollingsworth, Harold, Jones, Owen, & Williams, 2011).
8. Victims of the disorder usually remain in fairly good health until the later stages of the disease when they may become less active. With less activity, they may become prone to illnesses such as pneumonia, which can result in death (Ames, Chiu, Lindesay, & Schulman, 2010).
9. According to the Alzheimer's Association, Alzheimer disease is the sixth leading cause of death in the United States overall, and deaths from Alzheimer disease increased 68 percent between 2000 and 2010.

## Common Treatments

1. No single approach or set of approaches is highly effective in all cases of Alzheimer disease.
2. Two types of medications have been approved to treat patients with memory loss and confusion: cholinesterase inhibitors (Aricept, Exelon, Razadyne, and Cognex) and *memantine* (Namenda). Such drugs prevent the breakdown of acetylcholine in the brain, a neurotransmitter essential to memory (Alzheimer's Association, 2013).
3. Behavioral interventions may help change everyday patient behaviors that are stressful for the family, such as wandering at night or urinary incontinence.
4. The needs of the caregivers must also be met via psychoeducation, psychotherapy, support groups, and regular time-outs.
5. Alzheimer disease day-care facilities (providing outpatient treatment programs and activities during the day) are becoming common. In addition, many assisted-living facilities are being built—apartments that provide supervision and are tailored to the needs and limitations of people with diseases such as Alzheimer disease.

Assignment 2

Prior to beginning work on this assignment, it is recommended that you read Chapter 1 in *Turning Points in Dynamic Psychotherapy: Initial Assessment, Boundaries, Money, Disruptions and Suicidal Crises* and Chapters 1, 2, and 4 in *The Psychiatric Interview: Evaluation and Diagnosis*.

Respond to at least one of your colleagues in the discussion forum before creating your assignment submission.

For this assignment, you will take on the role of a mental health professional providing a consultation to a colleague. Your colleague in this case happens to be a licensed clinical psychologist. Carefully review the PSY645 Fictional Mental Health Consultation Scenario (Links to an external site.) which provides information on your colleague's patient and specific questions your colleague has posed to you as a consultant. Once you have reviewed the scenario, research a minimum of two peer-reviewed articles in the Ashford University Library related to the situation(s) presented in the scenario and how these have been approached and treated in previous cases.

Write an evaluation of the patient's symptoms and presenting problems within the context of one theoretical orientation (e.g., psychoanalytic, cognitive, behavioral, humanistic, etc.). Summarize views of these symptoms and presenting problems within the context of at least one historical perspective and two theoretical orientations different from the one used in your evaluation (e.g., cognitive, humanistic, psychodynamic, integrative) in order to provide alternative viewpoints. To conclude, justify the use of diagnostic manuals and handbooks besides the *DSM-5* that might be used to assess this prospective patient.

The Mental Health Consultation:

- Must be two to three double-spaced pages in length (not including title and references pages) and must be formatted according to APA style as outlined in the Ashford Writing Center (Links to an external site.).
- Must include a separate title page with the following:
  - Title of paper
  - Student's name
  - Course name and number
  - Instructor's name
  - Date submitted
- Must use at least two peer-reviewed sources in addition to the course text.
- Must document all sources in APA style as outlined in the Ashford Writing Center.
- Must include a separate references page that is formatted according to APA style as outlined in the Ashford Writing Center.

## PSY645 Fictional Mental Health Consultation Scenario

You have received the following email from a colleague working at a local crisis house.

*encrypted message*

Here is the case we talked about briefly over the phone. Please let me know your thoughts. This one really has me stumped.

John Smith, PsyD
Clinical Psychologist (PSY042)



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Bob is a 38-year-old male. He presented to the crisis house late last night, appearing disheveled and poorly groomed. He repeatedly stated, "The police are after me," but did not articulate any reason why the police would be looking for him. His speech was pressured and circumstantial; he had significant psychomotor agitation and elevated body temperature. Bob reported having been in psychiatric treatment "for years," but refused to share previous diagnoses and would not complete a release of information to allow examination of his medical history. When I shared with Bob that his medical history is important information for me to know in order to help him, he screamed, "You work for the police, don't you? I bet you're a cop!" Bob was admitted to the crisis house due to risk of further decompensation without this level of care.

Normally, I would wait a few days to observe Bob and make a diagnosis, but I need to make a diagnosis within 24 hours of admittance according to our crisis house policy. Additionally, I do not currently have access to a tox screen or a toxicology report for Bob. Help me understand what's happening with him so I can make a provisional diagnosis.

References attached:

Akhtar, S. (2009). *Turning points in dynamic psychotherapy : Initial assessment, boundaries, money, disruptions and suicidal crises*. London, England: Karnac Books. Retrieved from http://www.ebrary.com

Tasman, A., Kay, J., & Ursano, R. J. (2013). *The psychiatric interview: Evaluation and diagnosis*.Chichester, England: John Wiley & Sons. Retrieved from http://www.ebrary.com

# 1. Initial Assessment

*Believe me, every heart has its secret sorrows, which the world knows not; and oftentimes we call a man cold when he is only sad.*

Henry Wadsworth Longfellow (1807-1882)

Most psychodynamic psychotherapy cases stumble, come to an impasse, or fail because the patient's suitability and motivation for treatment had not been properly evaluated. Indeed, some psychotherapists take pride in starting a case 'cold' i.e. without a formal assessment of patients' psychopathology, ego-capacities, and psychological-mindedness. This approach, popular with some 'classical' psychoanalysts and those who naively imitate them, often leads to unpleasant surprises. Even in the absence of major fiascos, the lack of agreement between the patient and therapist about the modality and aims of treatment can contribute to future difficulties.

It therefore seems preferable to conduct a proper assessment before deciding upon the start of psychotherapy. This period, starting from the very first moment of contact between the patient and therapist usually spans over one to three sessions, preferably conducted on consecutive days.[1] It provides an opportunity for the assessment of the nature and severity of the patient's psychopathology. It also gives the two parties a chance to get an emotional 'feel' for each other. Through direct questioning, encouragement to elaborate on what has hitherto remained emotionally abbreviated, and patiently listening in a non-judgmental way, the therapist gathers

important information about the patient. Through expressing his distress, following the clarifying leads of the therapist's interjections, and listening to his own self, the patient begins to feel more organized. Experiencing a dignified sense of human affinity and feeling 'held' (Winnicott, 1960) in an informed setting, the patient senses an opportunity for betterment and psychic growth.

These developments, while happening silently, are both the result of a proper initial evaluation and the facilitators of it. Their end-point is the mutual agreement between the two parties to undertake the work of psychodynamic psychotherapy with a well-laid out framework and clearly understood plans. However, before arriving at such closure, a number of steps have to be traversed. Some of these steps are concrete and formal, others nearly imperceptible.

### *RESPONDING TO THE FIRST PHONE CALL*

The first contact between the therapist and a prospective patient often occurs via telephone. Many things can be learned and many trends can be discerned during this contact. Careful attention should therefore be paid to what the patient says at this time. Both the form and the content of his or her message should be noted. One might find that the patient is cryptic and reluctant to give information. Or, one might note that the patient is talkative and has difficulty restraining himself. To be sure, no definite conclusion can be drawn from these bits and pieces of information but one should tuck them into the back of one's mind and use them as background or as topics of specific investigation once the patient arrives for the first interview. The following clinical encounter illustrates this point.[2]

#### CLINICAL VIGNETTE 1

> While setting up an appointment via telephone, John Schmidt asked me twice whether my office building had a name, such as the Pan Am Building, the Chrysler Building, and so on. I was intrigued by his insistence, since I had already given him the street number of my building. I also noted that both the buildings he mentioned were in New York and not in Philadelphia, where I practice. I politely repeated that

my building did not have a name, keeping my sense of curiosity for later.

During the evaluation session, the first thing I learned was that his full name was John Schmidt, Jr. Next, I gathered that he had a pattern undermining his achievements, in the realm of both romance and business, just when success was around the corner. Much unconscious guilt seemed to lurk in his psyche. To look for the sources of such guilt, I turned to exploring his childhood development. Now I learned that despite having an older brother, it was he who was named after his father. Upon my inquiring about it, he agreed that this was not customary but said that he had never thought about the reasons for this unusual situation. Further questioning revealed that his older brother was mildly retarded. At this point, I ventured a hypothesis. Could it be that his older brother had at first been named after their father, only to be given a different name after the discovery of his retardation? The patient was moved by this suggestion and, though he did not remember hearing any such thing while growing up, began talking about his sadness about his brother and his guilt over his own success, which he had impressively undermined on many occasions.

As all this came pouring out, I became aware that he had unconsciously given me a clue to his problem by insisting on the phone that my building (me) have a bigger, better name than merely a number. Now I brought up our telephone conversation and pointing out that his insistence upon my building (i.e. I) having a better name was a disguised way of 'returning' his borrowed name to his older brother. In essence, it was his way to repair the damage he had felt he had done. The patient began to sob and it was clear that he felt understood in a way that he had never experienced before.

What this dramatic example demonstrates is that by paying close attention to the patient's phone call, one can pick up important clues regarding his or her problem. These can be used to clarify and document the hypotheses that one begins to develop during the evaluative sessions.

In addition to this, there are other guidelines to keep in mind while responding to a call by a prospective patient.

- It is advisable not to hurry in returning the phone call from a person whose name one does not recognize and who might be a prospective patient. Contrary to ordinary 'good manners', it is better that one waits a little (say, from a few hours to even a full day) before answering such a call. An interval of this sort allows one to 'suddenly recall' that one actually knows this person (e.g. he may be an ongoing patient's boyfriend) and should actually not call him or her back. Or, one might receive collateral information (e.g. from another person's phone call) which affects the manner in which one would handle this call.

- It is also good to return a phone call from a potential patient when one can spare some 5-10 minutes of peaceful and uninterrupted time. While lengthy conversation at this point is hardly indicated, having the cushion of a few minutes comes in handy if unexpected complications begin to arise.

- Rather than giving a specific time that is convenient for oneself, the therapist should try to involve the patient in choosing the time for the first appointment. Asking such questions as 'How urgent do you think the situation is?' or 'When was it that you were planning to see me?' permits the patient to negotiate a realistically needed and feasible appointment. More importantly, allowing the patient to exercise some control subtly emphasizes the mutuality of the therapeutic undertaking and helps restore the patient's self-respect at a time of difficulty and self-doubt.

- Patients' questions about fees and billing should be answered in a factual manner. It is inappropriate and misleading to tell a patient to come in saying 'we will discuss the fee issue when you are here'. This can put the patient, who comes and reveals his

inner turmoil, in a disadvantage if he can not afford the therapist's fees and has to be referred elsewhere.

- Conditions put by the patient for coming or not coming should neither be accepted nor rejected. One should emphasize that both parties need to have open-mindedness about such matters. Neither undue flexibility nor stern rigidity is helpful. What is needed is a firm adherence to the stance of neutrality, curiosity, and respect for the complexity of mental processes.

- It is considerate to inform the patient right away of any constraints from one's own side. For instance, if one does not have time to take a new patient or one is leaving soon for a long vacation, the patient should be informed of it. Such forthrightness helps preclude feelings of betrayal and may prevent even more serious complications in highly regressed and needy patients.

- One should give clear and specific directions about the location of one's office and not assume that the patient knows his way around. Often, the patient's lateness for his first appointment is the result of the vague directions given by the therapist rather than of resistance and enactment.

## *THE PATIENT'S ARRIVAL FOR THE INITIAL INTERVIEW*

The patient's appearance, behavior, and manner of arrival also can provide significant information even before a formal evaluation has begun. There are many things to be noted here: is the patient appropriately dressed? How is his personal hygiene? Are there any outstanding mannerisms, scars, or tattoos? Does he look angry, sad, happy, nervous? Also, does he come on time? Does he arrive late or, conversely, too early? Or does the patient come at a completely different time than was agreed upon?

### CLINICAL VIGNETTE 2

After having waited for Gina Spencer, who had sought a consultation with me, for about twenty minutes, I received a frantic phone call from her. She was looking for my office in a building five blocks away. Where did I say my office was? When I repeated my

address, she realized her 'mistake' and wanted to know if she could still come over for her appointment. Thinking that not much time would be left by the time she arrived, I offered her an appointment on a subsequent day. She apologized for her 'mistake' and accepted my offer.

On the day before Gina's second appointment, I came out of my office after the last patient of the day had left to find her sitting in my waiting room. She was enraged and said that she felt very humiliated by my having 'abused' her in this fashion! Puzzled, I asked what it was that she felt I had done to her. She responded by saying that I had kept her waiting for an entire hour while seeing another patient. It took her a few minutes to realize that she had come a day earlier than her scheduled appointment!

Now, there were these two enactments even before we began a formal consultation. First, she went to the wrong building and was frantically looking for me. Second, she came at the wrong time and felt 'abused' by me. I kept these in mind and decided to see what in our 'third' encounter (i.e. our first formal interview) might shed light on the communications contained in these enactments. (Besides, of course, I noted the propensity toward acting out, resistance, sado-masochism, and use of paranoid defenses).

In her subsequent appointment, for which she arrived punctually, Gina told me that her main difficulty was constant anger at men, sexual disinterest, and depressive mood swings with occasional suicidal thoughts. She revealed that her father, to whom she was very attached, had abruptly left the family when she was five years old. She never saw him afterwards and was always 'searching' for him. When she was eight years old, her mother remarried. Her stepfather sexually abused her until she was thirteen years old. At this time, the patient moved out the house and started living with an aunt. As this material came out, I brought to her attention that her frantically 'search-

ing' for me the first time and feeling 'abused' by me the second time were perhaps her ways of putting me in the place of her real father and stepfather, respectively. Till the time I was in either position, I added, she could not relate to me. Perhaps she needed a third chance, a new experience. The patient began to cry and, after composing herself, revealed more details of her anguished life.

The point I am trying to make here is that enactments as gross as these cannot be ignored. They must be thought about and recognized as up for discussion. Vigilance combined with tact is the key here. This applies not only to the patient's appearance and behavior but also to the things that they might bring along with them.

### CLINICAL VIGNETTE 3

As Alex Bartlett, a thirty-four year-old lawyer, entered my office for his first interview, I noticed that he was carrying a popular magazine in his hand. Sitting down, he put the magazine on the table near him. The session proceeded along conventional lines while, in a corner of my mind, I kept wondering about the magazine. Oblivious to my concern, he went on to describe the interpersonal difficulties that had led to his seeking help. He said while finding women was not difficult for him, keeping them involved certainly seemed a problem. One after another, they left him complaining of his aloofness and self-sufficiency. I found myself looking at the magazine he had brought along but decided to wait before saying anything about it.

Moving on to his family background, Alex revealed that his parents had divorced when he was four and, for the following three years, his mother toiled hard to raise him and his two older sisters. She worked long hours and expected the children to be well-behaved. Alex grew up to be a courteous young man who was repeatedly abandoned by women who found him nice but unengaging. He suffered greatly since he wanted involvement and mutuality in his life. At this point, I

> asked him about the magazine. He seemed surprised and said that he had brought it for reading in the waiting room. I asked him if he thought that I would have no reading material there and if he could see how this seemingly innocuous behavior betrayed his anxiety about dependence and attachment. I added that perhaps it was this sort of 'self-sufficiency' that was found unacceptable (and unconsciously rejecting) by his girlfriends. He was taken aback but could readily see the dynamics in action. His eyes filled up with tears and he said, 'But I can't help it. I have always relied upon myself.' Yet there was a clear sense in the office that an aspect of his problematic 'character armor' (Reich, 1933) had already been made ego-dystonic.

I can offer many other examples of this sort but will suffice to say that the therapist must note and make use of the messages contained in the physical possessions patients bring with them.

There are still other things to observe. For instance, the arrival of an adult patient (who is not psychotic, organically impaired, or a fresh immigrant to the country) in the company of a relative or friend should raise questions in the consultant's mind. Is there ego impairment here? Paranoia? Separation anxiety? Some phobia? Enactment of some unconscious fantasy? Such behavior could reflect any of these or might imply something completely different. The point is to observe it, consider it data. Similarly, the observation that the patient arrives carrying too many things should be silently registered. It may lead to something or it may not, but it cannot be ignored. Finally, our own very first feelings about the patient should be jotted down in the back of our minds for further private exploration. This might yield useful information about either or both parties in the dyad of a consultation.

## *ASSESSING THE NEED FOR TREATMENT*

### *Nature And Severity Of Symptoms*

The first formal step in initial assessment consists of a relatively straightforward exploration of the patient's presenting symptoms. Such inquiry might begin with a simple statement like: 'What

seems to be the reason that has led you to come here?' or, even more briefly: 'Tell me what brings you here?' This would lead the patient to describe his or her predominant difficulties. The interviewer, after listening patiently for a while should summarize for the patient the main symptoms and, in doing so, organize the relevant clusters of complaints. For instance, the interviewer might say: 'From what you have told me so far, it seems that you are experiencing three main difficulties: first, depression, including crying spells, hopelessness, and occasional suicidal thoughts; second, an increasing alienation from your family involving disagreements about your boyfriend and your place of residence; and third, some confusion about whether you wish to continue your education or drop out from school altogether'. Such an intervention helps the patient organize his or her thinking, demonstrates to the patient that the therapist has already begun his work, and, by providing identifiable categories to the often diffuse distress, gives the patient an intellectual handle on it. It might limit the patient's freedom somewhat, but this can be rectified by asking open-ended questions pertaining to what one might have missed somewhat later in the interview.

Once the patient's main symptoms are identified, more detailed investigation of each should follow. The account now provided by the patient might be fleshed out further by the interviewer's asking more direct questions, preventing the patient from becoming too tangential, and exploring the presence or absence of secondary and related symptoms. In the case of depression, for instance, these might include excessive drinking, incapacity for caring for children, and manic episodes. As the details of each cluster of symptoms become clear, the interviewer might begin thinking about the possible connections between the various clusters. However, it is preferable to keep such early hypotheses to oneself at this point.

While remaining reserved on this front, the therapist should by no means stay passive and non-directive. He should allow the patient to elaborate and offer details but he should also feel free to stop the patient from going on and on about what has already been established. More importantly, he should not shy away from what appears difficult and anxiety-producing to the patient. In this context, the following reminder by Gill and Redlich (1954) is important.

> The technique of quickly leaving painful subjects often is interpreted by the patient as a reluctance to attack major difficulties. A patient's anxiety may even be heightened by the feeling that if the therapist is fearful, the problem must be serious indeed. A bold attack which shows that the therapist knows what he is about, that he can lay his finger on the trouble and is not afraid, may not only be very reassuring but may go far toward helping the patient overcome the ever-present tendencies to evasion, whether these are conscious or not. (p. 31)

One area of pain and anxiety to which an entire section of this book (Chapter Five) is devoted pertains to suicide, which must be directly and fearlessly explored, especially when the patient's presenting complaints involve depression. Similar forthrightness needs to be maintained vis-à-vis addictions and sexual deviations. The calm, unhurried but firm manner of the therapist lays the groundwork for the 'working alliance' (Greenson, 1965) within the dyad.

*Level Of Character Organization*

Assuming that the patient is non-psychotic (since the presence of psychosis aborts a dynamic interview and reverts it back to the traditional psychiatric history-taking[3]), the essential task of this part of evaluation is to distinguish between neurotic and borderline levels of personality organization. Using the terms 'oedipal' and 'pre-oedipal' for these two groups respectively, Greenspan (1977) has outlined seven dimensions of personality functioning that help differentiate between them:[4]

> (i) capacity for distinguishing internal versus external reality; (ii) cohesion, organization and resistance to fragmentation even under stress of the self and object representations; (iii) capacity for experiencing and perceiving a variety of discriminated affect states; (iv) level of defenses,(v) capacity to modulate impulses appropriate to external situation; (vi) capacity for gen-

> uine attachment and separation, and for the experience of sadness and mourning; and (vii) capacity for integration of love and hate. (p. 385)

Within the interview situation, coming to grips with the above largely translates into the exploration of the following three areas.

(1) *The degree of identity consolidation.* In the neurotic character organization, there is a well-established identity while in the borderline organization there is identity diffusion (Kernberg, 1975, 1984; Akhtar, 1984, 1992a). The features of identity diffusion include markedly contradictory character traits, temporal discontinuity in the self-experience, feelings of emptiness, gender dysphoria, subtle body-image disturbances, and inordinate ethnic and moral relativism (Akhtar, 1984). Not all of these features can be elicited and explored to an equal degree through formal questioning. Some (e.g. feelings of emptiness) are more evident in the patient's complaints, while others (e.g. temporal discontinuity in the self-experience) become clear only through obtaining a step-by-step longitudinal account of the patient's life. Still other features (e.g. subtle disturbances of gender identity) are discernible, at least in the beginning mainly through the overall manner of the patient's relating to the interviewer. Yet it is helpful to ask the patient to describe himself. One might say something like this: 'Now that you have told me about your difficulties, can you please describe yourself as a person?' In the description offered by the patient, one should look for consistency versus contradiction, clarity versus confusion, solidity versus emptiness, a well developed sense of masculinity or femininity versus gender dysphoria, and a sense of ethnicity and inner morality versus the lack of any historical or communal anchor.

If the patient is unable to provide a coherent description, this should not be immediately construed as implying identity diffusion. This could be due to anxiety, lack of psychological mindedness, cultural factors, poor verbal skills or low intelligence. These factors should be ruled out before making a conclusion regarding the presence or absence of identity diffusion in a given instance.

Sensing difficulty in the communicative path of the patient, the therapist might decide to help him by conducting the inquiry in a piecemeal fashion. For instance, he might ask about the patient's

religious beliefs, practices, and their continuity with what was handed down to him during childhood; feelings of ethnicity and of belonging to a certain regional or communal group; continuity of contact with friends and associates from earlier periods of life; clarity and stability of vocational goals; sublimations and hobbies; and so on. He may then surmise the status of the patient's identity based on the information gathered. A patient might not be able to describe himself well, yet may turn out to posses a consolidated identity. Conversely, one might come across in a patient

> peripheral areas of self-experience that are contradictory to a well-integrated, central area of subjective experience, peripheral areas that the patient experiences as ego-alien or ego-dystonic, not fitting into his otherwise integrated picture of himself. These isolated areas may be an important source of intrapsychic conflict or interpersonal difficulties but should not be equated with identity diffusion. (Kernberg, 1984, p. 37)

(2) *The nature of predominant ego defenses.* The 'neurotic' or higher level character organization is characterized by the predominance of repression as the main ego defense and the borderline organization by the predominance of splitting and related defenses (Kernberg, 1967, 1975, 1984; Volkan, 1976). Splitting manifests in five different ways (Akhtar and Byrne, 1983): (i) inability to tolerate much ambivalence, (ii) intensification of affects, (iii) reckless decision-making process, (iv) ego-syntonic impulsivity, and (v) marked oscillations of self-esteem. The individual using splitting tends to have an all-or-nothing approach to life. He sees good and bad as mutually exclusive. He is overly controlled or loses all control. He attacks the entire problem and gets overwhelmed or avoids the problem altogether and feels defeated. He has a tendency towards 'now or never; murderous rage or total denial of anger; either my way or your way; either this way or not at all' (Schulz, 1980, p. 184).

In the interview situation, the patient's verbal productions, as well as his overall attitudes, give hints toward the existence, or more accurately, the predominance, of splitting. Confronting the

patient with contradictions in the information provided by him and seeing his response also helps discern the tendency toward splitting. It may help distinguish borderline from potentially psychotic levels of organization (Kernberg, 1984). Demonstrating gross psychic contradictions (e.g. a Catholic nun moonlighting as a stripper, a tongue-tied and shy individual being a stunning public orator) to the patient leads in the former instance to anxiety and awkwardness coupled with recognition of contradictions and a temporarily improved observing ego. In the latter, however, such confrontation leads to a greater tenacity of compartmentalizations and recourse to increasingly odd 'logic' to defend the validity of keeping ill-fitting sectors of personality apart.

(3) *The nature of object relations.* Taking a detailed family history (including questions about parents and their marriage, siblings, and, if the patient is married, their spouse) provides an opportunity to asses the patient's capacity for meaningful object relations. The patient who has a higher level of character organization (e.g. obsessional, phobic, hysterical) shows the capacity for relating to others as truly separate individuals with their own strengths, weaknesses, and independent motivations. The one with a lower level character organization (1) gives premium to his own feelings (e.g. 'I hate him', 'I find him adorable') over the actual description of someone else (e.g. 'My mother is a school teacher and a very kind person'), (2) uses extreme adjectives (e.g. 'She is brilliant!'), (3) fails to take into account the concerns and motivations others may have independently of him, and (4) has few non-exploitative relationships (as evidenced by lack of concern for nephews, nieces, and pets, i.e. from whom one can derive little direct benefit). When these features are prominent, the character organization is usually in the borderline range even though phenotypically the patient might appear to be functioning better. A marked presence of the fourth element is suggestive of antisocial personality disorder.

## ASSESSING SUITABILITY FOR TREATMENT

### *Psychological Mindedness*

A quick survey of the literature reveals that different people mean different things by 'psychological mindedness' or at least emphasize different aspects. Reiser (1971), for instance, delineated three

components of psychological-mindedness: (1) sensitivity to symbolic meanings and to situational resemblances between life events in historical context, (2) empathy for others' affective experiences, and (3) interest in human behavior and the motives that underlie it. He emphasized that psychological-mindedness, in contrast to curiosity, is inwardly directed. It is more passive, reflective, and receptive than curiosity, which is driving and compelling. Lower et al. (1972) described psychological-mindedness as including 'a capacity for insight, introspective, intuition, verbality, remembering dreams and fantasies, awareness of transference, of internal conflict; sensitivity to own feelings and curiosity about drives' (p. 615). Applebaum (1973) proposed the following definition: 'A person's ability to see relationships among thoughts, feelings, and actions, with the goal of learning the meanings and causes of his experience and behavior' (p. 36). He distinguished such psychological interest for purposes of understanding oneself and others from the intellectualized, exhibitionistic, merely playful, or self-condemnatory uses of introspection.

While these investigators do offer many 'clinical pearls', it is Coltart (1988) who provided the most detailed guidelines about the assessment of psychological-mindedness in the diagnostic interview. Though acknowledging that the whole is often greater than the sum of its parts, she outlined nine points 'in an approximate order of discovery, rather than importance, under two headings' (p. 819): the history, and developments in the interview arising from the history. Under the first heading, Coltart suggested that the diagnostician should look for:

> 1. The capacity to give a history which deepens, acquires more coherence, and becomes textually more substantial as it goes on... 2. The capacity to give such a history without much prompting, and a history which gives the listener an increasing awareness that the patient feels currently related in himself, to his own story; properly—if unhappily—the product of the connective aetiology of his life's circumstances... 3. The capacity to bring up memories with appropriate affects. (p. 819)

Under the second heading, Coltart included the following:

> 4. Some awareness in the patient that he has an unconscious mental life... 5. Some capacity to step back, if only momentarily, from self-experience, and to observe it reflectively—either spontaneously, or with the help of a simple interpretation from the assessor, who should make opportunity for this sort of intervention... 6. A capacity, or more strongly a wish, to accept and handle increased responsibility for the self... 7. Imagination... 8. Some capacity for achievement, and some realistic self-esteem... 9. Overall impression... something deeply recognizable, but ultimately not fully definable, about the assessor's experience of a thorough, intense, working consultation with a psychologically minded person. (pp. 819-820)

I am in agreement with Coltart. However, I think that she became a bit over-inclusive in listing capacity for achievement under psychological-mindedness. On the other hand, she did not include some other ways to assess the patient's psychological-mindedness. For instance, a patient who has kept an ongoing journal displays a capacity for reflectiveness, a wish for psychic dialogue, and a respect for mental life. The same applies to a patient who spontaneously offers a dream during the initial evaluation. This is especially significant if the patient is not in the mental health field and thus not biased in that direction. Yet another evidence of psychological-mindedness is the patient's spontaneous offering of a genetic explanation of either his or her own or someone else's behavior.

To summarize, it seems that psychological-mindedness is best reflected by observing the following things: (1) *a capacity for reflective self-observation* as evidenced by the patient's giving a coherent and affectively resonant history as well as by his or her ability to be aware (or become aware during the interview) of internal conflicts; (2) *an interest in one's mental life* as evidenced by a history of having kept journals, and by spontaneously mentioning dreams and fantasies in the initial interview; (3) *a belief in psychic causality* as evidenced by the patient's offering a genetic explanation of his or her

own or another's behavior and by his or her capacity to entertain a mental basis for certain accidents, onset of a physical illness, and so on; and (4) *a readiness to see symbolic meanings* and enter into a metaphorical dialogue as evidenced by a positive, even welcoming, response to a trial interpretation.[5]

Two caveats are in order here. First, the presence of only one among these four factors should not lead to the conclusion that the patient is psychologically-minded. Two, an attempt should be made to distinguish an actual deficiency in psychological-mindedness from its pallor due to anxiety in the interview situation. Supportive, empathic remarks may diminish the anxiety and improve psychological mindedness in the latter but not in the former instance.

### *Other Mental Functions*

(1) *Benign regression.* In order to enter and benefit from dynamic psychotherapy, an individual must posses the capacity to renounce logic and reality on a transient and ego-replenishing basis. Without such 'benign regression' (Balint, 1959, 1968), psychotherapy tends to become a mere intellectual exercise. The way to assess this capacity is ask the patient about their leisure time (e.g. Sundays, vacations), their being able to have peaceful solitude, and their ability to play with children and pets.[6]

(2) *Ego strength.* Since dynamic psychotherapy can stir up latent conflicts and cause anxiety, it is important to have some sense of the patient's ego strength. This can be ascertained by asking the patient how he deals with stressful situations (e.g. examinations, job interviews, children's illness) as well as by observing how the patient conducts himself in the interview himself. Incapacity to tolerate anxiety and poor impulse control are suggestive of a weak ego and, therefore, negative prognostic indicators in-depth psychotherapy.

(3) *The 'intermediate area of experience'.* According to Winnicott (1953), the 'intermediate area of experience' refers to the psychic space where a confluence of reality and unreality occurs even though such matters do not form its content per se. It is where imagination is born and paradox reigns supreme. It contains phenomena that are subjectively experienced and are neither questioned nor not questioned for their literal verity. Its clinical impor-

tance lies in the fact that transference phenomena should stay within this area and not become too 'real' in order to be interpretable. Assessment of the patient's capacity in this regard can be done by questions pertaining to the patient's ability to play, create, and enjoy fiction, movies and poetry, all of which require a make-believe sort of mental attitude. His responses to the therapist's tentative interpretations which offer imaginative ways of understanding his problems is also telling in this regard.

(4) *Superego.* Some assessment of superego functioning is also essential. A harsh superego makes the patient feel unworthy of deep and sustained help and prepares the ground for a 'negative therapeutic reaction' (Freud, 1923) once the treatment gets underway. Resistance to uncovering deeper layers of psyche where anxiety, guilt, and shame-producing wishes and fantasies lurk can be strengthened by a strict superego. Too lax a superego can also pose problems, with the patient lying, withholding information, and misrepresenting financial resources in order to pay a lower than realistic fee for treatment.

### *ASSESSING FEASIBILITY OF TREATMENT*

While the assessment of psychopathology yields information about the need for treatment and the assessment of psychological mindedness, ego strength, and superego function yields information about the suitability for treatment, it is the assessment of the patients motivation and his or her reality situation that reveals whether a meaningful treatment can actually be established.

#### *Motivation*

Patients who are themselves desirous of change are the ones most suited for in-depth psychotherapy. Recognizing, at least to some extent, their own role in the subjective and interpersonal distress they are feeling, such individuals are better prepared to take a look at their own selves with the psychic lens created in the therapeutic dyad. It should however be acknowledged, in all fairness, that most patients arriving at the psychotherapist's door are not so prepared; they seek symptomatic relief. Here the assessment of self-concern as well as the concern the patient shows towards others who are impacted by his 'symptoms' is important. Finally, there are patients who seek treatment largely at the behest of an exhaust-

ed spouse, irate parent, or disgruntled employer. The temptation to regard these patients as lacking motivation is great. However, simply because the patient has been 'forced' to come by someone else does not automatically translate into lack of desire for change. Careful evaluation of each individual case in point is therefore indicated though with the following caveats in mind.

*First,* it should be remembered that motivation does not refer to conscious motivation alone. Klauber (1981) has eloquently made this point:

> What commonly brings the patient is the pressure of his immediate suffering, usually on himself, but not infrequently on his doctor or his family. But in any case, his conscious motivation whether for analysis or against it, is only a partial indicator of his unconscious motivation. It is his unconscious motivation which has to be determined—the repressed wish, so to speak, behind the manifest content of his presentation and the relevance of this wish to the present crisis in his life. (p. 151)

*Second,* those individuals who seem very well-motivated for change sometimes turn out not to be so; a nucleus of hard resistance at times dwells deep within their psyche. Patients who have extensively read psychiatric and psychoanalytic literature and seem gifted in their grasp of unconscious trends at times turn out to be operating largely from a false self constellation (Balsam, 1984). Others, while appearing quite devoted to the therapeutic enterprise reveal tenacious 'some day...' fantasies of an entirely conflict-free existence that keep them from being truly involved in a process of psychic change (Akhtar, 1996). Sadly, these resistances are not infrequent among those working in the mental health field.

*Third,* those who claim to have been pushed to seek treatment by others might have unconsciously engineered such referral by incremental doses of unacceptable behavior. The help-seeking cry of others on their behalf reflects the repudiated healthy parts of their own personality; these have been deposited into others by 'healthy projective identification' (Hamilton, 1986). The following observation by Armstrong (2000) pointedly underscores this dynamic.

chewed upon them at his leisure. As the interview progressed, a second interaction with cats emerged. He liked to bring a cat's face very, very close to his own face and then breathe in the air that came out of the cat's nostrils. Both these acts gave him deep gratification though he also worried about their apparent oddity and did not quite know what to make of them.

The next day, while describing his family background, Dr. Liebowitz came upon the topic of his mother. He sighed, saying: 'You don't want to know about her. She is so controlling and so intrusive that I cannot describe. She lives about a thousand miles from here but I constantly feel her claws digging in to me.' As he said this, he grabbed the upper part of his left arm with his right hand, making the latter appear like a claw, and dug his nails into the skin. Seeing the connection between the biting off of a cat's nails and the alleged claw of his mother on his arm, I said: 'Did you notice what you just said?' He was puzzled. 'What?' he responded. I said, 'What do you make of you using the word "claws" in connection with your mother and how do you connect her "claws" with a cat's nails?' He was dumbfounded but gradually became somber and began to talk about his chronic difficulty of maintaining an optimal distance from his mother. With further elaboration during the session, the biting off of the cat's nails and breathing the air coming out of the cat's nostrils could be seen to symbolize the two sides of this distance-closeness conflict. As this clarification settled in our dialogue, I could see him become more animated and curious about his intrapsychic life.

In the end, it seems that the issue of motivation is far from simple. The categorical division of 'motivated' or 'unmotivated' patients should therefore be put aside in favor of the following dimensional queries. What aspect of his psychopathology is the patient motivated to get help for? What has caused this motivation? What is his conscious motivation and what is his unconscious mo-

tivation? How can one mobilize forces within the patient to enhance his motivation for psychic growth? What fears, concerns, and self-defeating tendencies might be responsible for his low motivation? To what extent, these can be brought to the patient's awareness and with what beneficial result? And so on. It is this kind of a broad-based and thoughtful approach to the issue of the patient's motivation that yields more productive information.

*Reality Factors*

The psychotherapeutic enterprise, despite its imaginary and imaginative dimensions, must be firmly anchored in reality. This is not only true vis-à-vis the therapeutic framework and the interpersonal boundaries it is dependent upon (see Chapter Two for more details) but also applies to the very fact of taking a patient into treatment. In other words, certain realistic conditions must be met before one agrees to treat a patient in intensive psychotherapy. Some certainty of sustained financial resources, for instance, is necessary. Without a proper investigation of this, the treatment at times comes to a screeching halt and, because a psychodynamic process involving transference and countertransference has been set into motion by this time, it becomes very difficult to sort out the role of the reality impediment in the continuation of care. (See Chapter Three for more details on the role of money in psychotherapy.)

Another requirement is that the patient resides within a reasonable distance of the therapist's office. A patient who lives far away might make earnest promises to maintain regular attendance for the sessions but generally fails to do so once the difficulty of travel meets the inevitable resistance to psychological uncovering. Therapists who are financially or otherwise needy are as vulnerable to compromises of judgment in such situations as are the renowned and charismatic 'specialists' sought out by long distance patients.

While by and large it is inadvisable to take patients who live a long distance away from the therapist's office, there might be exceptions to this rule. Three such situations are: (i) the distance is rendered manageable by rapid means of transport, (ii) there is no adequately trained psychotherapist in the patient's vicinity, (iii) the patient is a mental health professional for whom the treatment is a part of psychoanalytic training and there is no training analyst where the patient lives or works. To be sure, problematic scenarios

can lurk in the background of these situations as well but they do require a more sympathetic consideration than where the pressure to be treated by a particular, usually renowned, therapist is mostly based on the idealization of him.

In these latter circumstances, the capacity of the therapist to contain and manage the prospective patient's idealization becomes crucial. A highly nuanced approach is needed in dealing with those who call after reading a book one has authored or after hearing a lecture one delivered somewhere out of town. This approach must avoid the extremes of defensive recoil and refusing to see the patient altogether or getting seduced into starting a treatment under unrealistic circumstances. Rather than rejecting the patient, the therapist might offer a consultation of about two to three hours in length (with or without a short break) with the explicit statement that this would not lead to an on-going treatment. Such consultation should encompass not only the tasks outlined above but also explore the patient's idealization of the therapist with the hope to bring it to a temporary closure; the reasons for it can be understood and resolved in a future treatment under more realistic circumstances.

A different problem is presented by individuals who seek out of town treatment because they themselves are pillars of their society and cannot afford to be 'discovered' seeking help. While exceptions exist, a consistent exploration of their vulnerability to shame can help them overcome this resistance.

### CLINICAL VIGNETTE 5

Max Robinson, a sixty year-old wealthy businessman from a small city some one hundred miles away from my office, consulted me in the midst of a marital crisis. His wife had discovered that he was having an extramarital affair and had threatened to divorce him. As matters got more heated, the prior occurrence of two more infidelities came out. Asking for her forgiveness, Max told her that he had been emotionally troubled for a long time and would seek psychiatric help.

The evaluation that followed revealed a history of much greater sexual promiscuity than these three affairs suggested. Max had been restless for years and

his sexual escapades had taken place in the setting of chronic boredom. Placed alongside a distinguished work record and overall stability of personality functioning, such contact hunger, coupled with a nearly total inability to love anyone, suggested the possible diagnosis of narcissistic personality disorder. I made a recommendation of psychodynamic psychotherapy on a twice a week basis with the consideration of converting it to psychoanalysis in the future. Clearly, it was not possible for him to undertake this treatment with me since he lived quite far from my office. Fortunately there was a psychoanalyst who practiced in his town; this was someone I knew and respected. The patient, it turned out, was unwilling to see this analyst, claiming he would be profoundly ashamed if someone in town saw him go in and out of a 'shrink's' office. This gave me an opportunity to explore the feelings of inferiority that were hidden inside of him and had, in part, fueled his promiscuity; the idea was that if a woman agreed to sleep with him, he must not be all that bad. As we were able to link his hesitation over going to the local analyst with his chronic self-doubt, Max's opposition to my recommendation diminished.

### *RECOMMENDING TREATMENT*

Once the core information about the patient's psychopathology has been gathered, his suitability for dynamic psychotherapy determined, and a sense of whether such treatment is realistically feasible has been gained, the therapist is in the position of making a recommendation. While there are always exceptions in the clinical situation, the choice, at this point, between recommending psychoanalysis, psychodynamic psychotherapy, or supportive interventions rests upon a telescoping of the three sets of information (psychopathology, ego and superego functions, and motivation and realities) into a composite gestalt. This does not rule out the fact that the patient's symptoms alone can, at times, affect the choice of treatment modality. For instance, three types of symptoms should

give one pause while recommending in-depth treatment, be it psychoanalysis proper or psychodynamic psychotherapy. These include (i) symptoms that are bizarre (e.g. communication with extraterrestrial beings); (ii) symptoms that are pleasurable (e.g. excessive drinking, sexual promiscuity in younger narcissistic patients); and (iii) symptoms that stand by themselves and are tenacious (e.g. monosymptomatic hypochondriasis). This last point has been made most emphatically by Klauber (1981) who states that 'the lack of capacity for varied forms of displacement implies a near-delusional mechanism' (p. 155).

All in all, the patients who have a mild to moderate degree of psychopathology, a higher level of character organization, outstanding psychological mindedness, good ego strength, well integrated superego, strong motivation, and relatively easy realities, should be taken into or referred for psychoanalysis proper (Bachrach & Leaff, 1978; Rothstein, 1982; Zimmerman,1982). Those patients who have moderate to severe psychopathology, an overall borderline level of personality organization regardless of its phenotypical picture, high or medium psychological mindedness, some compromise of ego and superego functions, moderately strong motivation, and only somewhat compromised realities, should be regarded as being suitable for psychodynamic psychotherapy. Finally, those who are very severely ill, betray a psychotic level of character organization, have medium or low level of psychological mindedness, moderate to severe impairment of ego and superego functions, weak motivation, and difficult realities, should be treated with supportive interventions including the adjunct measures of medications, group interventions and even hospitalization. However, these guidelines must be treated as such and not turned into rigid rules. Their aim is to underscore the plausibility of differential therapeutics in this realm, not to box in the clinician in prefabricated and inviolable categories.

Once the therapist has arrived at such clarity, he should inform the patient that his diagnostic evaluation is over and share his conclusions with the patient in simple, jargon-free language. He might include in his comments hints of how he arrived at his conclusions. Quoting something the patient had said, recounting a particular emotional outburst, and reminding the patient of a slip of the tongue enhance the patient's sense of participation and mutuality

even at this phase. This, in turn, facilitates the patient's receptivity to the information being given.

Two other things should be kept in mind. Firstly, it might be good to preface one's comments with the caveat that conclusions arrived at in one to three sessions are necessarily tentative. The interviewer might also indicate at this time the need for further investigations of a social (i.e. family interview), psychometric, or laboratory kind, if he thinks that these might help to clarify the situation. Secondly, while using ordinary language is preferable there is no reason to be wishy-washy or apologetic if a patient asks for a specific psychiatric diagnosis. Exploring the patient's reasons for asking this might reveal further, significant information. However, such exploration should not be used as a delay tactic, and a patient who wants to know his diagnosis should be told. The emphasis in statements made to the patient must, however, remain upon the patient's subjective experience and not upon the behavioral concomitants typical of the nosological entity though these might have to be included as well. The following ways of explaining borderline and narcissistic personality labels illustrate this point well:

- *Borderline personality disorder.* 'As we grow from a child to an adult, we develop two capacities: one is to want and need "good" things, such as "good" relationships, "good" love, "good" sex, "good" job, "good" house, and so on. The other capacity we develop is to tolerate the disappointing fact that we will not get "good" stuff all the time. The individual who has a borderline personality disorder has the first capacity but lacks the second one. As a result, when faced with disappointments, he gets very hurt and like any other person who is frequently hurt, he gets angry. This anger comes in the way of the mind's peaceful functioning in the realms of both his relationships and vocation. Life gets splintered and is lived in pieces. At times, the individual vents his rage on self and others or tries to get rid of it by numbing his mind (with the use of substances) or distracting himself by impulsive gratifications. All in all, borderline personality disorder is a very painful condition to have.'

- *Narcissistic personality disorder.* 'The person with a narcissistic personality disorder is someone who is preoccupied with his

own self. While it might come across as such, this is hardly a matter of vanity. The fact is that the person secretly feels quite worried about his own self and carries a profound vulnerability to shame. Having been raised on praise without much love and affection, such a person has become dependent upon admiration. This is what he constantly seeks. He feels perpetually compelled to improve his talents, polish his image, and "sell" himself to others. Now, all this takes a lot of effort, and energy. It is truly tiresome. Besides it has the painful consequence of his becoming unable to pay attention to others and also not feeling really loved by anybody; he feels that people like him only because of what he has accomplished not for who he is. He feels alone in this world. While socially successful and admired by others, the narcissistic person lives in a private world of self-doubt, inferiority and insatiable longing for genuine love and acceptance.'

This manner of telling the patient's diagnosis to him should put to rest the prevalent notion that patients misunderstand diagnostic terminology and are narcissistically injured by it. In holding onto this old-fashioned idea, one is liable to overlook that the interviewer's cryptic attitude, fudging, and uncomfortable avoidance can also have alienating and adverse effects on the patient.

Following the discussion of the nature of the patient's problem, the focus should shift to issues of its treatment. The interviewer should now inform the patient of what he thinks is the ideal treatment for the patient's malady, explaining, especially if asked, the reasons for this recommendation. The patient should also be informed, especially if things are unclear, of alternate approaches to treating the condition involved, and encouraged to ask questions about anything that seems unclear Questions raised by the patient should be answered factually, and the interviewer should not derail or mystify the patient by 'interpreting' the reasons behind such questions. For instance, the patient may ask why the frequency of two to three times a week is needed for dynamic psychotherapy. Or, he might ask about the difference between psychoanalysis and psychotherapy. Subtle controversies in the field notwithstanding, it is possible to answer such questions in a simple, straightforward way. Regarding frequency, one might say the following: 'the prob-

lems we are dealing with here are deep and solving them requires the sort of access to your inner world that can only be provided by such frequency.' One might explain the difference between psychoanalysis and psychotherapy not only in terms of frequency of visits and the use of couch but, to a certain extent, in terms of the nature of the patient's activity (i.e., free association) and the therapist's 'quieter' stance vis-à-vis the patient's report of his thoughts, feelings, fantasies, and dreams. In the end, it is the therapist's straightforward and collaborative manner in dealing with the patient's questions that counts.

### *Concluding Remarks*

In this chapter, I have attempted to offer an account of what constitutes a thorough initial assessment of a potential patient for psychodynamic psychotherapy. I have divided my comments into the categories of (i) forming early impressions, (ii) assessing psychopathology, (iii) assessing psychological mindedness and other ego functions, and (iv) assessing the patient's motivation and realities that might impact upon the feasibility of proper treatment.[7] I have described how pooling the four sets of data helps choose a treatment modality and then described the process of making recommendations to the patient, answering his questions, and, through all this, beginning to set the ground rules for treatment being undertaken.

Conducting these tasks is hardly restricted to gathering objective information; the therapist's subjective experience plays a key role throughout the evaluation process. Indeed, vigilance towards early 'countertransference' yields all sorts of useful clinical data, as I have already shown in this chapter. What I wish to underscore now is that while the arousal of strong feelings in the therapist does not necessarily preclude his taking the patient into on-going treatment, circumstances where this might be the case do exist. Intense discomfort with a patient based upon cultural differences and/or the nature of psychopathology at hand might, at times, not be 'containable' by the therapist's work ego. Instead of becoming unduly valiant, it might then be preferable not to take the patient into treatment. Politics, the last taboo in the clinical field, can also contribute to insurmountable difficulties. Finally, there is the issue

of the therapist's competence to treat a particular patient. While all sorts of professional and legal checks and balances exist in order to assure this, ultimately the assessment of one's competence rests upon a honest self-scrutiny and fearless soul searching.[8]

This brings up the fact that in-depth psychotherapy constitutes an intrapsychic and interpersonal journey that is unpredictable and, at times, dark and mysterious. Two people undertaking such a trip together need to establish and maintain clear limits and boundaries to prevent themselves from getting derailed. This forms the topic of the next chapter.

## 2. Boundaries

*I never, or almost never, occupy the middle of my cage;*
*my whole being surges towards the bars*

André Paul Guillaume Gide (1869-1951)

As human enterprises, dynamic psychotherapy and psychoanalysis are intensely paradoxical at their base. On the one hand, they are grounded in theoretical formulations regarding development, mental functioning, psychopathology and technique. On the other hand, they involve a deep and sustained emotional relationship between two individuals. It is this central paradox that dictates that, in the conduct of these treatments, deliberateness and spontaneity, knowledge and surprise, and discipline and freedom co-exist in a gestalt of harmony. (For more on this matter, see Parsons, 2001.) Clearly, such a complex 'game' cannot be played without an agreed-upon guidelines and framework. The concept of 'boundaries' enters the discourse at this point.

In this chapter I will elucidate this concept in some detail. I will categorize the plethora of notions that pervade this realm into boundaries of three types: intrapersonal (intrapsychic), personal, and interpersonal. This centripetal movement of discourse will bring up the concept of 'optimal distance' (Bouvet, 1955; Balint, 1959; Mahler et al., 1975; Akhtar, 1992b), its potential overlap with 'interpersonal boundaries', and the cultural variations and psychopathology of boundaries and distance. Following this, I will address the various types of boundary violations and also note ways

to prevent such mishaps and to deal with their socio-clinical aftermath.[9] My discussion of technical matters, however, will not be restricted to this aspect of boundaries. I will also describe the measures needed to set up a clear and firm therapeutic frame from the outset and to safeguard it from major encroachments by transference and countertransference distortions.

### *INTRAPSYCHIC, PERSONAL AND INTERPERSONAL BOUNDARIES*

The term 'boundaries' is used in psychoanalytic literature in three different ways: (i) intrapsychic boundaries, (ii) personal boundaries, and (iii) interpersonal boundaries. Each of these categories has its developmental origins, phenomenological subtleties, cultural and pathological variants, and implications for technique. However, these concepts overlap each other and the following elucidation of them in separate sections is a transparent artifice in the service of didactic clarity.

#### *Intrapsychic Boundaries*

Although Freud's (1900) early topographic model (dividing the mind into conscious, preconscious and unconscious systems) and later structural model (with entities like id, ego and superego) both implied separation barriers within the mind itself, the term 'boundaries' was not used by him. It appeared, with a prefix, as 'ego boundaries' for the first time in a paper by Tausk (1918). Later it was popularized by Federn (1952) who described 'inner ego boundaries 'as barriers that separate the ego from other mental structures. Klein's (1935, 1940) and Fairbairn's (1952) models of endopsychic structure also contained splits, schisms, and sequestered schemas within the mind.

With Hartmann's (1950) differentiation between 'ego' and 'self' and Jacobson's (1964) refinement of 'self' as 'self-representation', the concept of boundaries came to be understood somewhat differently. Jacobson (1964) proposed that the initial intrapsychic structure is a fused self-object representation that evolves through primary libidinal identifications with the mother. Gradually, differentiation between self- and object-representations begins. The propensity for their defensive re-fusion exists and is intensified by the presence of too much aggression within a psychic economy: this can lay the foundation of a psychotic core. Under loving cir-

cumstances, the self- and object-representation differentiation continues and is followed by the synthesis of 'good' and 'bad' self-representations into a composite self-representation and of 'good' and 'bad' object-representations into a composite internal object representation. These intrapsychic clusters are the metapsychological counterparts of identity formation (Kernberg, 1975, 1976). Here Erikson's (1950, 1956) work is pertinent. Besides emphasizing the synthesis of sequestered ego (self) fragments, Erikson underscored the importance of bringing together the past, present, and (wished-for) future views of the self; temporal continuity and continuity amidst change was seen by him as the hallmark of healthy identity.

*Personal Boundaries*

The boundaries of the self as a distinct organism have been described from various perspectives. Freud's (1895) *Reizchutz* or 'protective shield' is perhaps the earliest concept in this realm. Under this rubric, Freud proposed the existence of a threshold of a stimulation by the external environment, the exceeding of which becomes psychologically traumatic. Later authors (Mahler, 1958; Khan, 1963; Gediman, 1971; Esman, 1983) expanded Freud's views to include the regulation of internal stimuli also among the functions of this structure; Rapaport's (1951) term 'stimulus barrier' thus became synonymous with Freud's (1895) protective shield. The origins of such a barrier were traced to mother-infant interactions whereby the mother regulates the stimulation her infant has to face. This maternal function is gradually internalized by the child who then develops self-regulatory capacity with regards to the tolerable amounts of excitement, activity, and stimulation.

Tausk's (1918) 'ego boundaries' and Federn's (1952) 'external ego boundaries that separate ego from the external reality' are also important concepts in this regard. These authors, however, did not regard such boundaries as static and rigid. Their 'soft' notions were gradually replaced, as Gabbard and Lester (1995) note in their comprehensive review of the topic, by reified concepts. Reich's (1933) description of 'character armor', Bick's (1958) 'skin around the ego' and Anzieu's (1990) 'psychic envelopes' are among the most prominent illustrations of this tendency. The psychiatric 'necessity' of distinguishing between psychotic and non-psychotic conditions, both in the form of their flagrant 'state' and their sub-

terranean 'trait' (Frosch, 1988a, 1988b) further consolidated the view that neat demarcations between self and non-self were possible and even desirable. Winnicott's (1953) delineation of the 'intermediate area of experience' and Searles' (1960) views about man's relationship with his non-human environment are prominent exceptions to this rigid me-not-me separation.

*Interpersonal Boundaries*

Psychoanalysts studying developmental processes (e.g. Mahler, 1958, 1971, 1972; Mahler et al., 1975; Winnicott, 1967, 1969, 1971; Tyson, 2005, 2006; Parens, 1979, 2006) invariably posit a view of boundaries as evolving from a 'dual unity' or 'symbiosis' or 'merger experiences' between two persons—i.e. mother and child.[10] Their models thus lay down the prototype for the interpersonal blurring of boundaries which, during adult life, can be accentuated by pathology or, in moderation, capitalized by the developmentally advanced capacities of mutuality (Bergman, 1980), collaborative work, love, sexual excitement (Kernberg, 1977, 1995) and friendship. Marital relationships especially test the resilience of the core self and flexibility of its outer boundaries.

This brings up the related issue of boundary-permeability, to which is relevant the work of Landis (1970) and Hartmann (1991), who described 'permeable' or 'impermeable' or 'thin' and 'thick' boundaries, respectively, as a broad way of organizing clusters of personality traits. Those with 'thin' boundaries displayed suggestibility, weakness of identity, and inconsistent defenses and behaviors. Those with 'thick' boundaries had stable identity and consistent behavior; they were also firm and assertive in interpersonal transactions. While constitutional factors did play a role here, the 'thickness' of boundaries showed a correlation with strong identification with the same-sex parent. It was also noted that if boundaries become 'too thick', rigidity and smugness results and if they become 'too thin' intense vulnerability to narcissistic injury and shame follows.

In sum, the term 'boundaries' seems to have intrapsychic referents (keeping mental contents or structures apart), personal referents (differentiating self from non-self), and interpersonal referents (regulating the impact of interacting with others). This last-mentioned emphasis upon the concept of boundaries is especially evi-

dent in the psychoanalytically informed literature on marital and family therapy (Sholevar, 1985, 1995) and, in an even broader way, in the psychoanalytically informed writings on ethnic conflict resolution (Volkan, 1988, 1997). Finally, it should be noted that the psychotherapeutic (or psychoanalytic) situation—with its fixed length of sessions, predictable rhythm of appointments and payments, relative anonymity of the therapist, abstinence, and neutrality—is a highly special set-up of interpersonal boundaries. It is a context that requires firm limits on the one hand, and, on the other, being subject to intersubjective processes like empathy and projective identification allows subtle and transitory mergers of two minds. The work that goes on in this situation tests all boundaries regardless of their being intrapsychic, personal, or interpersonal.

### *The Related Concept of Optimal Distance*

The term 'optimal distance' was introduced into psychoanalytic literature by Bouvet (1958). In a paper titled 'Technical variation and the concept of distance', he defined 'distance' as 'the gap that separates the way in which a subject expresses his instinctual drives from how he would express them if the process of "handling" or "managing" these expressions did not intervene' (p. 211). Bouvet went on to explain that this 'managing' represents an aspect of the ego defense, and 'draws attention to the exterior aspect of the ego's activity, while "defense" characterizes more particularly its internal aspect' (p. 211).

A peculiar tension seems to exist in this definition. On the one hand, by regarding the gap between two manners of drive discharge as its cardinal characteristic, Bouvet posits an intrapsychic definition of the word 'distance'. On the other hand, by focusing on 'managing' or the 'exterior' aspect rather than on 'defense' or the 'internal' aspect of the ego's activity, Bouvet leans toward an interpersonal definition of distance. This stance is more apparent in the following passage from the same paper.

> The distance that a patient will take from his analyst varies constantly during the analysis, but in general it tends to diminish as the analysis progresses, until it disappears. It is this point which I call the *rapprocher*

> (which signifies in French 'drawing close', but progressively). Once attained, this partial *rapprocher* can be jeopardized by other conflicts, but appears to be more easily reestablished, and to lead finally to a more general *rapprocher.* (pp. 211-212)

The same intrapsychic-interpersonal tension in the definition of 'distance' is evident in the writings of Mahler (1971; Mahler et al., 1975). She begins her view of 'distance' as being within the largely interpersonal mother-child matrix but ends up with an internalized capacity for establishing optimal distance—in other words, with an ego-attribute. 'Optimal distance' for her is 'a position between mother and child that best allows the infant to develop those faculties which he needs in order to grow, that is, to individuate' (Mahler et al., 1975, p. 291). This distance varies from one phase of development to the other. In the symbiotic phase, the optimal distance is pretty much zero. In differentiation phase, it reaches its zenith. In the rapprochement sub-phase (from eighteen to twenty-four months) no distance appears satisfactory as there is intense conflict between progressive drives for self-expression and separation on the one hand, and regressive wishes for closeness and merger on the other. Only after this phase is traversed with the help of a tolerant and loving mother does the capacity for self and object constancy appear. The ability to maintain optimal distance from love-objects now develops. This definition is an obviously interpersonal one.

In other writings, however, Mahler takes a more intrapsychic perspective referring to the distance 'between the self and the object world' (1975, p. 193). That she means internalized objects here is confirmed by the very next sentence, which refers to the

> oscillation between longing to merge with the good object representation, with the erstwhile (in one's fantasy at least) blissful union with the symbiotic mother and the defense against re-engulfment by her (which causes loss of autonomous self identity). (1975, p. 193)

The symbiotic and practicing phase described by Mahler (1965, 1971; Mahler et al., 1975) have a close correspondence with Balint's

(1959) 'ocnophilia' and 'philobatism', respectively. The ocnophilic world consists of objects separated by horrid spaces and the philobatic world of friendly expanses dotted with unpredictable objects. The ocnophil lives from object to object, cutting short his travels through empty spaces. The philobat lives in cordial spaces, avoiding contact with dangerous objects. The ocnophil is a homebody, the philobat an eternal vagabond. Balint traced the ocnophilic tendency to the early tactile contact with mother and the philobatic bent to the latter separation-tolerant, visual contact with the mother. His acknowledgment that the two tendencies always co-exist parallels Mahler's (1972) recognition of 'man's eternal struggle against both fusion and isolation' (p. 130).

One thing is clear. All three authors dealing with distance (Bouvet, Mahler and Balint) imply that it is a Janus-faced concept with both intrapsychic and interpersonal referents. One way out of this paradox is to use the concept only in one particular context at a time. Thus in describing an individual's character, 'optimal distance' is best used in its intrapsychic sense i.e. as an ego-capacity. And, in describing the individual's relationships, therapeutic or otherwise, the term is best used in its interpersonal sense. However, this does not seem entirely satisfactory since both intrapsychic and interpersonal dimensions are active in all circumstances at the same time. This is most clear in the course of development when the intrapersonal is on the way to becoming intrapsychic and that, in turn, is tried out in the interpersonal realm. The best way out of this conundrum is, I believe, to accept the paradox and to regard the dialectical tension between the two perspectives (intrapsychic and interpersonal) as being inherent to the concept. Finally, it should be added that the vicissitudes of the Oedipus complex also contribute to the capacity to maintain optimal distance. Exclusion from parental sexuality and acceptance of generational boundaries are cardinal achievements of this phase (Freud, 1924). However, this does not imply complete sensual and aggressive disjunction between generations.

Putting everything together, it appears that at the preoedipal level, optimal distance refers to a psychic position that permits intimacy with others without loss of autonomy and separateness without painful aloneness. At the oedipal level, optimal distance can be viewed as the capacity to renounce primary oedipal objects in a

way that (on the aggressive side) permits individual autonomy without sacrifice of traditional continuity and (on the libidinal side) establishment of the incest barrier without total obliteration of aim-inhibited, cross-generational eroticism.

This makes it abundantly clear that the 'interpersonal boundaries' and 'optimal distance' are, in some ways, conceptual twins. Both refer to the ego's modulation of relationship between self and others. Both are developmentally derived, though might also have some constitutional substrate. Both are, to a greater or lesser extent, products of modal child-rearing, hence culture-bound.

### *CULTURAL VARIATIONS*

The clarity, firmness, and permeability of boundaries are governed not only by constitutional and psychological factors, but by the culture-at-large as well. While it is easy to see how child-rearing patterns in one or the other society might uphold this or that degree of psychic separateness and autonomy as being desirable, the fact that psychically extraneous variables (e.g. density of population, means of communication and travel) and one's large group's history, literature, and mythology can also affect personal and interpersonal boundaries often comes as a surprise to mental health practitioners. Take, for instance, intrapsychic boundaries, especially those keeping the conscious secondary process mental contents separate from the primary process material of the unconscious. Comparing a group of poets and artists with a group of bankers and surgeons on this parameter alone would readily reveal that the optimal conscious-unconscious separation differs greatly between them. The former have much greater access to their unconscious goings-on and are more comfortable with the seemingly inexplicable messages from the vaults of their psyche. Modal prototypes of intrapsychic boundaries clearly differ in these groups.

A psychically autonomous and separate self is also not universal. Such a structure is the end-product, or at least the desired end-product, of the childhood separation-individuation process (Mahler et al., 1975) and its re-working during adolescence (Blos, 1967) in the Western Anglo-Saxon culture. To regard this developmental trajectory as ubiquitous to human experience betrays psychoanalytic colonialism. Careful observation of mother-child inter-

actions in India and Japan, experience of treatment of children and adolescents from those cultures, and reconstructions in the analyses of adults living there (Carstairs, 1957; Roland, 1998; Kakar, 1985; Freeman, 1998; Bonovitz, 1998) have revealed that the clearly demarcated 'psychoanalytic self' is not the modal psychic structure. Instead of an individualized self, the prevalent psychic organization is one of 'familial self' (Roland, 1988). Such a self is characterized by intense emotional connectedness and reciprocity with others and draws its narcissistic sustenance from 'strong identification with the reputation and honor of the family and other groups' (p. 8). Its modes of cognition and relating are highly context-bound and differ from the individualistic and autonomous self typically seen in the West, especially North America.

The degree to which an individual's self remains permeable to influence from others, especially one's elders, also varies from culture to culture. Writing of Indian patients, for instance, Kakar (1985) states that

> the relational orientation is still the 'natural' way of viewing the self and the world. Thus it is not uncommon for family members, who often (and significantly!) accompany the patient for the first interview, to complain about the patient's autonomy as one of the symptoms of his disorder. (p. 446)

The emphasis in such cultures is upon inter-dependence and not upon autonomy. Friendships are deep. People take all sorts of relatives into account while making important life decisions. 'Infantile objects are relinquished very gradually and this process does not take place to the degree necessary in cultures where the child is being prepared to live an adult life that is independent of the extended family' (Bonovitz, 1998, p. 182). Not surprisingly, the view of what is 'optimal distance' between two individuals (and their psyches) also varies in these cultures. This effects what is felt to be the normal frequency of contact between relatives and friends, the extent of intimacy in relationships, and even the amount of physical contact between people.

All four variables mentioned above (i.e. the porous versus closed nature of intrapsychic boundaries, individual versus famil-

ial self, relational versus autonomous orientation and average-expectable optimal distance) impact upon the conduct of cross-cultural psychotherapy and psychoanalysis. Overlooking this can lead to assumptions and interventions that result in hurting the patient and/or creating falsehood in the therapeutic alliance.

### *PSYCHOPATHOLOGY*

Psychopathology often involves disturbances of boundaries. In fact, the more severe the psychopathology, the greater is the disturbance of boundaries. This applies to all three realms (i.e., intrapsychic, personal, and interpersonal) of boundaries. A few examples should suffice to illustrate this proposition.

Intrapsychic boundaries between various psychic structures (e.g., between id and ego, between ego and superego, and between ego and ego-ideal) are affected in a number of ways by psychopathology. Schizophrenic psychoses, for instance, involve a diminished demarcation between id and ego. The primary process begins to alter thinking; wishes and dreads of the inner world come to dominate the ego's perception of external reality. Another situation where collapse of intrapsychic boundaries is evident is narcissistic and hypomanic character pathology. The usual gap between ego and ego-ideal closes in these conditions resulting in confusion between real and wishful self-perceptions; boastfulness, cockiness, and irreverence are the behavioral counterparts of this. Yet another situation is the fusion between a harsh superego and the ego, leading to the syndrome of 'messianic sadism' (Akhtar, 2007) where malignant prejudice and cruelty towards others becomes morally sanctified.

In contrast to such intrapsychic boundary dissolutions are states characterized by the cropping up of abnormal barriers between clusters of mental content. The syndrome of identity diffusion (Kernberg, 1975, 1984; Akhtar, 1984) that underlies severe personality disorders and the defensive separation of self-representations in 'dissociative character' (Brenner, 1994, 2001) are prime examples of this type of intrapsychic boundary proliferation. Contradictory self-states, including those representing different eras of life, exist in sequestered form without being synthesized into a composite whole.

On the outer rind of personality, the boundaries that separate self from non-self also show alterations in states of psychopathology. In psychoses and 'psychotic characters' (Frosch 1988a, 1988b; Volkan & Akhtar, 1997; Akhtar, 1997), blurring of such demarcations is a central feature. In the 'as-if' personality (Deutsch, 1942), the permeability of personal boundaries is greatly increased resulting in rapid identifications with others which are 'lost' with a comparable ease. The exact opposite is true of bull-headed narcissistic and paranoid characters who refuse to be influenced by anyone, or of those with Asperger syndrome (Wing, 1981) who remain peculiarly disconnected and cold in their interactions.

This brings up the psychopathology of 'optimal distance'. While agoraphobia, claustrophobia, and difficulties in adjusting to a marital relationship are often the result of conflicts over optimal distance, it is in the setting of severe personality disorders that distance related problems become most evident. For individuals with these conditions, involvement with others stirs up a characteristic 'need-fear dilemma' (Burnham et al., 1969): to be intimate is to risk engulfment and to be apart is to court aloneness. This can lead to various compromise solutions. The borderline continues to go back and forth (Akhtar, 1990; Gunderson, 1985; Melges & Swartz, 1989). The narcissist can sustain allegiances longer and shows such oscillations in 'slow motion' (Adler, 1981; Kernberg, 1970). The paranoid bristles at any change in distance initiated by others, preferring the 'reliability' of his fear of being betrayed (Blum, 1981). The schizoid opts for withdrawal on the surface while maintaining an intense imaginative tie to his objects (Akhtar, 1987; Fairbairn, 1952; Guntrip, 1969). The anti-social and the hypomanic, though internally uncommitted, develop swift intimacy with others. In essence, all severe personality disorders show impairment of the capacity to maintain optimal distance. Their problems are gross, however. More subtle anxieties in this realm, accompanied by fantasies of 'tethers, orbits, and invisible fences' (Akhtar, 1992b) surrounding one, can exist in less disturbed individuals. These are often discernible only during the work of in-depth psychotherapy or psychoanalysis.

*BOUNDARY VIOLATIONS*

Though transgressions of the therapeutic frame occurred from the earliest days of psychoanalysis and psychodynamic therapy[11], the term 'boundary violations' itself gained popularity only after the seminal book by Gabbard and Lester (1995). According to them, 'boundary violations' refer to egregious enactments on the therapist's part that are harmful to the patient. While such acts can emanate from predatory and psychopathic tendencies on the therapist's part, most times their occurrence is a matter of psychodynamic 'co-creation' by the patient and the therapist.[12] In other words, it is the unchecked interplay of transference and countertransference that leads to boundary violations.

Gabbard and Lester (1995) emphasize that behaviors constituting 'boundary violations' differ from those subsumed under the term 'boundary crossings'. There are four distinctions between them:

- 'Boundary crossings' involve a transient blurring of the selves of patient and therapist and the resulting proneness to enactment is caught 'mid-way' by the therapist. He then reflects upon what was about to happen and uses that knowledge for the advancement of therapy. In contrast, 'boundary violations' are characterized by a loss of self-reflection on the therapist's part. Consequently, such behaviors destroy the viability of treatment.

- 'Boundary crossings' are enactments that are discussed by both therapist and patient whereas 'boundary violations' are typically placed outside of the context of therapy. It is as if those behaviors (e.g. hand-holding, kissing) had nothing to do with the treatment that is being carried on.

- 'Boundary crossings' are generally responded to by the therapist and patient by reflection and attempts to understand what just took place. 'Boundary violations', in contrast, are unresponsive to the therapist's own efforts to understand and control them. There is also an aura of secrecy about such acts.

- 'Boundary violations', in contrast to 'boundary crossings', are exploitative of the patient and are harmful to the treatment process. There is a profound neglect of the patient's interests on the therapist's part. At times, there might even be a deliberate attempt to manipulate and hurt the patient.

Subtle overlaps between the two concepts notwithstanding, this view of 'boundary violation' prepares one to observe, record, and reflect upon their occurrence in a variety of realms as the treatment process unfolds.

*Sexual Boundary Violations*

In the course of intensive psychotherapy, one frequently encounters 'erotic' (Freud, 1915) and 'erotized' (Blum, 1973; Akhtar, 1994, 1996) transferences. The former emanates from unresolved oedipal longings and is generally subtle in expression. The latter arises from oral hunger, carries more explicit sexual demands, and has a coercive nature. The therapist dealing with the former begins to feel enthusiasm towards the patient. The therapist dealing with the latter feels burdened and manipulated. Paradoxically, then, the patient who is less stridently demanding of sexual involvement with the therapist gives rise to a more 'real' erotic counter-resonance in the therapist. The risk of the therapist developing a 'love-sickness' (Twemlow & Gabbard, 1989; Gabbard & Lester, 1995) is great under such circumstances.

A number of other variables contribute to the therapist finding himself on the 'slippery slope' of countertransference acting out. The most common scenarios causing this are the following:

- The therapist of an abused female patient might be under the sway of 'disidentification with the aggressor' (Gabbard, 1997) whereby he might disavow any (transference) connection with the patient's abusers and try to be at the utmost kind and indulgent towards her. Consequently he might make heroic efforts to 'help' the patient and, in the process, transgress boundaries (e.g. by hugging and kissing the patient).

- The therapist and patient might act out their repressed oedipal fantasies. 'The female patient may have harbored a childhood

fantasy that she was somehow taking care of her depressed father in despair over an empty marriage. The analyst, on the other hand, may be unconsciously rescuing his depressed mother to heal the patient. Female patients who have childhood suffered trauma may be particularly appealing to the love-sick analyst who is intent upon rescue' (Gabbard, 2006, p. 42).

- A male therapist might mistake his female patient's desire for maternal tenderness and nurturance for sexual advance and, in a state of personal vulnerability, succumb to the temptations this causes in him.

Sexual boundary violations are more likely to occur if the patient has been sexually abused as a child and is re-creating a similar situation though, of course, with the hope that a repetition of early trauma will not occur this time. The likelihood of violations markedly increases if the therapist is characterologically unable to handle erotic countertransference or has become so due to romantic and sexual deprivation in his current life (Gabbard & Lester, 1995; Celenza, 2007).

*Narcissistic Boundary Violations*

Though the therapist's misuse of the power difference in the dyad does contribute to sexual boundary violations, there are egregious behaviors where themes of domination, subjugation and control occupy the center stage. Naming them 'narcissistic boundary violations', Levine (2005) underscores the role of self-aggrandizement in them. Haughty disregard of the patient's autonomy, taking over the daily conduct of his life, advising him to marry this or divorce that person are all manifestations of such violations. This may result from the therapist acting out a particular countertransference stimulated by the patient. More often, it emanates from the therapist's narcissistic character pathology even if that is brought into play, at a given time, by a patient's 'seductions'.

CLINICAL VIGNETTE 6

Bill Silverberg had been in intensive treatment with a highly charismatic therapist known for his stylish clothes and expensive cars. The therapy floundered.

Bill dropped out and, a few years later, his therapist passed away. Six months later, Bill entered into treatment with me.

A highly masochistic man with a tall and lanky frame, Bill had a 'father problem'. On the one hand, he despised his father for constantly ridiculing him during his childhood. On the other hand, he was dependent upon the old man's financial largesse. Unable to make ends meet on his own, Bill received a monthly stipend from his wealthy father. His treatment with me was characterized by a powerful father transference in which he attempted to both flatter and devalue me. Praising me to great extent, he would defeat all interpretations by turning them into trite witticisms. Gradually, however, I learned that this sadomasochistic game was actually an advance over his original tendency to be utterly subservient to authority figures.

Now a memory from his previous treatment emerged. Bill told me that once he was going to Napa Valley, California, and mentioned it to his therapist. The latter responded by not only giving him tips about the wineries to visit but by talking about his own extensive (and expensive!) wine collection. Bill brought back a bottle of wine to his therapist as a gift. It was accepted without question. This soon became a pattern. Bill would bring wine for his therapist who would take it without any question or discussion. Then one day, Bill brought a case of wine bottles for his therapist who gave him his car keys and asked Bill to put it in the trunk of his car before starting the session!

The enactment of narcissistic-masochistic (and homosexual) transference-countertransference fantasies is clearly evident here. What is disturbing though is not the patient's 'seductions' and submission but the therapist's nonchalance and smug exploitation of his patient.

# 3. Money

*It is better to have a permanent income than to be fascinating*

Oscar Wilde (1854-1900)

Nearly a hundred years ago, Freud (1913) noted that most people approach matters of money with 'inconsistency, prudishness, and hypocrisy' (p. 131). Little has changed since then. It is still difficult for people to talk about their realities, fantasies, feelings, and aspirations involving money in a peaceful manner. This is not only because money is important in external reality but also because it has powerful meanings in the inner world of emotions. Not surprisingly, concerns about money readily become drawn into psychopathology and its treatment. The conceptual and technical knots in the encounter between money and psychotherapy have myriad forms indeed (Krueger, 1986a; Borneman, 1976; Rothstein, 1986).

In this chapter, I will attempt to shed light on these problems and their potential solutions. I will begin with a brief survey of literature on the symbolic significance of money and then delineate the psychopathological syndromes involving money.[18] My focus, however, will be upon how various aspects of our clinical work, including the therapeutic frame, transference, and countertransference are impacted upon by matters of money. Elucidation of these will lead me to explore the technical dilemmas rampant in this realm and suggest some ways of handling them.

### *PSYCHOLOGICAL SIGNIFICANCE OF MONEY*

In a paper titled 'Character and Anal Erotism', Freud (1908) listed parsimony as a major trait of the obsessional personality. He traced the reluctance such individuals show in parting with money to the pleasure felt by the anal-phase child in retaining feces. Invoking illustrations from fairy tales, mythology, language, and dreams, Freud declared that money and feces were equated in the unconscious. He stated that two factors facilitate this equation. First, the striking contrast between a precious and a worthless substance makes the former a perfect disguise for the latter. Second,

> the original erotic interest in defecation is, as we know, destined to be extinguished in later years. In those years, the interest in money makes its appearance as new interest which has been absent in childhood. This makes it easier for the earlier impulsion, which is in the process of losing its aim, to be carried over to the newly emerging aim. (p. 175)

Freud's notions were phenomenologically embellished by his early pupils (Ferenczi, 1914; Jones, 1918; Fenichel, 1938, 1945) though with little addition to their theoretical basis. The feces-money equation thus became the established psychoanalytic dictum and miserliness was firmly ensconced as an anal trait.

However, as psychoanalytic motivational theory evolved from its instinctual foundations to include the ego, object-relational, and self-psychological perspectives, additional views regarding the emotional significance of money were voiced. Klein (1937) saw the origin of greed in the early oral phase and stated that its purpose was a hungry, destructive introjection of the frustrating breast. Money came to symbolize this elusive source of security later in life; children's fears of poverty betrayed the expectation of punishment over unmitigated hostile phantasies towards the mother. According to Klein, the adult depressive's dread of becoming destitute could be traced to this very dynamic of early childhood. Extension of her ideas was evident in Kernberg's (1975, 1976, 1984) descriptions of narcissistic personality that included the intense fervor with which some of these individuals pursue wealth. It was

CHAPTER

# 1 Listening to the Patient

## Listening: The Key Skill in Psychiatry

It was Freud who raised the psychiatric technique of examination – listening – to a level of expertise unexplored in earlier eras. As Binswanger (1963) has said of the period prior to Freudian influence: psychiatric "auscultation" and "percussion" of the patient was performed as if through the patient's shirt with so much of his essence remaining covered or muffled that layers of meaning remained unpeeled away or unexamined.

This metaphor and parallel to the cardiac examination is one worth considering as we first ask if listening will remain as central a part of psychiatric examination as in the past. The explosion of biomedical knowledge has radically altered our evolving view and practice of the doctor–patient relationship. Physicians of an earlier generation were taught that the diagnosis is made at the bedside – that is, the history and physical examination are paramount. Laboratory and imaging (radiological, in those days) examinations were seen as confirmatory exercises. However, as our technologies have blossomed, the bedside and/or consultation room examinations have evolved into the method whereby the physician determines what tests to run, and the tests are often viewed as making the diagnosis. So can one imagine a time in the not-too-distant future when the psychiatrist's task will be to identify that the patient is psychotic and then order some benign brain imaging study which will identify the patient's exact disorder?

Perhaps so, but will that obviate the need for the psychiatrist's special kind of listening? Indeed, there are those who claim that psychiatrists should no longer be considered experts in the doctor–patient relationship, where expertise is derived from their unique training in listening skills, but experts in the brain. As we come truly to understand the relationship between brain states and subtle cognitive, emotional, and interpersonal states, one could also ask if this is a distinction that really makes a difference. On the other hand, the psychiatrist will always be charged with finding a way to relate effectively to those who cannot effectively relate to themselves or to others. There is something in the treatment of individuals whose illnesses express themselves through disturbances of thinking, feeling, perceiving, and behaving that will always demand special expertise in establishing a therapeutic relationship – and that is dependent on special expertise in listening (Clinical Vignette 1).

All psychiatrists, regardless of theoretical stance, must learn this skill and struggle with how it is to be defined and taught. The biological or phenomenological psychiatrist

*The Psychiatric Interview: Evaluation and Diagnosis*, First Edition. Allan Tasman, Jerald Kay and Robert J. Ursano.

This chapter is based on Chapter 1 (Paul C. Mohl) of *Psychiatry*, 3rd Edition.

Clinical Vignette 1

A 28-year-old white married man suffering from paranoid schizophrenia and obsessive–compulsive disorder did extremely well in the hospital, where his medication had been changed to clozapine with good effects. But he rapidly deteriorated on his return home. It was clear that the ward milieu had been a crucial part of his improvement, so partial hospitalization was recommended. The patient demurred, saying he didn't want to be a "burden". The psychiatrist explored this with the patient and his wife. Beyond the obvious "burdens" of cost and travel arrangements, the psychiatrist detected the patient's striving to be autonomously responsible for handling his illness. By conveying a deep respect for that wish, and then educating the already insightful patient about the realities of "bearing schizophrenia", the psychiatrist was able to help the patient accept the needed level of care.

listens for subtle expressions of symptomatology; the cognitive–behavioral psychiatrist listens for hidden distortions, irrational assumptions, or global inferences; the psychodynamic psychiatrist listens for hints at unconscious conflicts; the behaviorist listens for covert patterns of anxiety and stimulus associations; the family systems psychiatrist listens for hidden family myths and structures.

This requires sensitivity to the storyteller, which integrates a patient orientation complementing a disease orientation. The listener's intent is to uncover what is wrong and to put a label on it. At the same time, the listener is on a journey to discover who the patient is, employing tools of asking, looking, testing, and clarifying. The patient is invited to collaborate as an active informer. Listening work takes time, concentration, imagination, a sense of humor, and an attitude that places the patient as the hero of his or her own life story. Key listening skills are listed in Table 1.1.

**Table 1.1 Key Listening Skills**

| | |
|---|---|
| Hearing | Connotative meanings of words |
| | Idiosyncratic uses of language |
| | Figures of speech that tell a deeper story |
| | Voice tones and modulation (e.g., hard edge, voice cracking) |
| | Stream of associations |
| Seeing | Posture |
| | Gestures |
| | Facial expressions (e.g., eyes watering, jaw clenched) |
| | Other outward expressions of emotion |
| Comparing | Noting what is omitted |
| | Dissonances between modes of expression |
| | Intuiting |
| Reflecting | Attending to one's own internal reactions |
| | Thinking it all through outside the immediate pressure to respond during the interview |

The enduring art of psychiatry involves guiding the depressed patient, for example, to tell his or her story of loss in addition to having him or her name, describe, and quantify symptoms of depression. The listener, in hearing the story, experiences the world and the patient from the patient's point of view and helps carry the burden of loss, lightening and transforming the load. In hearing the sufferer, the depression itself is lifted and relieved. The listening is healing as well as diagnostic. If done well, the listener becomes a better disease diagnostician. The best listeners hear both the patient and the disease clearly, and regard every encounter as potentially therapeutic.

## The Primary Tools: Words, Analogies, Metaphors, Similes, and Symbols

To listen and understand requires that the language used between the speaker and the hearer be shared – that the meanings of words and phrases are commonly held. Patients are storytellers who have the hope of being heard and understood. Their hearers are physicians who expect to listen actively and to be with the patient in a new level of understanding. Because all human beings listen to so many different people every day, we tend to think of listening as an automatic ongoing process, yet this sort of active listening remains one of the central skills in clinical psychiatry. It underpins all other skills in diagnosis, alliance building, and communication. In all medical examinations, the patient is telling a story only she or he has experienced. The physician must glean the salient information and then use it in appropriate ways. Inevitably, even when language is common, there are subtle differences in meanings, based upon differences in gender, age, culture, religion, socioeconomic class, race, region of upbringing, nationality and original language, as well as the idiosyncrasies of individual history. These differences are particularly important to keep in mind in the use of analogies, similes, and metaphors. Figures of speech, in which one thing is held representational of another by comparison, are very important windows to the inner world of the patient. Differences in meanings attached to these figures of speech can complicate their use. In psychodynamic assessment and psychotherapeutic treatment, the need to regard these subtleties of language becomes the self-conscious focus of the psychiatrist, yet failure to hear and heed such idiosyncratic distinctions can affect simple medical diagnosis as well (Clinical Vignettes 2 and 3).

### Clinical Vignette 2

A psychiatric consultant was asked to see a 48-year-old man on a coronary care unit for chest pain deemed "functional" by the cardiologist who had asked the patient if his chest pain was "crushing". The patient said no. A variety of other routine tests were also negative. The psychiatrist asked the patient to describe his pain. He said, "It's like a truck sitting on my chest, squeezing it down". The psychiatrist promptly recommended additional tests, which confirmed the diagnosis of myocardial infarction. The cardiologist may have been tempted to label the patient a "bad historian", but the most likely culprit of this potentially fatal misunderstanding lies in the connotative meanings, each ascribed to the word "crushing" or to other variances in metaphorical communication.

Clinical Vignette 3

A psychiatrist had been treating a 35-year-old man with a narcissistic personality and dysthymic disorder for 2 years. Given the brutality and deprivation of the patient's childhood, the clinician was persistently puzzled by the patient's remarkable psychological strengths. He possessed capacities for empathy, self-observation, and modulation of intense rage that were unusual, given his background. During a session, the patient, in telling a childhood story, began, "When I was a little fella…". It struck the psychiatrist that the patient always said "little fella" when referring to himself as a boy, and that this was fairly distinctive phraseology. Almost all other patients will say, "When I was young/a kid/a girl (boy)/in school", designate an age, etc. On inquiry about this, the patient immediately identified "The Andy Griffith Show" as the source. This revealed a secret identification with the characters of the TV show, and a model that said to a young boy, "There are other ways to be a man than what you see around you". Making this long-standing covert identification fully conscious was transformative for the patient.

In psychotherapy, the special meanings of words become the central focus of the treatment.

## How Does One Hear Words in This Way?

The preceding clinical vignettes, once described, sound straightforward and easy. Yet, to listen in this way, the clinician must acquire specific yet difficult-to-learn skills and attitudes. It is extremely difficult to put into words the listening processes embodied in these examples and those to follow, yet that is what this chapter attempts to do.

Students, when observing experienced psychiatrists interviewing patients, often express a sense of wonder such as: "How did she know to ask that?" "Why did the patient open up with him but not with me?" "What made the diagnosis so clear in that interview and not in all the others?" The student may respond with a sense of awe, a feeling of ineptitude and doubt at ever achieving such facility, or even a reaction of disparagement that the process seems so indefinable and inexact. The key is the clinician's ability to listen. Without a refined capacity to hear deeply, the chapters on other aspects of interviewing in this textbook are of little use. But it is neither mystical nor magical nor indefinable (though it is very difficult to articulate); such skills are the product of hard work, much thought, intense supervision, and extensive in-depth exposure to many different kinds of patients.

Psychiatrists, more than any other physicians, must simultaneously listen symptomatically and narratively/experientially. They must also have access to a variety of theoretical perspectives that effectively inform their listening. These include behavioral, interpersonal, cognitive, sociocultural, and systems theories. Symptomatic listening is what we think of as traditional medical history taking, in which the focus is on the presence or absence of a particular symptom, the most overt content level of an interview. Narrative–experiential listening is based on the idea that all humans are constantly interpreting their experiences, attributing meaning to them, and weaving a story of their

lives with themselves as the central character. This process goes on continuously, both consciously and unconsciously, as a running conversation within each of us. The conversation is between parts of ourselves and between ourselves and what Freud called "internalized objects", important people in our lives whose images, sayings, and attitudes become permanently laid down in our memories. This conversation and commentary on our lives includes personal history, repetitive behaviors, learned assumptions about the world, and interpersonal roles. These are, in turn, the products of individual background, cultural norms and values, national identifications, spiritual meanings, and family system forces (Clinical Vignette 4).

### Clinical Vignette 4

A 46-year-old man was referred to a psychiatrist from a drug study. The patient had both major depression and dysthymic disorder since a business failure 2 years earlier. His primary symptoms were increased sleep and decreased mood, libido, energy, and interests. After no improvement during the "blind" portion of the study, he had continued to show little response once the code was broken, and he was treated with two different active antidepressant medications. He was referred for psychotherapy and further antidepressant trials. The therapy progressed slowly with only episodic improvement. One day, the patient reported that his wife had been teasing him about how, during his afternoon nap, his snoring could be heard over the noise of a vacuum cleaner. The psychiatrist immediately asked additional questions, eventually obtained sleep polysomnography, and, after appropriate treatment for sleep apnea, the patient's depression improved dramatically.

It seems that three factors were present that enabled the psychiatrist in Clinical Vignette 4 to listen well and identify an unusual diagnosis that had been missed by at least three other excellent clinicians who had all been using detailed structured interviews that were extremely inclusive in their symptom reviews. First, the psychiatrist had to have readily available in mind all sorts of symptoms and syndromes. Second, he had to be in a curious mode. In fact, this clinician had a gnawing sense that something was missing in his understanding of the patient. There is a saying in American medicine designed to focus students on the need to consider common illnesses first, while not totally ignoring rarer diseases: when you hear hoofbeats in the road, don't look first for zebras. We would say that this psychiatrist's mind was open to seeing a "zebra" despite the ongoing assumption that the weekly "hoofbeats" he had been hearing represented the everyday "horse" of clinical depression. Finally, he had to hear the patient's story in multiple, flexible ways, including the possibility that a symptom may be embedded in it, so that a match could be noticed between a detail of the story and a symptom. Eureka! The zebra could then be seen although it had been standing there every week for months.

Looking back at Clinical Vignette 3, we see the same phenomenon of a detail leaping out as a significant piece of missing information that dramatically influences the treatment process. To accomplish this requires a cognitive template (symptoms and syndromes; developmental, systemic, and personality theories; awareness of cultural perspectives),

a searching curious stance, and flexible processing of the data presented. If one is able to internalize the skills listed in Table 1.1, the listener begins automatically to hear the meanings in the words.

## Listening as More Than Hearing

Listening and hearing are often equated in many people's minds. However, listening involves not only hearing and understanding the speaker's words, but attending to inflection, metaphor, imagery, sequence of associations, and interesting linguistic selections. It also involves seeing – movement, gestures, facial expressions, subtle changes in these – and constantly comparing what is said with what is seen, looking for dissonances, and comparing what is being said and seen with what was previously communicated and observed. Further, it is essential to be aware of what might have been said but was not, or how things might have been expressed but were not. This is where clues to idiosyncratic meanings and associations are often discovered. Sometimes, the most important meanings are embedded in what is conspicuous by its absence.

There appears to be a biogrammar of primary emotions that all humans share and express in predictable, fixed action patterns. The meaning of a smile or nod of the head is universal across disparate cultures. The amygdala and the inferior temporal lobe gyrus have been identified as the neurobiological substrate for recognition of and empathy for others and their emotional states. Further research has identified that these parts of the brain are, on the one hand, prededicated to recognizing certain gestures, facial expressions, and so on, but require effective maternal–infant interaction in order to do so (Schore, 2001). All of this is synthesized in the listener as a "sense" or intuition as to what the speaker is saying at multiple levels. The availability of useful cognitive templates and theories enables the listener to articulate what is heard (Clinical Vignette 5).

### Clinical Vignette 5

A 38-year-old Hispanic construction worker presented himself to a small-town emergency department in the Southwest, complaining of pain on walking, actually described in Spanish-accented English as "a little pain". His voice was tight, his face was drawn, and his physical demeanor was burdened and hesitant. His response to the invitation to walk was met by a labored attempt to walk without favor to his painful limb. A physician could have discharged him from the emergency department with a small prescription of ibuprofen. The careful physician in the emergency department responded to the powerful visual message that he was in pain, was beaten down by it, and had suffered long before coming in. This recognition came first to the physician as an intuition that this man was somehow more sick than he made himself sound. A radiograph of the femur revealed a lytic lesion that later proved to be metastatic renal cell carcinoma. To hear the unspoken, one had to be keenly aware of the patient's tone and how he looked, and to keep in mind, too, the cultural taboos forbidding him to give in to pain or to appear to need help.

As has been implied, not only must one affirmatively "hear" all that a patient is communicating, one must overcome a variety of potential blocks to effective listening.

## Common Blocks to Effective Listening

Many factors influence the ability to listen. Psychiatrists come to the patient as the product of their own life experiences. Does the listener tune in to what he or she hears in a more attentive way if the listener and the patient share characteristics? What blocks to listening (Table 1.2) are posed by differences in sex, age, religion, socioeconomic class, race, culture, or nationality? What blind spots may be induced by superficial similarities in different personal meanings attributed to the same cultural symbol? Separate and apart from the differences in the development of empathy when the dyad holds in common certain features, the act of listening is inevitably influenced by similarities and differences between the psychiatrist and the patient.

**Table 1.2 Blocks to Effective Listening**

| | |
|---|---|
| Patient–psychiatrist dissimilarities | Race |
| | Sex |
| | Culture |
| | Religion |
| | Regional dialect |
| | Individual differences |
| | Socioeconomic class |
| Superficial similarities | May lead to incorrect assumptions of shared meanings |
| Countertransference | Psychiatrist fails to hear or reacts inappropriately to content reminiscent of own unresolved conflicts |
| External forces | Managed care setting |
| | Emergency department |
| | Control-oriented inpatient unit |
| Attitudes | Need for control |
| | Psychiatrist having a bad day |

Would a woman have reported the snoring in Clinical Vignette 4 or would she have been too embarrassed? Would she have reported it more readily to a woman psychiatrist? What about the image in Clinical Vignette 2 of a truck sitting on someone's chest? How gender and culture bound is it? Would "The Andy Griffith Show", important in Clinical Vignette 3, have had the same impact on a young African-American boy that it did on a Caucasian one? In how many countries is "The Andy Griffith Show" even available, and in which cultures would that model of a family structure seem relevant? Suppose the psychiatrist in that vignette was not a television viewer or had come from another country to the USA long after the show had come and gone? Consider these additional examples (Clinical Vignette 6).

### Clinical Vignette 6

A female patient came to see her male psychiatrist for their biweekly session. Having just been given new duties on her job, she came in excitedly and began sharing with her therapist how happy she was to have been chosen by her male supervisor to help him with a very important project at their office. The session continued with the theme of the patient's pride in having been recognized for her attributes, talents, and hard work. At the next session, she said that she had become embarrassed after the previous session at the thought that she had been "strutting her stuff". The therapist reflected back to her the thought that she sounded like a rooster strutting his stuff, connecting her embarrassment at having revealed that she strove for the recognition and power of men in her company, and that she, in fact, envied the position of her supervisor. The patient objected to the comparison of a rooster, and likened it more to feeling like a woman of the streets strutting her stuff. She stated that she felt like a prostitute being used by her supervisor. The psychiatrist was off the mark by missing the opportunity to point out in the analogous way that the patient's source of embarrassment was in being used, not so much in being envious of the male position.

It is likely that different life experiences based on gender fostered this misunderstanding. How many women easily identify with the stereotyped role of the barnyard rooster? How many men readily identify with the role of a prostitute? These are but two examples of the myriad different meanings our specific gender may incline us toward. Although metaphor is a powerful tool in listening to the patient, cross-cultural barriers pose potential blocks to understanding (Clinical Vignettes 7 and 8).

### Clinical Vignette 7

A 36-year-old black woman complained to her therapist (of the same language, race, and socioeconomic class) that her husband was a snake, meaning that he was no good, treacherous, a hidden danger. The therapist, understanding this commonly held definition of a snake, reflected back to the patient pertinent, supportive feedback concerning the care and caution the patient was exercising in divorce dealings with the husband.

In contrast, a 36-year-old Chinese woman, fluent in English, living in her adopted country for 15 years and assimilated to Western culture, represented her husband to her Caucasian, native-born psychiatrist as being like a dragon. The therapist, without checking on the meaning of the word "dragon" with her patient, assumed it connoted danger, one of malicious intent and oppression. The patient, however, was using "dragon" as a metaphor for her husband – the fierce, watchful guardian of the family – in keeping with the ancient Chinese folklore in which the dragon is stationed at the gates of the lord's castle to guard and protect it from evil and danger.

Clinical Vignette 8

In a family session, a psychiatrist from the South referred to the mother of her patient as "your mama", intending a meaning of warmth and respect. The patient instantly became enraged at the use of such an offensive term toward her mother. Although being treated in Texas, the patient and her family had recently moved from a large city in New Jersey. The use of the term "mama" among working-class Italians in that area was looked upon with derision among people of Irish descent, the group to which the patient was ethnically connected. The patient had used the term "mother" to refer to her mother, a term the psychiatrist had heard with a degree of coolness attached. What she knew of her patient's relationship with her mother did not fit in with a word like mother; hence, almost out of awareness, she switched terms, leading to a response of indignation and outrage from the patient.

Even more subtle regional variations may produce similar problems in listening and understanding.

Psychiatrists discern meaning in that which they hear through filters of their own – cultural backgrounds, life experiences, feelings, the day's events, their own physical sense of themselves, nationality, sex roles, religious meaning systems, and intrapsychic conflicts. The filters can serve as blocks or as magnifiers if certain elements of what is being said resonate with something within the psychiatrist. When the filters block, we call it countertransference or insensitivity. When they magnify, we call it empathy or sensitivity. One may observe a theme for a long time repeated with a different tone, embellishment, inflection, or context before the idea of what is meant comes to mind. The "little fella" example in Clinical Vignette 3 illustrates a message that had been communicated in many ways and times in exactly the same language before the psychiatrist "got it". On discovering a significant meaning that had been signaled previously in many ways, the psychiatrist often has the experience: "How could I have been so stupid? It's been staring me in the face for months!"

Managed care and the manner in which national health systems are administered can alter our attitudes toward the patient and our abilities to be transforming listeners. The requirement for authorization for minimal visits, time on the phone with utilization review nurses attempting to justify continuing therapy, and forms tediously filled out can be blocks to listening to the patient. Limitations on the kinds and length of treatment can lull the psychiatrist into not listening in the same way or as intently. With these time limits and other "third-party payer" considerations (i.e., need for a billable diagnostic code), the psychiatrist, as careful listener, must heed the external pressures influencing the approach to the patient. Many health benefit packages will provide coverage in any therapeutic setting only for relief of symptoms, restoration of minimal function, acute problem solving, and shoring up of defenses. In various countries, health-care systems have come up with a variety of constraints in their efforts to deal with the costs of care. Unless these pressures are attended to, listening will be accomplished with a different purpose in mind, more closely approximating the crisis intervention model of the emergency room or the medical model for either inpatient or outpatient care. In these settings, the thoughtful psychiatrist will arm himself or herself with checklists, inventories, and scales for objectifying the severity of illness and response to treatment: the ear is tuned only to measurable and observable signs of responses to therapy and biologic intervention (Clinical Vignette 9).

Clinical Vignette 9

An army private was brought to the emergency room in Germany by his friends, having threatened to commit suicide while holding a gun to his head. He was desperate, disorganized, impulsive, enraged, pacing, and talking almost incoherently. Gradually, primarily through his friends, the story emerged that his first sergeant had recently made a decision for the entire unit that had a particularly adverse effect on the patient. He was a fairly primitive character who relied on his wife for a sense of stability and coherence in his life. The sergeant's decision was to send the entire unit into the field for over a month just at the time the patient's wife was about to arrive, after a long delay, from the USA. After piecing together this story, the psychiatrist said to the patient, "It's not yourself you want to kill, it's your first sergeant!" The patient at first giggled a little, then gradually broke out into a belly laugh that echoed throughout the emergency room. It was clear that, having recognized the true object of his anger, a coherence was restored that enabled him to feel his rage without the impulse to act on it. The psychiatrist then enlisted the friends in a plan to support the patient through the month and to arrange regular phone contact with the wife as she set up their new home in Germany. No medication was necessary. Hospitalization was averted, and a request for humanitarian dispensation, which would have compromised the patient in the eyes of both his peers and superiors, was avoided as well. And, with luck, the young man had an opportunity to grow emotionally as well.

With emphasis on learning here and now symptoms that can bombard the dyad with foreground static and noise, will the patient be lost in the encounter? The same approach to listening occurs in the setting of the emergency department for crisis intervention. Emphasis is on symptom relief, assurance of capacities to keep oneself safe, restoration of minimal function, acute problem solving, and shoring up of defenses. Special attention is paid to identifying particular stressors. What can be done quickly to change stressors that throw the patient's world into a state of disequilibrium? The difference in the emergency room is that the careful listener may have 3–6 hours, as opposed to three to six sessions for the patient with a health maintenance organization or preferred provider contract, or other limitations on benefits. If one is fortunate and good at being an active listener–bargainer, the seeds of change can be planted in the hope of allowing them time to grow between visits to the emergency department. If one could hope for another change, it would be for a decrease in the chaos in the patient's inner world and outer world.

## Crucial Attitudes That Enable Effective Listening

The first step in developing good listening skills involves coming to grips with the importance of inner experience in psychiatric treatment and diagnosis. The advent of modern diagnostic classifications has been responsible for enormous advances in reliability and accuracy of diagnosis, but their emphasis on seemingly observable phenomena has

allowed the willing user to forget the importance of inner experience even in such basic diagnoses as major depressive disorder. Consider the symptom "depressed mood most of the day" or "markedly diminished interest or pleasure" or even "decrease or increase in appetite". These are entirely subjective symptoms. Simply reporting depression is usually not sufficient to convince a psychiatrist that a diagnosis of depression is warranted. In fact, the vast majority of psychiatric patients are so demoralized by their illnesses that they often announce depression as their first complaint. Further, there are a significant number of patients who do not acknowledge depression yet are so diagnosed. The clinician might well comment: "Sitting with him makes me feel very sad".

The psychiatrist must listen to much more than the patient's overt behavior. There are qualities in the communication, including the inner experiences induced in the listener, that should be attended to. The experienced clinician listens to the words, watches the behavior, engages in and notices the ongoing interaction, allows himself or herself to experience his or her own inner reactions to the process, and *never forgets that depression and almost all other psychiatric symptoms are exclusively private experiences.* The behavior and interactions are useful insofar as they assist the psychiatrist in inferring the patient's inner experience.

Therefore, to convince a clinician that a patient is depressed, not only must the patient say she or he is depressed, but the observable behavior must convey it (sad-looking face, sighing, unexpressive intonations, etc.); the interaction with the interviewer must convey depressive qualities (sense of neediness, sadness induced in the interviewer, beseeching qualities expressed, etc.). In the absence of both of these, other diagnoses should be considered, but in the presence of such qualities, depression needs to remain in the differential diagnosis.

Even when we make statements about brain function with regard to a particular patient, we use this kind of listening, generally, by making at least two inferences. We first listen to and observe the patient and then infer some aspect of the patient's private experience. Then, if we possess sufficient scientific knowledge, we make a second inference to a disturbance in neurochemistry, neurophysiology, or neuroanatomy. When psychiatrists prescribe antidepressant medication, they have inferred from words, moved into inner experiences, and come to a conclusion that there is likely a dysregulation of serotonin or norepinephrine in the patient's brain.

As one moves toward treatment from diagnosis, the content of inner experience inferred may change to more varied states of feelings, needs, and conflicts, but the fundamental process of listening remains the same. The psychiatrist listens for the meaning of all behavior, to the ongoing interpersonal relationship the patient attempts to establish, and to inner experiences as well.

Despite all of the technological advances in medicine in general and their growing presence in psychiatry, securing or eliciting a history remains the first and central skill for all physicians. Even in the most basic of medical situations, the patient is trying to communicate a set of private experiences (how does one describe the qualities of pain or discomfort?) that the physician may infer and sort into possible syndromes and diagnoses. In psychiatry, this process is multiplied, as indicated in Figure 1.1.

It was widely assumed that development, and problems related to development, effect the inner experiences of various affects. Does, for example, a person with borderline personality disorder experience "anxiety" in the same qualitative and quantitative manner in which a neurotic person does? What is the relationship between sadness and

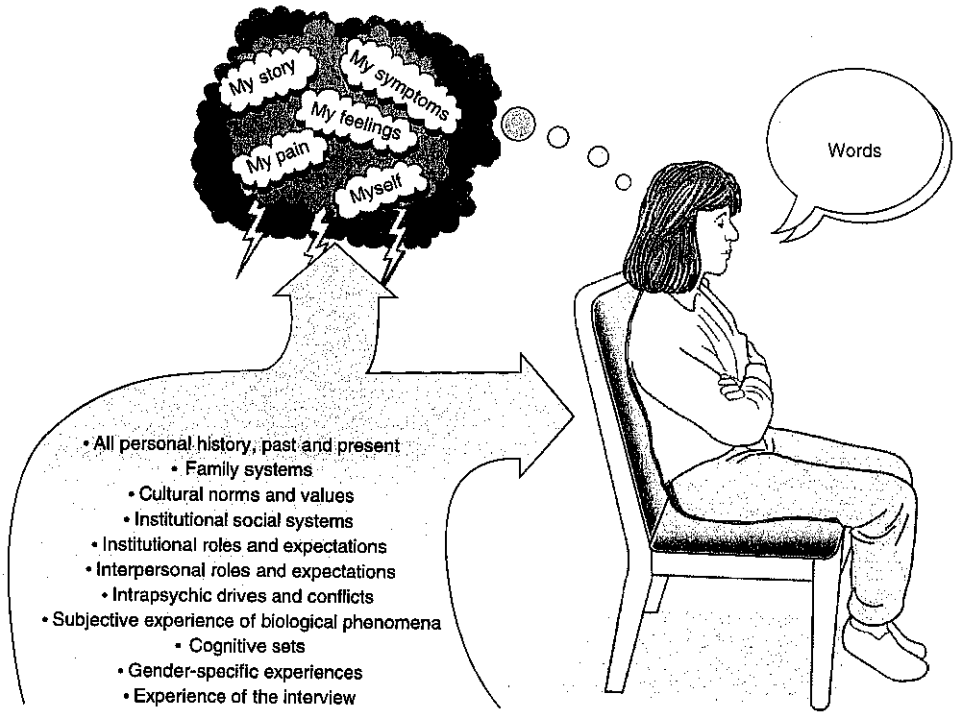


**Figure 1.1** *Finding the patient (Kay and Tasman, 2006).*

guilt and the empty experiences of depression? This perspective underlies the principle articulated in text after text on interviewing that emphasizes the importance of establishing rapport in the process of history taking. It is incredibly easy for the psychiatrist to attribute to the patient what she or he would have meant and what most people might have meant in using a particular word or phrase. The sense in the narrator that the listener is truly present, connected, and with the patient enormously enhances the accuracy of the story reported.

Words that have been used to describe this process of constant attention to and inference of inner experience by the listener include interest, empathy, attentiveness, and noncontingent positive regard. However, these are words that may say less than they seem to. It is the constant curious awareness on the listener's part, that she or he is trying to grasp the private inner experience of the patient, and the storyteller's sense of this stance by the psychiatrist that impel the ever more revealing process of history taking. This quality of listening produces what we call rapport, without which psychiatric histories become spotty, superficial, and even suspect. There are no bad historians, only patients who have not yet found the right listener.

It is well established that two powerful predictors of outcome in any form of psychotherapy are empathy and the therapeutic alliance. This has been shown again and again in study after study for dynamic therapy, cognitive therapy, behavior therapy, and even medication management. The truth of this can be seen in the remarkable therapeutic success of the

**Table 1.3 Attitudes Important to Listening**

| |
|---|
| The centrality of *inner experience* |
| There are no bad historians |
| The answer is always inside the patient |
| Control and power are shared in the interview |
| It is OK to feel confused and uncertain |
| Objective truth is never as simple as it seems |
| Listen to yourself, too |
| Everything you hear is modified by the patient's filters |
| Everything you hear is modified by your own filters |
| There will always be another opportunity to hear more clearly |

"clinical management" cell of the National Institutes of Mental Health Collaborative Study on the Treatment of Major Depression. Although the Clinical Management Cell was not as effective as the cells that included specific drugs or specific psychotherapeutic interventions, 35% of patients with moderate to severe major depressive disorder improved significantly with carefully structured supportive clinical management alone (Elkin *et al.*, 1989).

Helpful psychiatric listening requires a complicated attitude toward control and power in the interview (see Table 1.3). The psychiatrist invites the patient/storyteller to collaborate as an active informer. He or she is invited, too, to question and observe himself or herself. This method of history taking remains the principal tool of general clinical medicine. However, as Freud pointed out, these methods of active uncovering are more complex in the psychic realm. The use of the patient as a voluntary reporter requires that the investigator keep in mind the unconscious and its power over the patient and listener. Can the patient be a reliable objective witness of himself or herself or his or her symptoms? Can the listener hold in mind his or her own set of filters, meanings, and distortions as he or she hears? The listener translates for himself or herself and his or her patient the patient's articulation of his or her experience of himself or herself and his or her inner world into our definition of symptoms, syndromes, and differential diagnoses, which make up the concept of the medical model.

Objective–descriptive examiners are like detectives closing in on disease. The psychiatric detective enters the inquiry with an attitude of unknowing and suspends prior opinion. The techniques of listening invoke a wondering and a wandering with the patient. Periods of head scratching and exclamations of "I'm confused", or "I don't understand", or "That's awful!", or "Tell me more", allow the listener to follow or to point the way for the dyad. Finally, clear and precise descriptions are held up for scrutiny, with the hope that a diagnostic label or new information about the patient's suffering and emotional pain be revealed.

It is embarking on the history taking journey together – free of judgments, opinions, criticism, or preconceived notions – that underpins rapport. Good listening requires a complex understanding of what objective truth is and how it may be found. The effective psychiatrist must eschew the traditional medical role in interviewing and tolerate a collaborative, at times meandering, direction in which control is at best shared and sometimes

wholly with the patient. The psychiatrist constantly asks: What is being said? Why is it being said at this moment? What is the meaning of what is being said? In what context is all this emerging? What does that tell me about the meaning of and what does it reflect about the doctor–patient relationship?

## Theoretical Perspectives on Listening

Listening is the effort or work of placing the therapist where the patient is ("lives"). The ear of the empathic listener is the organ of receptivity – gratifying and, at times, indulging the patient. Every human being has a preferred interpersonal stance, a set of relationships and transactions with which she or he is most comfortable and feels most gratified. The problem is that for most psychiatric patients, they do not work well, but the psychiatrist, through listening and observing, must understand the patient. Beyond attitudes that enable or prevent listening, there is a role for specific knowledge. It is important to achieve the cognitive structure or theoretical framework and use it with rigor and discipline in the service of patients so that psychiatrists can employ more than global "feelings" or "hunches". In striving to grasp the inner experience of any other human being, one must know what it is to be human; one must have an idea of what is inside any person. This provides a framework for understanding what the patient – who would not be a patient if he fully understood what was inside of him – is struggling to communicate. Personality theory is absolutely crucial to this process.

Whether we acknowledge it or not, every one of us has a theory of human personality (in this day and age of porous boundaries between psychology and biology, we should really speak of a psychobiological theory of human experience), which we apply in various situations, social or clinical. These theories become part of the template alluded to earlier, which allows certain words, stories, actions, and cues from the patient to jump out with profound meaning to the psychiatrist. There is no substitute for a thorough knowledge of many theories of human functioning and a well-disciplined synthesis and internal set of rules to decide which theories to use in which situations.

Different theoretical positions offer slightly different and often complementary perspectives on listening (Table 1.4). Each of the great schools of psychotherapy places the psychiatrist in a somewhat different relationship to the patient. This may even be reflected in the physical placement of the therapist in relation to the patient. In a classical psychoanalytic stance, the therapist, traditionally unseen behind the patient, assumes an active, hovering attention. Existential analysts seek to experience the patient's position and place themselves close to and facing the patient. The interpersonal psychiatrist stresses a collaborative dialogue with shared control. One can almost imagine the two side by side as the clinician strives to sense what the storyteller is doing to and with the listener. Interpersonal theory stresses the need for each participant to act within that interpersonal social field.

In the object relations stance, the listener keeps in mind the "other people in the room" with him and the storyteller, that is, the patient's introjects who are constantly part of the internal conversation of the patient and thus influence the dialogue within the therapeutic dyad. In connecting with the patient, the listener is also tuned in to the fact that parts and fragments of him or her are being internalized by the patient.

**Table 1.4 Theoretical Perspectives on Listening**

| Theory | Focus of Attention | Listening Stance |
|---|---|---|
| Ego psychology | Stream of associations | Neutral, hovering attention |
| Object relations | Introjects (internalized images of others within the patient) | Neutral, hovering attention |
| Interpersonal | What relationship is the patient attempting to construct? | Participant observer |
| Existential | Feelings, affect | Empathic identification with the patient |
| Self-psychology | Sense of self from others | Empathic mirroring and affirmation |
| Patient centered | Content control by patient | Noncontingent positive regard, empathy |
| Cognitive | Hidden assumptions and distortions | Benign expert |
| Behavioral | Behavioral contingencies | Benign expert |
| Family systems | Complex forces maneuvering each member | Neutral intruder who forces imbalance in the system |

The listener becomes another person in the room of the patient's life experience, within and outside the therapeutic hour. Cognitive and behavioral psychiatrists are kindly experts, listening attentively and subtly for hidden assumptions, distortions, and connections. The family systems psychiatrist sits midway among the pressures and forces emanating from each individual, seeking to affect the system so that all must adapt differently.

Referring again to Clinical Vignette 3, we can see the different theoretical models of the listening process in the discovery of the meaning of "little fella". Freud's model is one in which the psychiatrist had listened repeatedly to a specific association and inquired of its meaning. Object relations theorists would note that the clinician had discovered a previously unidentified, powerful introject within the therapeutic dyad. The interpersonal psychiatrist would see the shared exploration of this idiosyncratic manner of describing one's youth; the patient had been continually trying to take the therapist to "The Andy Griffith Show". That is, the patient was attempting to induce the clinician to share the experience of imagining and fantasizing about having Andy Griffith as a father.

Existentialists would note how the psychiatrist was changed dramatically by the patient's repeated use of this phrase and then altered even more profoundly by the memory of Andy Griffith, "the consummate good father" in the patient's words. The therapist could never see the patient in quite the same way again, and the patient sensed it immediately. And Kohut would note the mirroring quality of the psychiatrist's interpretation of the meaning of this important memory. This would be mirroring at its most powerful, affirming the patient's important differences from his family, helping him to consolidate the memories. The behavioral psychiatrist would note the

reciprocal inhibition that had gone on, with Andy Griffith soothing the phobic anxieties in a brutal family.

A cognitive psychiatrist would wonder whether the patient's depression resulted from a hidden assumption that anything less than the idyllic images of television was not good enough. The family systems psychiatrist would help the patient see that he had manipulated the forces at work on him and actually changed the definition of his family.

The ways and tools of listening also change, according to the purpose, the nature of the therapeutic dyad. The ways of listening also change depending upon whether or not the psychiatrist is preoccupied or inattentive. The medical model psychiatrist listens for signs and symptoms. The analyst listens for the truth often clothed in fantasy and metaphor. The existentialist listens for feeling, and the interpersonal theorist listens for the shared experiences engendered by the interaction. Regardless of the theoretical stance and regardless of the mental tension between the medical model's need to know symptoms and signs and the humanistic psychiatrist's listening to know the sufferer, the essence of therapeutic listening is the suspension of judgment before any presentation of the story and the storyteller. The listener is asked to clarify and classify the inner world of the storyteller at the same time he or she is experiencing it – no small feat!

## Using Oneself in Listening

Understanding transference and countertransference is crucial to effective listening. Tomkins, LeDoux, Damasio, and Brothers have given us a basic biological perspective on this process. However, one defines these terms, whatever one's theoretical stance about these issues. To know ourselves is to begin to know our patients more deeply. There are many ways to achieve this. Personal therapy is one. Ongoing life experience is another. Supervision that emphasizes one's emotional reactions to patients is still a third. Once we have started on the road to achieving this understanding by therapy, supervision, or life experience, continued listening to our patients, who teach us about ourselves and others, becomes a lifelong method of growth.

To know oneself is to be aware that there are certain common human needs, wishes, fears, feelings, and reactions. Every person must deal in some way with attachment, dependence, authority, autonomy, selfhood, values and ideals, remembered others, work, love, hate, and loss. It is unlikely that the psychiatrist can comprehend the patient without his or her own self-awareness. Thus, Figure 1.1 should really look like Figure 1.2. The most psychotic patient in the world is still struggling with these universal human functions (Clinical Vignette 10).

In this case, the psychiatrist was able to connect with a patient's inner experience in a manner that had a fairly dramatic impact on the clinical course. That is the goal of listening. The art is hearing the patient's inner experience and then addressing it empathically, enabling the patient to feel heard and affirmed. There are no rules about this, and at any given point in a clinical encounter, there are many ways to accomplish it. There are also many ways to respond that are unhelpful and even retraumatizing. The skilled psychiatrist, just as she or he never forgets that it is the patient's inner experience that is to be heard, also never stops struggling to find just the right words, gestures, expressions, and inflections

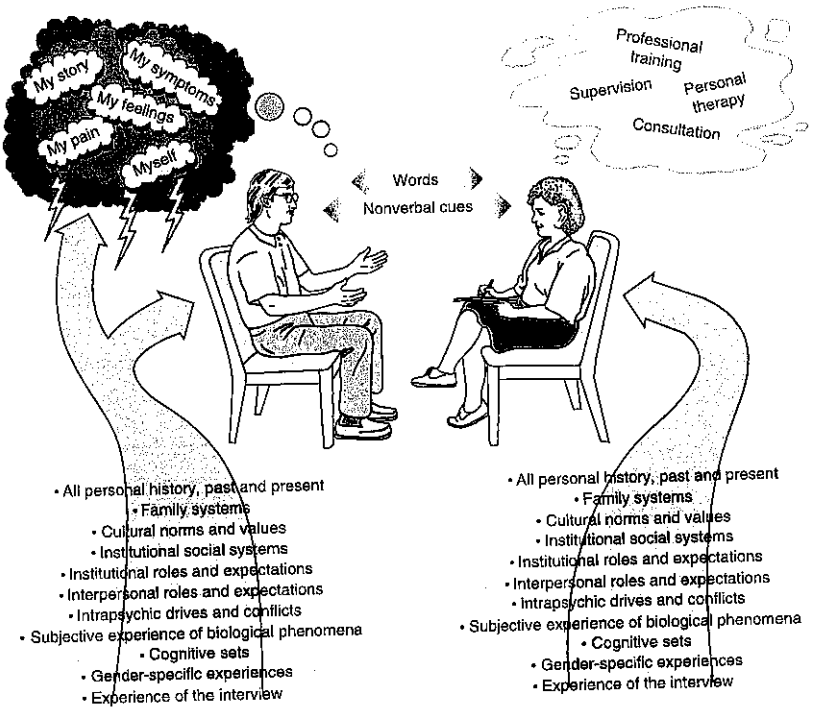


**Figure 1.2** *The therapeutic dyad (Kay and Tasman, 2006).*

## Clinical Vignette 10

A young man with paranoid schizophrenia had been admitted in 1979 to the hospital following a near lethal attack on his father. When asked about this incident, he became frankly delusional, speaking of the Arab–Israeli conflict, the preciousness of Jerusalem, how the Israelis must defend it at all costs. Unspoken was his conviction that he was like the Israelis, with the entire world attacking and threatening him. He believed his father had threatened and attacked him when, in fact, his father had done little more than seek to be closer, more comforting, and advising with the patient. The psychiatrist understood the patient to be speaking of that core of selfhood that we all possess, which, when threatened, creates a sense of vulnerability and panic, a disintegrating anxiety unlike any other. The psychiatrist spoke to the patient of Anwar Sadat's visit to Jerusalem and engaged him in a discussion of how that had gone, what the outcome had been, had the threat been lessened or increased? The patient, although still delusional, visibly relaxed and began to speak much more directly about his own sense of vulnerability and uncertainty over his personal integrity and its ability to withstand any closeness. He still required neuroleptic medication for his illness; however, his violent thoughts and behaviors reduced dramatically. He was able to begin interacting with his father, and his behavior on the ward changed as well.

that say to a patient, "you have been understood". The most clever diagnostician or insightful interpreter who cannot "connect" with the patient in this manner will miss valuable information. This issue has been addressed by writers who have pointed out how little understood are the concepts of support and empathy (Peteet, 1982).

Being human is also to be a creature of habit and pattern in linguistic, interpersonal, and emotional realms. The skilled psychiatrist listens with this ever in mind. What we see in the interview, what we hear in interactions may be presumed to be repetitions of many other events. The content may vary, but the form, motive, process, and evolution are generally universal for any given individual. This, too, is part of listening. To know what is fundamentally human, to have a well-synthesized rigorous theory, and to hear the person's unique but repetitive ways of experiencing are the essence of listening. These skills "find" the patient in all his or her humanity, but then the psychiatrist must find the right communication that allows the patient to feel "found".

## To Be Found: The Psychological Product of Being Heard

Psychiatric patients may be lonely, isolated, demoralized, and desperate, regardless of the specific diagnosis. They have lost themselves and their primary relationships, if they ever had any. Many therapists believe that before anything else can happen, they must be found, and feel found. They can only be found within the context of their own specific histories, cultures, religions, genders, social contexts, and so on. There is nothing more healing than the experience of being found by another. The earliest expression of this need is in infancy and we refer to it as the need for attachment. Referring to middle childhood, Harry Stack Sullivan spoke of the importance of the pal or buddy. Kohut spoke of the lifelong need for self-objects. In lay terms, it is often subsumed under the need for love, security, and acceptance. Psychiatric patients have lost or never had this experience. However obnoxious or destructive or desperate their overt behavior, it is the psychiatrist's job to seek and find the patient. That is the purpose of listening.

If we look back to Clinical Vignette 3, wherein the phrase "little fella" bespoke such deep and important unverbalized meaning, the patient's reaction to the memory and recognition by the psychiatrist was dramatic. He had always known he was different in some indefinable ways from his family. That difference had been both a source of pride and pain to him at various developmental stages. However, the recognition of the specific source, its meaning, and its constant presence in his life created a whole new sense of himself. He had been found by his psychiatrist, who echoed the discovery, and he had found an entire piece of himself that he had enacted for years, yet which had been disconnected from any integrated sense of himself.

Sometimes objectifying and defining the disease/disorder enables the person to feel found. One of the most challenging patients to hear and experience is the acting out, self-destructive, demanding person with borderline personality disorder. Even as the prior sentence conveys, psychiatrists often experience the diagnosis as who the patient is rather than what he or she suffers. The following case conveys how one third-year resident was able to hear such a patient, and in his listening to her introduce the idea that the symptoms were not her but her disorder (Clinical Vignette 11).

## Clinical Vignette 11

The psychiatrist was working the midnight Friday to 11 a.m. Saturday shift in a Psychiatric Emergency Room. The patient was a 26-year-old woman brought in by ambulance after overdosing on sertraline following an argument with her boyfriend. She had been partying with him and became enraged at the attention he was paying to the date of a friend who was accompanying them. After being cleared medically, the patient was transferred to psychiatry for crisis intervention. It was about 4 a.m. when she arrived. She was crying and screaming for the psychiatric staff to release her. In the emergency department, she had grabbed a suture scissors attached to the uniform of the charge nurse. The report was given to the psychiatric resident that she had been a "management problem" in the medicine ER.

The psychiatrist sat wearily and listened to the patient tell her story with tears, shouts, and expletives sputtered through clenched teeth. She stated that she did not remember ever being happy, that she frequently had thoughts of suicide, and that she had overdosed twice before, following a divorce from her first husband at the age of 19 and then 8 months prior to this episode when she had been fired from a job for arguing with her supervisor. Her parents had kept her 6-year-old and 7-year-old sons since her divorce. She was currently working as a file clerk and living with her boyfriend of 2 months. She stated that she felt like there was a cold ice cube stuck in her chest as she watched her boyfriend flirting with the other woman. She acknowledged that she felt empty and utterly alone even in the crowded bar. She created an unpleasant scene and they continued to argue until they got home. Then he had laughed at her and left, stating that he would come back when she had cooled down.

The resident sat quietly and listened. He looked dreary. The night had been a busy one. She looked at him and complained, "Don't let me and my problems bore you!" He looked at her and said, "Quite the contrary. I've been thinking as you speak that I know what disorder you suffer from". With that statement, he pulled out the DSM-IV and read with her the description of the symptoms and signs of borderline personality disorder. She had been in therapy off and on since she was 16 years old. No one had ever shared with her the name of the diagnosis but instead had responded to her as if the disorder was the definition of who she was. In his listening, he was able to hear her symptoms as a disorder and not the person. And in his ability to separate the two, he was able to allow her to distance herself from the symptoms, too, and see herself in a new light with her first inkling of her own personhood.

Gender can play a significant role in the experience of feeling found. Some individuals feel that it is easier to connect with a person of the same sex; others, with someone of the opposite sex. Clinical Vignette 6 is an excellent example of this. In these days of significant change in and sensitivity to sex roles, a misinterpretation such as that early in treatment could result in a permanent rupture in the alliance. Psychiatrists vary in their sensitivity to

**Table 1.5 The Basic Sciences of Listening**

| |
|---|
| Neurobiology of primary affects |
| Universality of certain affective expressions |
| Neurobiology of empathy |
| Biological need for interpersonal regulation |
| Psychobiology of attachment |
| Biological impact of social support |
| Environmental impact on central nervous system structure and function |

the different sexes. Some may do better with those who have chosen more traditional roles; others may be more sensitive to those who have adopted more modern roles.

We now know that just as there is a neurobiological basis for empathy and countertransference, there is a similar biological basis for the power of listening to heal, to lift psychological burdens, to remoralize, and to provide emotional regulation to patients who feel out of control in their rage, despair, terror, or other feelings (Table 1.5). Attachment and social support are psychobiological processes that provide the necessary physiological regulation to human beings. A neurobiological view supports the notion of the patient's capacity to perceive empathy through the powerful nonverbal, universally understood communication of facial expressions. His research in basic human emotions sets forth the idea of their understanding across cultures and ages. It further supports the provocative idea that facial expressions of the listener may generate autonomic and central nervous system changes not only within the listener but within the one being heard, and vice versa. Indeed, the evidence is growing that new experiences in clinical interactions create learning and new memories, which are associated with changes in both brain structure and function. When we listen in this way, we are intervening not only in a psychological manner to connect, heal, and share burdens but also in a neurobiological fashion to regulate, modulate, and restore functioning. When patients feel found, they are responding to this psychobiological process.

## Listening to Oneself to Listen Better

To hold in mind what has been said and heard after a session and between sessions is the most powerful and active tool of listening. It is a crucial step often overlooked by students and those new at listening. It is necessary to hear our patients in our thoughts during the in-between times in order to pull together repetitive patterns of thinking, behaving, and feeling, giving us the closest idea of how patients experience themselves and their world. In addition, many of our traumatized patients have not had the experience of being held in mind, of being remembered, and their needs being thought of by significant others. These key experiences of childhood affirm the young person's psychological being. It is important to distinguish this kind of "re-listening" to the patient – an important part of the psychiatrist's ongoing processing and reprocessing of what has been heard and experienced – from what some may leap to call countertransference. One way of identifying this distinction would be to differentiate listening to oneself as one reviews in one's mind the

patient's story versus becoming preoccupied and stuck with one's thoughts and feelings about a particular aspect of a patient (Clinical Vignette 12).

As the verbal interaction with the patient occurs, psychiatrists may find themselves expressing thoughts and feeling in ways that may be quite different from their usual repertoire. The following case is an example.

This sort of listening to oneself in order to understand the patient requires a good working knowledge of projective identification. Projective identification is a phrase

Clinical Vignette 12

A second-year resident, rotating through an inpatient unit that serves the psychiatric needs of very severely ill psychotic patients with multiple admissions, dual diagnoses, homelessness, criminal records, significant histories of medical noncompliance, and, in some, unremitting psychosis, was particularly struggling with a 33-year-old white woman admitted for the 11th time since age 19. The patient invariably stopped medications shortly after discharge, never kept follow-up appointments, and ended up on the streets psychotic and high on crack cocaine. She would then be involuntarily committed for restabilization. And so the cycle would repeat itself. The resident would see the patient on daily rounds. The patient's litany was the same day after day: "I'm not sick. I don't need to be here. I don't need medicines". And regularly she refused doses.

The resident spoke often of her patient to other residents in her class and often found herself ruminating about the patient's abject lostness. She began her regular supervision hours either frustrated or feeling hopeless that anything would change with this patient because the patient flatly refused to acknowledge her disorder. The patient's level of denial was of psychotic proportions. Shortly after a particularly difficult encounter with the patient concerning her refusal to take an evening dose of haloperidol, the resident came to supervision with the report that she had awakened terrorized by dreaming the night before that she had been diagnosed with schizophrenia. She had been intensely affected by overwhelming pain, confusion, and despair as she heard the diagnosis in her dream. "IT CAN'T BE!" she screamed, waking herself with a shaking start. "I'M NOT SICK! I DON'T NEED TO BE HERE! I DON'T NEED MEDICINE!" The words of her patient echoed in her mind as her own echoed in her ears. She had taken the patient's story and words home with her and kept them in mind at an unconscious level to be brought up in her dream, the ultimate identification with the patient. How more intensely can one be empathic with her patient than to dream as if she is experiencing the same horrifying reality? The patient and resident continued to struggle, but after the dream the resident was able to approach the patient and her story from a position of understanding the patient's need to maintain a lack of awareness or absence of insight. To acknowledge the presence of the disorder was more than the patient's already fragmented ego could bear. And now the resident "heard" it.

used to describe a defense mechanism in which the patient, in an effort to master intolerably terrifying emotions, unconsciously seeks to engender them in the therapist and to identify with the psychiatrist's ability to tolerate and handle the feelings (Clinical Vignettes 13 and 14).

### Clinical Vignette 13

A 45-year-old divorced white woman, being followed for bipolar disorder and borderline personality traits and stable for several years on lithium, was in weekly psychotherapy. During the prior weekend, she had moved into another apartment closer to her work. On the day of the move, she overslept and woke up with a start. The admonition to herself as she awoke was, "You lazy bitch! You can never manage on your own". She had earlier, as a child, experienced a mother who was needy, engulfing, punishing, hostile, critical, and dependent upon the patient. Her therapist, having some knowledge of the patient and her background, said, "Your mother is still with you. It was she in your head continuing to bombard you with derogatory statements". The same patient was often 10 or 15 minutes late for sessions, and her therapist found herself irritated at the patient's habitual tardiness. To her own surprise and enlightenment, the therapist also found herself thinking, "What a chaotic woman! She'll never manage to be here on time". She, too, had heard the voice of her patient's mother. In the next session, she wondered with her patient if she found herself wishing to place her therapist in the position of her mother, wanting at once to be engulfed and punished.

### Clinical Vignette 14

A psychiatrist was treating a 40-year-old man who was in the process of recognizing his own primary homosexual orientation. In the course of treatment, he became enraged, suicidal, and homicidal. After one session, the psychiatrist, while driving home, experienced the fantasy that when he got home, he would find his patient already there, having taken the psychiatrist's family hostage. The psychiatrist became increasingly terrified, even outright paranoid that this fantasy might actually come to pass. The patient was a computer expert who had indeed discovered the unlisted phone number and address of his therapist. But the psychiatrist realized that this fantasy was far out of keeping with his own usual way of feeling and the patient's way of behaving and viewing him. On arriving home to discover his family quite safe, the psychiatrist called the patient and scheduled him as his first for appointment the following morning. When the patient arrived, the psychiatrist said, "You know, I think I'm only now beginning to appreciate just how terrified and desperate all of this makes you". The patient slumped down into his chair, heaved a sigh, and said, "Thank God!"

## Listening in Special Clinical Situations

### Children

Listening to younger children often involves inviting them to play and then engaging them in describing what is happening in the play action. The psychiatrist pays careful attention to the child's feelings. These feelings are usually attributed to a doll, puppet, or other humanized toy. So if a child describes a stuffed animal as being scared, the psychiatrist may say, "I wonder if you, too, are scared when..." or "That sounds like you when...". The following case is an example (Clinical Vignette 15).

Clinical Vignette 15

A 4-year-old boy was brought in for psychiatric evaluation. He and his father had come upon a very serious automobile accident. One person had been thrown from the car and was lying clearly visible on the pavement with arms and legs positioned in grotesque angles, gaping head wound, obviously dead. The child's father was an off-duty police officer who stopped to assist in the extraction of two other people trapped in the car. The father kept a careful eye on the youngster who was left in the car. The child observed the scene for about 30 minutes until others arrived on the scene and his dad was able to leave. That night and for days to come, the child preoccupied himself with his toy cars, which he repetitiously rammed into each other. He was awakened by nightmares three times in the ensuing weeks. During his evaluation in the play therapy room, he engaged in ramming toy cars together. In addition, he tossed dolls about and arranged their limbs haphazardly. As he was encouraged to put some words to his action, he spoke of being frightened of the dead body and of being afraid to be by himself. He was afraid of the possibility of being hurt himself. He came in for three more play sessions, which went much the same way. His preoccupation with ramming cars at home diminished and disappeared as did the nightmares. The content of his play was used to help him put words and labels on his scare.

### Geriatric Patients

Working with the elderly poses its own special challenges. These challenges include not only the unique developmental issues they face but also the difficulty in verbalizing a lifetime of experience and feelings, and, commonly, a disparity in age and life experience between the clinician and the patient.

It is challenging to elicit the elements of a story, especially when they span generations. The elderly are often stoic. In the face of losses that mark the closing years of life, denial often becomes a healthy tool, allowing one to accept and cope with declining abilities and the loss of loved ones. The psychiatrist must appreciate that grief and depression can often be similar in some respects (Clinical Vignette 16).

## Clinical Vignette 16

A psychiatrist was asked to examine an 87-year-old white man whom the family believed to be depressed. They stated that he was becoming increasingly detached and disinterested in the goings-on around him. When seen, he was cooperative and compliant, but he stated that he didn't believe he needed to be evaluated. The patient had faced multiple losses over the past few years. After retiring at the age of 65, he had developed the habit of meeting male friends at a coffee shop each morning at 7 a.m. Now, all but he and one other were dead, and the other was in a nursing home with the cognitive deficits of primary dementia of the Alzheimer's type, preventing his friend from recognizing him when visiting. The patient's wife had died 15 years ago after many years of marriage. He had missed her terribly at first but then after a year or so he got on with his life. Several years later, he suffered a retinal detachment that impaired his vision to the point that he was no longer able to drive himself to get about as he once had. What he missed most was the independence of going places when it suited him, rather than relying on his son or grandson to accommodate him within their busy schedules. He had taken to watching televised church services rather than trouble his son to drive him to church. His mind remained sharp, he said, but his body was wearing out, and all the people with whom he had shared a common history had died. His answers were "fine" and "all right" when questions of quality of sleep and mood were asked – despite the fact that he had experienced significant nocturia. When questioned about his ability to experience joy, he retorted, "Would you be?" His youngest sister had died the year prior to the evaluation. She was 76 years old and had been on home oxygen for the last 18 months of her life for end-stage chronic obstructive pulmonary disease. He had been particularly close to her because she was only 3 years old when their mother had died. He had been her caretaker all her life.

Although he denied feelings of guilt, he said that it "wasn't right" that he had outlived the youngest member of his family. His family said that he had taken her death especially hard and was tearful and angry. The focus of his anger during the final stages of her illness was at the young doctors whom he perceived as having given up on her. After her death, it fell to him to dispose of her accumulated possessions as she had no children and her husband had preceded her in death many years before. At first, he said that he couldn't face the task. Finally, some 2 months later, he was able to close her estate. During that period of time, he had significant sleep disturbance, reduced energy, and his family often experienced him as crotchety and complaining. They and the patient attributed it to mourning her loss. However, recently he was emotionally detached, not very interested in life around him, and they found it particularly alarming that he had said to his son that he was "ready to die". What did all this mean? Was he depressed? Was he physically ill, creating the sense of apathy and disinterest? Was he grieving? He was not suicidal. He did not suffer negative thoughts about his own personhood. He was not having thoughts that he had let anyone down. Together, he and the psychiatrist decided that he was indeed grieving. This time, he was grieving for his own decline and imminent death. He, in fact, was in the final acceptance phase of that process. In a family meeting, in the discussions about the feelings of each member of the family, it became apparent that he was facing the end of life, which evoked many emotions in those who loved him.

## Chronically Mentally Ill

Listening to the chronically mentally ill can be especially challenging, too. The unique choice of words characteristic of many who have a thought disorder requires that the physician search for the meanings of certain words and phrases that may be peculiar and truly eccentric. Clinical Vignettes 1, 10, and 12 are examples of this important challenge for the psychiatric listener (Clinical Vignettes 17 and 18).

### Clinical Vignette 17

A young man with schizotypal personality disorder and obsessive–compulsive disorder presented for months using adjectives describing himself as "broken and fragmented". Only after listening carefully, not aided by the expected or normal affect of a depressed person, was the psychiatrist able to discern that his patient was clinically depressed but did not have the usual words to say it or was unable to discuss it.

### Clinical Vignette 18

A 32-year-old black woman who had multiple hospitalizations for schizophrenia and lived with her mother was seen in the community psychiatric center for routine medication follow-up. Her psychiatrist found her to have an increase in the frequency of auditory hallucinations, especially ones of a derogatory nature. The voices were tormenting her with the ideas that she was not good, that she should die, that she was worthless and unloved. Her psychiatrist heard her say that she had wrecked her mother's car 2 weeks previously. The streets had been wet and the tires worn. She had slid into the rear of a car that had come to an abrupt stop ahead of her on a freeway. Although her mother had not been critical or judgmental, the patient felt overwhelming guilt as she watched her mother struggle to arrange transportation for herself each day to and from work.

Chronically psychiatrically disabled patients may have a unique way of presenting their inner world experiences. Sometimes the link to the outer world is not so apparent. The psychiatrist is regularly challenged with making sense of the meanings of the content and changes in intensity or frequency of the psychotic symptoms.

## Physically Ill Patients

In consultations with a colleague in a medical or surgical specialty, one is evaluating a patient who has a chronic or acute physical illness. The psychiatrist must listen to the story of the patient but also keep in mind the story as reflected in the hospital records and medical and nursing staff. Then the psychiatrist serves as the liaison not only between psychiatry and other medical colleagues, but also between the patient and his or her caregivers (Clinical Vignette 19).

### Clinical Vignette 19

A 35-year-old woman was hospitalized for complications of a pancreas/kidney transplant that was completed 20 months previously. Prior to surgery she had been on dialysis for over a year awaiting a tissue match for transplantation. That year she had been forced to take a leave of absence from her job as a social worker with a local child and adolescent community center. At the time of this hospitalization, she had been back at work for only 8 months when she developed a urinary tract infection that did not respond to several antibiotics. Her renal function was deteriorating and her doctors found her to be paranoid, hostile, and labile. Her physicians dreaded going into her room each morning and began distancing themselves from her.

Psychiatric consultation was sought following a particularly difficult interaction between the patient and her charge nurse, the leader of the transplant team, and the infectious disease expert. She was hostile, blaming, agitated, circumstantial, refused further medications, and pulled out her intravenous lines. The consultation requested assistance in hospital management.

When interviewed, the patient was lying quietly in bed but visibly stiffened when the psychiatrist introduced herself. She very quickly exhibited the symptoms described in the consultation. This patient had struggled with juvenile onset diabetes since the age of 9. Despite the fact that she consistently complied with diet and insulin, control of blood sugars had always been difficult. As complication after complication occurred, she often developed the belief that her physicians thought that she was a "bad" patient. And now, the hope that her life would normalize to the point that she could carry on with her career was dashed. She felt misunderstood and alone in her struggle with long-term, chronic illness. The psychiatrist resonated with the story emotionally and listened for ways to address symptoms from a biological standpoint as well. The patient felt reassured that someone was there to appreciate the tragic turn that her life had taken.

## Growing and Maturing as a Listener

Transference/countertransference influences not only relationships in traditional psychotherapy but also interactions between all physicians and patients and is always present as a filter or reverberator to that which is heard. However, even the most experienced of listeners are not always aware of the ways in which their patients' stories are impacted by countertransference. Patients come, too, with tendencies and predispositions to experience the listener, the other person in the therapeutic dyad, in familiar but distorted fashion. The patient may idealize and adapt to interpretations. She or he may be hostile and distrustful, identifying the psychiatrist in an unconscious way with one who has been rejecting in the past. Listening to the "flow of consciousness", the psychiatrist discerns a thread of continuity and purposefulness in the patient's communications. As the psychiatrist becomes more and more familiar with his or her patient, he or she will discover the

connections between threads and the meaning will become apparent. This awareness may come as a sign and symptom, fantasy, feeling, or fact.

There is an increasing recognition that to be a healing listener one must be able to bear the burden of hearing what is told. Like the patient, we fear what might be said. A patient's story may be one of rage in response to early childhood attachment ruptures or abuse, of sadness as losses are remembered, or of terror in response to disorganization during the experience of perceptual abnormalities accompanying psychotic breaks. The patient's stories invariably invoke anger, shame, guilt, abject helplessness, or sexual feelings within the listener. These feelings, unless attended to, appreciated, and understood, will block the listening that is essential for healing to take place. Every insight is colored by what the listener has known. It is impossible to know that which is not experienced. The psychiatrist comes with his or her own experiences and the experiences he or she has had with others. To listen in the manner we are describing here is another way of truly experiencing the world. The experiences include the imaginings of how it must be to be 87 years old as a patient when one is a 35-year-old doctor just finishing residency, to be female when one is male, to be a child again, to grow up African-American in a small white suburb of a large city, to be an immigrant in a new country, to be Middle Eastern when one is Western European, and so on. One comes to know by listening with imagination, allowing the words of the patient to resonate with one's own experiences or with what one has come to know through hearing with imagination the stories of other patients or listening to the thoughts or insights of supervisors (Clinical Vignette 20).

### Clinical Vignette 20

A Jewish resident was treating an 8-year-old Catholic boy who came in one day and mentioned offhandedly that he was about to go to his first confession. The psychiatric resident made no particular note of the issue and kept on listening to the boy's play and its themes. He noted that guilt, which had been an ongoing theme, was prominent again. When he presented the session in supervision, the supervisor wondered about the connection. It emerged that there was a large gulf between the therapist and the boy. Jewish concepts of sin and atonement are different from Christian ones, and the rituals surrounding them have rather different intentions and ideas of resolution. The resident had missed the opportunity to explore the young boy's first introduction, within his religious context, to the belief in a forgiving God, a potentially important step in helping the child to resolve his ongoing struggles with guilt over his own greedy impulses.

The best psychiatrists continue all their professional lives to learn how to listen better. This may be thought of not only as a matter of mastering countertransference but of self-education. One must learn to recognize when there are impasses in the treatment and to seek education, from a colleague or, perhaps, even from the patient. Consider these two examples.

How can the psychiatrist's demeanor convey to the patient that he or she is safe to tell his or her story, that the listener is one who can be trusted to be with him or her, to worry with him or her, and serve as a helper? Much is written about the demeanor of the psychiatrist. The air, deportment, manner, or bearing is one of quiet anticipation – to receive that which the patient has come to tell and share in the telling. Signals of anticipation and curiosity may be conveyed by such statements as "I've thought about what you said last time", "How do you feel about...?", "What if...?" (Clinical Vignette 21).

Clinical Vignette 21

A psychiatrist began treating a Nigerian native who was suffering from posttraumatic stress disorder (PTSD) after being assaulted at work. After several sessions, the psychiatrist felt a sense of being at a loss in terms of what the patient was expecting out of their work and how the therapist was being seen by the patient. He then took several sessions to inquire of the patient about his tribe, its structure, family roles, definitions of healing, ideas of illness and wellness, etc. After this exploration, the psychiatrist adopted a different stance with the patient, heard the patient's communications very differently, and the therapy proceeded much more smoothly and comfortably to a successful conclusion.

Efforts of clarification often serve as bridges between sessions and communicate that the listener is committed to a fuller understanding of the patient. Patients have the need to experience the psychiatrist as empathic. Empathy describes the feeling one has in hearing a story which causes one to conjure up or imagine how it would have been to have actually have had an experience oneself. How does one integrate all this so that it is automatic but not deadened by automaticity? How does the psychiatrist continue to hear the "same old thing" with freshness and renewal? How does one encourage the patient with consistency, clarity, and assurance in the face of uncertainty and occasional confusion? Not by assurance that everything will be all right when things might probably not be. Not by attempting to talk the patient into seeing things the clinician's way but rather by the psychiatrist's having the capacity to hear things his or her patient's way, from the patient's perspective.

Psychiatry is one of those rare disciplines where the experience of listening over and over again allows the listener to grow in their capacities to hear and to heal. Hopefully, we get better and better as the years advance, become smoother, and develop a style that blends with our personality and training. We are renewed by the shared experiences with our patients.

To hear stories of the human condition reminds the psychiatrist that he or she, too, is human. There is time to make discoveries in the patient's stories from previous times, and maybe in previous patients. Patients will always endeavor to tell their stories. The psychiatrist continues to grow by being the perpetual student, always with an ear for the lesson, the remarkable life stories of his or her patients.