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How I Talk With My Patients

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Interpreting, describing, explaining, questioning, misunderstanding

In this paper the author attempts to describe and illustrate how he talks with his patients. He avoids use of language that invites the patient to engage predominantly in conscious, secondary process thinking, when unconscious dimensions of thinking are what are called for. He values misunderstandings because they tend to invite conjecture, possibility, a sense of humility, in the face of the unknown and unknowable human condition. The author finds that certainty on the part of the analyst undermines the analytic process and patient's potential for psychic growth. The author discusses the ways describing, as opposed to explaining, in the analytic conversation, better facilitates the analytic process. A clinical example is provided in which the author discusses his own thought processes as he talks with one of his patients.

Perhaps the most important clinical questions, and the most difficult ones for me as a practicing psychoanalyst, are those not so much concerned with *what* I say to my patients, as they are with *how* I talk with my patients. In other words, my focus over the years has moved from *what I mean* to *how I mean*. Of course, the two are inseparable, but in this paper I place emphasis on the latter. I will discuss problems and possibilities spawned by the recognition that we can never know the patient's experience; the impossibility of generalizing about how we talk with patients

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given that it is incumbent upon the analyst to reinvent psychoanalysis with each patient; the analyst's approach to the patient's fear of psychic change; the way in which the analyst's "off-ness," his misunderstandings and misstatements may foster creative expression on the part of both patient and analyst; and the ways in which describing experience, as opposed to explaining it, better fosters discourse that addresses the unconscious level of what is occurring in the

analysis. In the clinical work I present, I describe my own spoken and unspoken thoughts concerning *how* I talk with the patient.

Patient and analyst in every moment of their work together bump up against the fact that the immediacy of their lived experience is incommunicable. No one has described the breach between the minds of human beings as well as William James (1890):

> *Each of these minds [in this lecture-hall] keeps its own thoughts to itself. There is no giving or bartering between them. No thought even comes into direct sight of a thought in another personal consciousness than its own. Absolute insulation, irreducible pluralism, is the law … The breaches between such thoughts [the thoughts of two different people] are the most absolute breaches in nature. [p. 226]*

Thus, in talking with patients, my own experience is incommunicable; the experience of the patient, inaccessible: I can never know the experience of the patient. Words and physical expression fall far short of communicating the patient's or my own lived experience. Nonetheless, the patient and I may be able to communicate *something like* our lived experiences by re-presenting the experience. This may involve using language that is particular to each of us and to the emotional event that is occurring, for example, by means of metaphor, irony, hyperbole, rhythm, rhyme, wit, slang, syntax, and so on, as well as bodily expression such as shifts in speaking tone, volume, tempo, and quality of eye contact.

This divide between the patient's subjectivity and my own is not an impediment to be overcome; it is a space in which a dialectic of separateness and intimacy may give rise to creative expression. In the analytic setting, if communicating individual experience were somehow possible, the patient and I would be robbed of the need/opportunity to creatively

imagine the experiences of the other. Paradoxically, the parts that are missing, the parts left out of our communications open a space in which we may be able, in some way, to bridge the gap between ourselves and others. The patient's experience of *being creative* in the act of communicating is an essential part of the process of his "dreaming himself more fully into existence" (Ogden 2004, p. 858), coming into being in a way that is uniquely his own.

The impossibility of knowing the experience of another person has important implications for the way I talk with my patients. For instance, I try not to tell a patient what he or she is thinking and feeling for the simple reason that I

cannot know this; instead, I try to limit myself to saying only what *I* think and feel. It is important to add that this is not a rigid rule I impose upon myself. Rather, as with almost everything having to do with talking with patients, how I talk to a patient, in every instance, hinges upon what is happening between this particular patient and me at this particular moment.

When I do speak with a patient about what I sense is happening emotionally in the session, I might say something like: "While you were talking [or during the silence], this room felt like a very empty place [or peaceful place, or confusing place, and so on]." In phrasing things in this way, I leave open the question of who is feeling the emptiness (or other feelings). Was it the patient, or I, or something the two of us have unconsciously created together (the "analytic field" [Civitarese 2008, 2016; Ferro 2005, 2011] or the "analytic third" [Ogden 1994])? Almost always, it is all three—the patient and I as separate individuals, and our unconscious co-creations.

I have found that asking a patient questions such as, "Why have you been so silent today?" or "Why did you decide to skip yesterday's session?" invite the patient to move to the surface level of his experience, to think and speak with me in conscious, logical, sequential, chronological, cause-and-effect (secondary process) modes of thinking. So, when I find myself asking questions that invite secondary process thinking on the part of either the patient or me, I pause to wonder, What is it about the unconscious aspect of what is occurring that is frightening me?

The analyst's feeling of certainty is often tied to the idea that there exists a proper "analytic technique" derived from ideas passed down

from one generation of analysts to the next (which may be codified by particular "schools" of analytic thinking). By contrast, I think of "analytic style" as one's own personal creation that is loosely based on existing principles of analytic practice, but more importantly is a living process that has its origins in the personality and experience of the analyst (Ogden 2007). It is essential that we not incorporate into our practice of analysis a now outmoded view that the patient's antagonism to the analytic process frequently represents an effort to kill the analysis or kill the analyst. Such a viewpoint forecloses the analyst's capacity to reflect upon the transference-countertransference dimensions of the patient's "opposition" to analytic work.[1] Schafer (1980, 1983a, 1983b) has written extensively about the dangers of such a practice and the need for holding an "affirmative attitude" (1983a, p. 12), an approach that entails a compassionate, understanding response to the patient's unconscious reasons

for fighting psychic change. In my experience, a patient's "unwillingness" or "inability" to do analytic work almost always reflects the transference-countertransference equivalent of the method he developed in infancy and childhood to protect his sanity and his very life, a method I view with respect and even admiration.

But when carried over into adulthood, the psychic techniques that helped the patient preserve his sanity and his life in infancy and childhood, may become severely limiting of the his capacity to learn from experience, to engage in mature relationships with both internal and external objects, to become himself in as full a way as he might. The patient's experience of these limitations, and the psychic pain associated with them, are almost always the underlying forces that lead the patient to seek out help from analysis.

If an analysis has progressed to any significant degree, differences can be felt by both the patient and me between the present situation and what we imagine to be the patient's childhood experience. First, the patient felt alone in infancy and childhood with regard to the problems he was facing—a terrifying feeling that he was trapped with people with whom genuine communication and real change were impossible (and

the patient and analyst experience something like this state of affairs in the transference-countertransference relationship). But the patient may also be able to sense that in some way he is no longer as utterly alone as he once was. Secondly, the patient is no longer a child, and is in possession of psychic capacities for handling the threat to his sanity and his life that he did not have available to him as a child. These felt differences have provided an important underpinning of hope in the analyses I have conducted.

In my experience, certainty may also impinge upon the analytic process when patient and/or analyst holds the parents exclusively responsible for the patient's current emotional problems. While it may seem true to the patient and me that he was severely neglected, disparaged, sexually or violently abused by his parents, I have come to realize that it is incumbent upon me not to introduce or join the patient in "parent-blaming." By participating in this oversimplification, I collude in robbing the patient of the opportunity to experience his life in a more complex, and perhaps more humane way, which may come to include an understanding of the patient's rational and irrational sense of responsibility for the problems he experienced in childhood. The patient's painful and guilt-ridden sense of responsibility for the destructiveness

of what occurred in his childhood may be kept from view by the firm belief on his part (and mine) that he was a passive victim of parental neglect or abuse.

A parent-blaming approach on the part of the analyst may so oversimplify the patient's experience of—or *inability* to experience (Winnicott 1974 [1971])—what occurred, that genuine integration of childhood experiences in all of their complexity is rendered all the more difficult. An experience with a patient with whom I worked in analysis many years ago comes to mind in this connection. As a child, he had been brutally beaten by his father. Of this I had not the slightest doubt. But it was only after a great deal of analytic work had been done that the patient became able to tell me a secret that felt unimaginably shameful to him: the "fact" that he had repeatedly provoked his father into anger to the point that he beat the patient. Only after the patient could entrust me and himself with this memory, or perhaps it was a fantasy (it made no difference in the analysis), could he come to understand that provoking his father, if indeed he did so, could only have

effort on his part to create the illusion that he had some control over his father's terrifying anger and violence. I said to the patient in response to his entrusting me with his secret, "If you provoked your father in the way you say you did, it was no doubt the best thing you could have done under the circumstances. I believe it saved your life to have some tiny sliver of a sense of control under those circumstances." If I had been judgmental from the outset of the analysis in the form of participating in parent-blaming, I think that the patient would have had much greater difficulty gaining access to his unconscious (or not yet experienced) unspeakably "shameful" memory/fantasy.

I have also found that a shift from *explaining* to *describing* facilitates the analytic process by freeing both the patient and me of the need to understand. "Merely" describing, as opposed to "discovering causes" for what is happening, reflects my sense of humility in the face of all that is "humanly understandable or humanly ununderstandable" (Jarrell 1955, p. 62) in the lives of my patients and in the life of the analysis.

An example of describing instead of explaining took place in an initial analytic meeting. Earlier in my development as an analyst, if a patient in an initial meeting were to begin by telling me that she felt terrified by coming to see me, I might have asked, "What terrifies you?" or "Why are you terrified?" More recently, when a patient began by telling me she was terrified to come to see me, I said, "Of course you are." My response was what I think of as a description-in-action, that is, a description of my acceptance of her exactly as

she is, that is, terrified of me, and a way of welcoming her fantasies instead of trying to dispel them by coming up with conscious, "logical," (secondary process) reasons for them or by means of reassurance. The patient was visibly surprised by what I said, which may have had something to do with her response, which surprised me: "I'm not sure I'm in the right office, but I'll stay for a while." Her response suggested that I was not what she expected, but she was now more curious than terrified, and was going "to stay for a while" to find out more about what, and with whom, she was getting herself involved.

A second example of describing rather than explaining occurred in a session several years into Mr. M's analysis. The patient said that he had begun to tell his wife a dream he had had in which their son was dead.

Before he could go into further detail, she said, "Stop, I don't want to hear any more." I said to Mr. M, "Good for her."

When I spontaneously said, "Good for her," I had in mind the idea (or perhaps more accurately, I felt) that just as the patient is all of the figures in his dreams, he is also all of the figures in his accounts of his daily life. In his story about telling his wife the dream, I viewed the patient as not only himself, but also his (interrupting) wife. I believe that the patient experienced my saying, "Good for her," as my recognizing and valuing *his act of interrupting himself*. The patient paused after I made this comment, and then said he felt relieved when she interrupted him. It seemed to me that his response was a reflection of his recognizing he had come some way in the course of the analysis in becoming able to interrupt himself when he felt the impulse to evacuate his unbearable feelings "into" others.

In neither of these examples did I explain something to the patient; instead, I offered succinct descriptions of feeling states: "Of course, you are" (what you are feeling now seems only natural) and "Good for her" (your stopping yourself from evacuating feeling is an achievement to be recognized).

A WOMAN NOT YET A GIRL

Ms. Y and I had spoken briefly by phone when she called to set up an appointment. When I opened the door to the waiting room, I was surprised to see a woman who I guessed was in her early twenties, but could have been much older or much younger. She was dressed in the accoutrements of the hippy, flower-child era. She wore an ankle-length dress that looked as if she had

purchased it at a second-hand clothing store. The dress was large enough to hide almost all curvature of her body. Beaded necklaces of an assortment of lengths and colors were draped from her neck in a way that added a further layer of distraction from the shape of her body.

Upon introducing myself as Doctor Ogden, the patient responded not in words, but by staring deeply into my eyes in the way (I imagined) a shabby medium or psychic might meet the eyes of a prospective customer. Ms. Y slowly lifted herself from the waiting room chair while maintaining eye contact with me. I said, “Please come in,” gesturing

toward the open door to the hallway, but by the slightest forward tilt of her head, she indicated that I should lead the way. I glanced back when I heard the patient closing the door to the waiting room, but once we were walking in the carpeted hallway between the waiting room and the consulting room, I could no longer hear her footfalls behind me. An image of Orpheus and Eurydice’s journey back from the underworld went though my mind as I decided not to turn to see if she was following. On reaching the consulting room, I opened the door and stepped aside to allow Ms. Y to enter the room ahead of me. She looked back at me to ask wordlessly where she should sit, or perhaps lie on the couch. Motioning to the armchair across the room, I said, “Please have a seat.”

I felt as if I were an actor in a film in which I was being asked to improvise a scene of doctor and patient sitting down to begin the first analytic session. There was an otherworldly quality that this patient seemed to work hard to sustain, but I was left with a feeling of deep sadness for this actress who seemed to be condemned to endlessly play a role in the same drama and to try to conscript people into playing the other characters in the play. (I spoke only two or three brief sentences and the patient said nothing in words during the complex scene that was evolving.)

I sat down in my chair which is positioned behind the couch and directly facing the patient’s armchair. After getting settled, I looked over at Ms. Y in a way that invited her to begin. There then followed a silence sufficiently long for me to study her face. She wore no makeup and while there was no trace of dirt on her face, I imagined that she had not bathed for some time, as if she were a gypsy. While she had facial features that I found attractive, she seemed utterly devoid of male or female sexuality. She was, in that sense, lifeless and consequently a bit of a cipher.

It became apparent after the silence went on for some time that Ms. Y was not gathering her thoughts; she was waiting for me to begin. I did not allow this silence to turn into a power struggle or a psychic hole into which the patient might fall. (I very rarely let a silence at the beginning of an initial analytic session go on for more than half-a-minute or so.) I said, "It feels to me as if our meeting began some time ago."

"Please tell me what you mean," Ms. Y said in a way that seemed to turn the tables, making me the patient and her, the analyst.

I said, rather uncomfortably, "I feel as if I've met several versions of you: while we spoke on the phone, when we met in the waiting room, and while we've been sitting here in this room."

She asked, "What's surprising about that?" But before I had a chance to respond, she added, "I suppose I'm odd."

I looked at her quizzically.

"I guess I try to be unconventional. You're not the first one to find me strange."

"'Strange' isn't a word I use very much. I don't find that being judgmental helps anyone very much."

She said, "That sounds very good, but ... I've lost track of what we were talking about." Her sardonic comment about the stereotypic nature of my response —"That sounds very good"—stung me by its accuracy.

"We're talking about how you sometimes lose track of yourself."

She said with tears welling in her eyes, "I suppose. I really don't know. I don't get what I'm supposed to be doing here."

"There is no *supposed to*." As I listened to myself say this, I felt as if I was not being a real analyst and was once again just playing the role of an analyst. I did not feel like myself, which was a very disturbing feeling. I felt genuinely confused about what I was doing in this room with this patient. Once I began to regain my bearings, it occurred to me that Ms. Y not only did not know why she was sitting in this room with me, she did not know who the woman in the performance was, or whether that woman was still a girl clothed in a costume that belonged more to her mother's generation than her own.

Ms. Y said, “I’m not good at school. I never have been. I say I’m bored, but I just don’t get the point of what they’re doing there. I’m reading a fantasy book now. You wouldn’t like it. My parents hate it. They try to get me to read their books, but they bore me to death. High literature.”

I said, “And you’re low literature?”

“I guess. Forget it. It’s not worth talking about.”

“You’re not?”

“No, I’m not.”

Throughout this part of the meeting I was aware that I was not asking questions about who Ms. Y was, I was describing what she was saying from a perspective that was surprising to her and began to capture her imagination, for instance, by re-casting her statement, “I’ve lost track of

what we’re talking about” to “We’re talking about how you sometimes lose track of yourself.”

I liked Ms. Y. I felt at this point in the session that she had some of the trappings of a woman, but she was psychically a girl who was playing dress-up. Her chronological age was immaterial. It seemed to me that she was not entirely a “no one,” “a missing soul”; I felt that there was a bit of someone there hiding in the costume, and a bit of someone who had not yet become herself in any substantial way. I could not know her experience, but I could have some sense of my experience of being with her. Part of what I had to work with consciously was a set of feelings of sadness for her along with discomfort with the feeling I was playing a role in her imprisoning theatre, a theatre in which she survived, as opposed to lived. At the very edge of my conscious awareness was my curiosity about my feeling I was Orpheus leading Eurydice, trying not to look back.

The patient startled me from my half-dreaming state when she said, “I don’t know why I’m here.”

I said, “How could you?” I did not respond with statements such as, “Something must have caused you to go to the trouble of coming to see me” or even, “I think you’re here because you feel you need help with something.” I did not want to push her to come up with conscious reasons or explanations for her

behavior, which would serve only as distractions from the unconscious dimension of what was happening.

There was then a long silence. I averted my gaze, which I thought would allow Ms. Y an opportunity to either study my face or to avert her gaze, if she chose to. I could see in the periphery of my vision that she was looking at me in a way that conveyed a sense that she did not know what to make of me. She seemed to me to be like a feral animal, a scavenger without a home. The thought went through my mind, "If she is homeless, what am I going to do with her?"

"Are you afraid of me?" she asked.

I said, "No, I'm not."

"How sweet," she said.

I felt as if I had been slapped across the face—I was being shown the emotional violence Ms. Y was capable of. In the scene being played out, I was in the role of a child whose affection and wish to be liked were met with derision. I also felt that there was some justification for her derisive comment, "How sweet," in that it was not entirely true that I was not frightened of her.

I said, "You can be tough when you need to be."

"I always need to be. I told you I'm strange."

I said, "I'm strange, too."

"What do you mean?" she said, sounding more interested than she had previously let herself be.

"Just look at this place. It's in the basement of a house. I spend most of my waking hours here. You have to be strange to do that."

"I guess. Your desk is pretty neat, but I noticed when I came in that there are shreds of paper on the floor that look like they're from one of those wire-bound notebooks that school kids use. To tell you the truth, I thought that was strange, but I liked it. And you're old. That's always a little creepy to me. Sorry if I've insulted you."

"Why shouldn't you take a look at me and at the things in my office that may tell you something about who you're taking a chance on?"

She said, “You’ve been looking at me, trying to figure me out.”

“I’d rather say that I’m trying to get to know you.”

She said, “You know already, don’t you?”

“So I’m a mind reader,” I said.

“I’ve known mind readers. Really.”

I said, “I don’t doubt it. I know you’re not here to have your mind read, but you may be here to learn how to read your own mind.”

“That’s a good one. Do they teach you that at shrink school?”

I gave no reply because I did not want to engage with her in that way, which I felt would only distract us from forming a more real form of relatedness. Also, I silently agreed with her that my comment sounded canned. I asked myself why I was talking in such a stilted manner with her, a manner that did not sound to me like myself.

After a pause of half-a-minute or so, she said, “I’m sorry. I’m at it again, aren’t I?”

“Could be.”

“My mother can read minds.”

“Really.”

“Not exactly. She’s in my head all the time telling me what’s wrong with what I’m doing. Not exactly telling. Yelling. I can’t get her out of my head.”

I was now better able to put into words for myself my sense that Ms. Y was showing me in the way she dressed that she and her mother were

one person, the same age, the same style of dressing, the same way of examining, the same way of thinking, the same way of talking, the same way of savaging. But, at the same time, her mother was other to her. The patient was very confused about this, as was I. She felt that her mother was in *her* head, but her head was still *not hers* at this point, which led her to feel afraid of losing herself entirely to the mother-in-her-head. These thoughts about what might be going on were by no means conclusions or explanations; they were impressions, possibilities, wonderings, feelings, descriptions (primarily of shame and loss of my ordinary sense of connection with myself). I did not ask

the patient questions about the voice in her head because I was again concerned that questions of that sort would elicit conscious-level (secondary process) responses, which would steer us to the surface, away from the more primitive, undifferentiated aspects of the experience that was occurring in this moment.

I said, “Sounds like a nightmare you can’t wake up from.”

“She’s telling me that I can’t trust you.”

“I’m not surprised.”

“You’re not afraid of her?”

“No, I’m not.” I did not ask her, “Why should I be?” because, again, I was not after explanations, I was after description. At this point in the session something had changed: I was being truthful when I said that I was not afraid either of the patient or of her mother-in-her-head.

“You should be.”

“Really.”

“I’m teasing you.” She was not only teasing me, she was flirting with me in a lovely way, in a way that reflected some of the ways she had a sense of self that she did not seem to feel was fully in her mother’s possession. Her flirting did not feel perverse or theatrical; it felt to me to be a genuine expression of her female way of liking me. There was now a sparkle in her eyes that stood in marked contrast to the pseudo-hypnotizing stare with which she met me in the waiting room.

As the end of the session drew near, I asked Ms. Y if she would like to meet again.

She replied, “Are you going to be the same then as you are now?”

I said, “Yes and no. I expect you’ll recognize me as the same person you met today, but I also expect something different will happen in our

meeting, which may mean you’ll have to get to know me again next time, and I’ll have to get to know you again.” I felt that I was being verbose and again falling into formulaic speech.

“Then I’ll have to call you to let you know.”

Ms. Y called a week later saying, “I’d like to meet with you one more time, if that’s all right with you.”

I said it was all right with me.

We continued to meet on a “one time only” basis for about two months before Ms. Y asked to meet regularly. We slowly increased the frequency of meetings to four-sessions per week as the patient came to experience me less and less as someone who wished to take over her mind or join her in theatrical performances. However, such suspicions were by no means absent from the transference, anymore than feelings that I was only an “imitation analyst” were absent from the countertransference.

In this account of an analytic session, I am describing what I noticed as opposed to collecting clues with which to decipher, figure out, or arrive at an interpretation. My questions to myself were not directed at finding out “Why?” or “How come?” or “What is the cause of the patient’s auditory hallucinations?” Instead I was interested in what it *feels like* to be inhabited in the way this patient was and in the strange and disturbing way in which I was talking with this patient. My observations, impressions and reveries were not in search of explanations for what was occurring; rather, they were elements I could make use of in my efforts to describe for the patient and myself who the patient was and who I was (at the ever-changing present moment of the session).

The reader will have noticed that I did not ask the patient to help me understand her experience. For example, I did not ask her to “fill in” references she made to particular experiences, such as the sound of her mother-in-her-head yelling critical comments at her. And I did not try to explain myself to the patient, and instead spoke to her in a way that I hoped would elicit in her a tolerable level of anxiety mixed with curiosity (for instance, when I said, “I’m strange too”). I should also say that my failures to speak naturally with the patient were not simply “mistakes”; they were productive expressions of my own loss of connection with myself that mirrored, but did not replicate, the patient’s experience of losing track of who she was.

And most of the time I did not attempt to help Ms. Y “understand” what I was saying. My comments were often of the sort: “Really” or “I’m

not surprised” or “No, I’m not [afraid].” I sometimes tried to describe (to offer metaphors for) what I imagined the patient was experiencing, for example, when I said, “Sounds like a nightmare you can’t wake up from.” It was

particularly important to include “sounds like” in talking with this patient whose mind was already occupied by (what felt to her to be) two people.

These aspects of the way I spoke with this patient reflect a strong feeling on my part that we all speak with a simultaneous wish to be understood and to be misunderstood, and that we listen to others both with the desire to understand and to misunderstand. The latter—the wish to misunderstand and be misunderstood—only in part reflects a desire not to be known, a desire to maintain an aspect of self that stands in necessary isolation (as described by Winnicott 1963). In my experience, the patient’s wish *to be misunderstood* often strives for more in the way of coming into her own in her own way than does *the wish to be understood*. The wish to be understood inherently carries a wish for closure, a wish to be recognized for who one is at present. By contrast, I find that the patient’s wish to be misunderstood involves a wish to dream herself up (as opposed to being seen by the analyst). Respecting the patient’s need for self-discovery places a demand on me not to “know too much” (Winnicott 1963, p. 189). Misunderstandings put the patient and me in a position to make use of the “off-ness” of my understanding in an effort to create renderings of her experience that neither she nor I could have anticipated—“it’s not *that*, it’s more like *this*”—a *this* that could not have been conceived of (dreamt up) without the particular “off-ness” of the understanding. I am reminded here of James Grotstein’s description (in a conversation we had more than twenty-five years ago) of a moment in his analysis with Bion. In response to one of Bion’s interpretations, Grotstein said, “I understand.” Bion impatiently responded, “Please try not to understand. If you must, meta-stand, para-stand, circum-stand, but *please* try not to understand” (Grotstein, personal communication, 1990). Understanding, from this perspective, is a rather passive mental activity compared with the act of misunderstanding and doing something with the “off-ness” of the understanding. The work of understanding carries the danger of “killing” an experience that was once alive in an analytic session. Once an experience has been “figured out,” it is

dead. Once a person is “understood,” he is no longer interesting, no longer a living, unfolding, mysterious person.

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