

Clinical Pearls of Wisdom Strung Together

Joseph E. Schwartz, MD

Massachusetts General Hospital

This will not be a review of the multitudes of psychotherapies nor an update of advances in psychotherapeutic concepts. What I have elected to address are some of the basics of psychoanalytically informed therapy, some of the basic pearls of wisdom. My experience has shown me that the forgetting fundamental pearls of wisdom is the cause of many treatment failures. It is my hope that these pointers strike a familiar note in the listener and will serve as encouragement to return to basic principals. The first is to be fat, dumb, and happy. What this means is that the therapist must assume that he or she was sitting in his or her office minding his or her own business when someone knocked on the door and asked for help. The therapist agreed to try.

Another pearl is that the therapist must resist attempts on the part of the patient to make the treatment more important to the therapist than to himself. That enacts maladaptive characterological or transferential patterns. The patient needs to be able to say when things might be getting worse again without realistic fear of injuring the all-too-involved therapist. And the

This transcript was originally presented in audiocassette format in Practical Reviews in Psychiatry, Volume 14, Number 10, October 1990. For additional copies, to obtain the audiocassette, or for subscription information, contact the publisher, Educational Reviews, Inc., 6801 Cahaba Valley Road, Birmingham, Alabama 35242 or call 1-800-633-4743. Outside the continental United States call (205) 991-5188.

(C) 1990 Educational Reviews, Inc.

therapist here's another pearl must be attuned to the distinction between suffering and the misery. That is, a suffering patient wants help, while the patient in misery, who is in a masochistic position, will actively fight attempts to get better. You must remember that misery is its own reward, and no good deed with go unpunished. In addition, an overly involved therapist will be more likely to intrude on the patient's defenses instead of respectfully understanding them and appreciating their function. If the therapist is not fat, dumb and happy these issues will be missed. Furthermore, an overly involved therapist plays into the patient's regression when the patient feels he or she is there for the doctor's sake or on a doctor's recommendation. Communicating to the patient that therapy is "needed" further induces regression as well and engenders narcissistic rage of dependency. Telling a person that therapy is "needed," except in realistical life-and-death situations, implies the promise of cure, a pot of gold at the end of the rainbow, and regression in function may follow. The contract to work in therapy is a promise to give the patient one's best efforts to understand and to help the patient understand him- or herself. Through that understanding, there is the hope of improving one's life.

Being fat, dumb, and happy does not imply an uncaring therapist, rather a professional who cares in a careful and skillful way. In summary, being fat, dumb, and happy leads to other pearls of wisdom; that is, not telling the patient that therapy is needed,

not promising a cure, respecting defenses which are to be worked through and not rammed through, distinguishing between suffering and masochism, and in general avoiding the iatrogenic regression in function that could follow from these things. You are holding the patient responsible for himself- that limits regression.

There is another point to be made about being fat, dumb and happy. A therapist is a human being. Therefore, he or she optimally should have a significant number of patients so that any one patient's love of the therapist or financial support of the therapist does not become excessively important. While it may sound quite trite, a therapist must have a real and satisfying life of his or her own so that patients run the least risk of being used for the therapist's gratification be it emotional or financial well-being.

Another pearl is your job is to understand, understand, and then to understand. There are so many understandings. There are many smaller pearls contained in this pearl as well. If you stick to the task, you will stay involved with the patient's emotional life - the psychic reality - and thereby avoid involvement in the patient's actual external life. Involvement in external realities enacts parenting in distinction to understanding, and you once again induce regression. You have failed to understand that the transference is not to you the person but to you in the psychic. The transference is to be understood, not enacted or manipulated.

Enacting things itself violates understanding and honesty and erodes the core of the work. ~~To repeat part of that, involvement in external realities enacts parenting as opposed to understanding it.~~ Furthermore, a therapist who tries to simply understand can find himself or herself quite interested in all aspects of the therapy process, including resistances. This will lead to continued interest even in bad weather, and we assume that good weather never lasts forever. Additionally, understanding as many aspects of the therapy process as possible will lead to the revelation of new material.

Here's a pearl. If you follow the process, the content tends to emerge spontaneously, willingly, and without assaulting the patient. ~~If you follow the process, the content tends to emerge spontaneously.~~ Early in therapy we have a crucial area to try to understand; that is, ~~why a patient came to treatment and what his or her goals are.~~ No treatment can proceed without at least some understanding of this. A therapy is a relationship to be used for a purpose. A therapy without some articulation and purpose will have no alliance, and therefore transference feelings have no purpose but for unconscious gratification. Limbic stimulation is not a purpose. ~~To repeat,~~ therapy is a relationship to be used for a purpose, and so there should be a goal. Without one, there is no alliance and unconscious gratification, or limbic stimulation is not a purpose of therapy. Transference experience without a goal to return to from time to time will often lead to running away and

useless regression in treatment. If a patient cannot articulate some goal, ambiguous as it may seem, the alliance should be formed early around the task of finding the goal the patient might have. Another very important pearl is when in doubt you should be able to keep your mouth shut if you want to. Now while it has long been recognized that silence is, in itself, a stimulus to the patient, and that silence is not neutral, it is still worthwhile to keep this pearl in mind. To be sure, silence can serve as a gentle prod to the patient's verbalization and can have the quality of respectful and patient attention, but it can also be used as a sadistic tool by an angry therapist or a defensive tool by a confused therapist.

There are several reasons I include this as a pearl of wisdom. First, the therapist who must speak in a silent moment in treatment is anxious and, instead of speaking, a self-analysis of the therapist's anxiety is indicated. At times, speaking inappropriately may be the first countertransference clue that the therapist somehow has gotten into a position where he feels he must show how smart or compassionate he is. He should ask why he is in that position. As well, silence is golden, and words are your tools to be used skillfully and with purpose, so that when you do speak you are using your tools.

Remember another pearl of wisdom. The mind always cops out to a lesser plea. The mind always cops out to a lesser plea, so that

when you are hearing something from a patient you often are not certain if it is a defense against something else. ~~If you speak too soon, you may never get to hear where something might be going. You might be interrupting a process you don't know about.~~

Keep in mind another pearl. Whatever the patient says to you is said to you as a transference figure even if it's about someone else. ~~If you understand what's being said to you in the transference, you understand a lot about the process.~~ Remember, the patient is talking to you as a transference figure all the time. Therefore, you may not know where things are going and you should be able to keep your mouth shut if you want to. Some examples might help. A patient came in early in treatment and began speaking in an uncharacteristically rapid manner about a number of topics. I didn't understand why and I remained silent, felt shut out, and came to accept my ignorance of this event. I asked the patient if she were aware of the difference in her speech today and she readily acknowledged she was and associated it with her mother, who kept her upstairs years ago as a teenager while her overly social sister entertained boys in the parlor downstairs. When she and her mother could no longer hear the talking going on, her mother would send her to the parlor to interrupt the presumed sexual activity. Now, the patient and I could have gotten caught up in the content of her verbalizations and never heard the other messages, namely that something had occurred in the last session that had stimulated her to interest and to fear. We needed to keep her distance from that experience and from me. She needed to take

space and couldn't sit comfortably with me without some sense of reprimand from her mother within. What we were able to do was simply see together that she was anxious about something in the therapy and tried to deepen her interest in unconscious process.

Another patient deeper into therapy came to a session after my vacation. She discussed her vacation, her self-referential position, the loss of her boyfriend, her ability to be with her friends and rely on them, and ultimately that she had missed having her sessions. I could have said many things about her various topics but in electing to wait and listen I heard her recap of our work, that is, her retreat to narcissism, her limiting her withdrawal by herself while on her own and during the session, her return to an abject-related position and a return to the therapy relationship. She limited her own regression and was actually quite proud of it. It was very important for both of us to see abilities in dealing with aloneness, abilities developed in therapy. It would be helpful to have knowledge of her capacity to deal with aloneness in planning a reasonable termination in the future.

There are many reasons for one to be able to use words somewhat sparingly. Interrupting a person's process will cause the patient frustration. Telling a patient something he knows may feel to him that you don't think much of his intelligence or ability. Telling a patient about a conflict he doesn't want to know about will not feel like a helpful gesture, it will feel more like ruining his

moment. If you wait until the patient is ready, asking to hear from you, what you will have to offer will be felt as helpful. If the patient never asks to hear from you, then one just doesn't talk but one may decide to address the phenomenon that the patient for some reason doesn't ask anything of you. Of course, then that becomes the topic.

For example, a new patient in analysis began each session with a "problem" and found the solution to her "problem" by herself 49 minutes later. By remaining silent, it was clear her anxiety about beginning the therapeutic relationship was dealt with by demonstrations of independence while covertly asking me to stay away. My silence enabled us to more calmly feel what was going on. The real topic was her getting comfortable in her own characteristic, independent way. In staying silent, I could also pick up some clues for what would come down the road later in the treatment about her discomforts.

Another reason to be able to be quiet is that words themselves have meaning. I don't mean the content of words but the meaning of the use of words. Speaking may be feeling your words, and your words may be used by the patient to feel like he is fed. A lot of words may actually be a lot of feeding, but the patient may never understand why he needs the feeding. Words can also be waste matter to be flushed away. A patient may speak to you to flush things away and may experience your words as ways to flush him away. For example, if you offer medication and the patient hears you say "go

away." The patients may hear your words as ways to get rid of their feelings, and instead of hearing or feeding through your words, he may feel a deprivation. One patient told me about his masturbation during the consultation phase of our meetings. We began therapy and after two months he became inextricably angry with me. After a while I inquired about it. He was able to tell me that when he told me about his masturbation it had stopped but had now once again returned. He feared therapy wasn't working. He was experiencing the failure of the using of words in a magical way to flush things away.

Words can represent the salts as well. A patient reacted to my use of the term "trauma," referring to her history of abuse by her parents. She had used that word herself but when she heard that term when I used it "trauma" as denigrating her, devaluating her, and enacting the trauma, that word had attacked her. ~~Until you have some clarity of the patient's process and the meaning of words to the patient, you would be wise to be able to shut up.~~ Another point is worthy of mention. ~~If you address a transference element it may well be greeted with appreciation and relief, with the patient feeling a sense of understanding something that had hitherto had been hard to fathom.~~ When you address not a transference element but a piece of the patient's character, your statements will be met by surprise, confusion, and often a sense of injury as if you were critical of the patient. You may create your own iatrogenic resistance by addressing character prematurely. It

is useful to distinguish between character and transference. This is another reason to be able to keep your mouth shut. Remember the steak story? It goes like this. He was served a steak by the host and asks, "Where did you get this steak?" The host said, "At the supermarket." Another host serves you a steak and you ask, "Where did you get this steak?" The second host answers "Why, what's wrong with it?" The meaning of your words is always dependent on the receiver's state of mind.

Before leaving the significance of words, remember yet another pearl. The words and the music must go together. The technique, intention, and the verbal messages must be consonant. You cannot say to a patient in words that anything can be verbalized in the therapy room, that we are interested in understanding and in being patient and in taking our time in doing so, and then announce a cancellation of a session in the last two minutes of a session. You would then be saying, "tell me your thoughts and feelings" but acting in a way to indicate that you didn't want to hear the patient's reaction to the cancellation. If you subsequently make the mistake of telling the patient he is angry about your leaving, you may be compounding your error. The anger may be about how you said you were cancelling, that is, with no chance for the patient to respond, and the anger may be intensified by your unwillingness to listen again as you insist the patient is angry for another reason. Now, by the time the interruption in treatment occurs, after this frustrating series of understandings there is yet

another way for the therapist to fail even further. By this time the patient is furious. First, with you for not listening to his reaction to your leaving. Second, he is angry for your insistence that it is his separation problem as opposed to how you said things. The patient will feel totally relieved of pain when you leave. You can then tell the patient he is using narcissistic defenses against loss by being glad you are leaving. This is a psychotherapeutic tragedy. Your words as a therapist tell the patient to be forthcoming, while the music is much more in the direction of the therapist saying to the patient "I am guilty about leaving you and I insist upon using you to allay my guilt. By being all at fault, I will beat you into taking my problems into yourself. When the words and music don't fit, don't force it. Try checking what's wrong with the composition. There is another pearl of wisdom that might be added. ~~The golden rule of emotional life. We do unto others as was done unto us. The patient may do to you what you did to him.~~ It can get to be quite a mess if you aren't listening carefully. Once you have a mess, you cannot argue your way out of it but you must understand your way through it without assignment of blame. There's an old story of a man walking along an icy tundra. He hears a bird who lies injured on the ground. The man places the bird inside his coat for warmth but ultimately after miles and miles he can no longer do even this. He spies freshly laid animal excrement and he wraps the bird in it for the warmth. The bird warms up, chirps happily, and then a wolf hears the chirping and eats the bird. The moral of the story is that the

person who puts you into it isn't always your enemy. The person who gets you out of it isn't necessarily your friend, and when you're in it up to your neck, keep your mouth shut and check on what's wrong with the composition. You may have erred, and that must be acknowledged before any patient can accept the knowledge of his or her own emotional distortions.

Remember another pearl. You cannot argue your way out of a neurosis - yours or your patient's. You can't argue your way out of it. You must understand it. There's another pearl that also makes it very hard to understand who is the man, the bird, and the wolf. That is, that the characterologically sicker or more regressed patient often talks through the skin and not with words. We all do that sometime but some people do it more than others. What this means is that in proverbial areas of emotional trouble, communication is not in words but in getting the therapist to feel exactly what the patient feels. This can be seen as a way to connect, to push a feeling out to someone else in an effort to obtain relief from the pain, as a way to be aggressive toward the therapist. The specific function served must be seen in the light of the patient/therapist diad, the kind of psychopathology and the state of the treatment relationship. What is important is to recognize that your countertransference may result from this kind of communication. An angry, withdrawn patient elicited in me the wish to out-withdraw him by staying silent, alternating with the wish to shake him by the collar. He was fully capable of talking when he wanted to. I

recognized how neither of my feelings was very useful and then how guilty and helpless I felt having seen that I could ask the question of whether the patient might be feeling the same thing and if his style, more than the content of his words, had communicated his feelings. Having seen talking through the skin, having seen the messes that derive from insecurities around steak dinners, having seen that patients talk to us in the transference all the time, and having seen that the mind cops out to a lesser plea, we hopefully might be convinced to talk less and listen more.

An apropos of listening more, the last pearl for today will be always count to three. What this means is when you advance a clarification or interpretation, or even when you ask a question, you should listen for the manifest answer and then the real answer. A patient may first agree and then disagree in subsequent associations, or he may disagree first and subsequently through association may agree next. Of course, initial agreement may be followed by further agreement, or initial disagreement may be followed by further disagreement. Counting to three means: (1) listen to what you say; (2) listen to the patient's initial response, and (3) listen for the further answers imbedded in associations. Whether the patient is undoing each reaction by the following one, whether he is making you feel helpless or confused, or what the specific meaning is of the combinations of yes and no described, it would almost be understood in the more specific light of the actual patient/therapist diad.

While there are pearls of wisdom that relate to different pathologies, I have tried to cover the highlights of inside-oriented work in a more general way. Perhaps all of these insights are a bit like the old baseball story in which an outfielder made a great catch. News reporters crowded around and asked him how he made such a difficult play. He replied that the catch was easy, that he had simply closed his glove over the ball as the ball entered the glove. But that the difficult part was getting into position to do so. So many of the pearls have to do with getting into good therapeutic position to make what then might feel like easy catches.