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    Joseph D. Lichtenberg

CRAFT AND SPIRIT
A GUIDE TO THE EXPLORATORY PSYCHO THERAPIES

JOSEPH D. LICHENBERG

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London
and working together. The state of arousal achieved through a mix
of pain and sensual sensation led finally to an orgastic sexual expe-
rience with postcoital relief. The experience being sought was Mary
ane's fantasy of ideal love conveyed through the perfect attunement
of pain and erotic intensification.

In this chapter, I indicated the significance of a therapist's focus
on emotions to gain entry into a patient's state of mind. I have
emphasized the place of tracking the emotions that had been experi-
enced during an event and the emotions that are involved in a
patient's intentions. In the next chapter I will shift to a focus on
speech. I will describe guidelines that promote bringing into focus
the elements of a patient's verbal rendering of experience that facili-
tate or obscure a therapist's attempt to share the patient's experi-
ence and intentions.

CHAPTER 4

"THE MESSAGE CONTAINS THE
MESSAGE"

OPENING COMMUNICATION TO ITS FULLEST
REVELATION

THE APPROACH I EMPHASIZE IN THIS CHAPTER, "the message con-
tains the message," sounds more like a maxim than a guideline for
psychotherapists. My intention in proposing it is to reorient the
manner in which therapists attend to the flow of a patient's com-
munication. I recommend listening to each patient's narrative, his
or her unique rendering of an event or description and explanation
of a symptom for what is stated as well as what is implied. Shifting
from a skeptical stance of a detective listening for what is hidden,
therapists attending to what is in or is close to awareness affirms
for patients the value of their spontaneous associations, of their ver-
ion of the story of their life as they bring it into their awareness.
Listening in this way, therapists avoid communicating to a patient
that the patient's message is really an attempt to divert both therap-
ist and self from something else. Implied in such a listening stance
is that what is not presented is necessarily of more therapeutic im-
portance than what is presented. Guided by "the message contains the
message," therapists see and hear the total delivered communica-
tion from the patient: verbal, gestural, and facial. They attempt to
familiarize themselves with their patients' intentions as the patient
Consciously wishes them to be known. When listened to in this way, patients feel safer to express themselves more freely and feel an enhanced esteem that allows them to explore and reflect in greater depth. In this way, patients are encouraged to make previously hidden or unconscious motives and messages more accessible to awareness.

Communication involves multiple points of selection. Our familiar invitation to a patient to say what comes into his mind implies that selections of psychological contents are made in or near conscious awareness. Using speech as an example (and remembering that speech is but one form of communication), we can recognize the various levels of selection that contribute to what a patient ends up telling a therapist. First is a selection operating at the body-brain level that involves adjusting the signal intensity of internal and external perceptions. The brain is consistently receiving information from a multitude of perceptual pathways. Consequently, selection at the body-brain level is absolutely necessary because so many stimulus inputs are present at all times that adaptive relevance must be preserved. All of this process is outside of and unavailable to conscious awareness. At a second level, the conscious product of the body-brain processing of bioperceptual information, what we refer to as cognition and emotion, gives substance and form to our inner speech, our inner monologue-dialogue, and our dreams. Inner speech, which may be words, images, and sensations, is a monologue in that it is from oneself to oneself but also a dialogue in that the shadow of another as audience is always implicit—sometimes explicit. Although inner speech is most commonly verbal employing a loose syntax, dreams, the product of sleep mentation, are primarily imagistic. Because inner speech and dream imagery tend to be rapid, the transition to dialogic discourse requires slowing down and grammatical revision as well as an unconscious and conscious strategic selection of what to reveal and what to hold back. The selection process is made both as a form of self-regulation, largely at the pre-speech level, and mutual regulation, largely at the level of dialogic speech. Each message that contains the message combines the influence of prior forms of self- and mutual regulation with a current version selectively and uniquely co-created that emerges in response to the challenge of the specific clinical moment.

For the therapist, unconscious and conscious selection occurs at the same diverse levels, and spoken communication is also chosen on the basis of unique self-generated criteria and with the receptivity of the patient as a criterion. Therapists have the additional task of selecting their principal focus of attention from among all the possible elements communicated by the patient. Successful inferences about the meaning of experiences derive from those elements of the patient’s communication to which therapists attach primary significance. Analytic theory began with the premise that behind the immediate content of a communication lay a hidden message. Free association, that is, the patient faithfully reporting every thought as it came to mind, had the aim of opening censored content to observation. The theory held that once a patient’s communication was free of censorship, the analyst could look behind the reported associations to infer the hidden message. Freud used the metaphor of an archaeological search in which archaeologists dig down through layer after layer to find the “truth” about earlier events. Similarly, analysts regarded themselves as digging down through layers of defenses, current experiences, and revisions of past events to find the truth about childhood traumas or fantasies based on drive distortions.

A positivist maxim is that “the truth shall set you free.” This led to the logical premise that, if patients beset with psychoneurotic symptoms would learn about the unresolved childhood conflicts that were presumed to be the source of their symptoms, they could use their insight and adult logic to make a nonsymptomatic adaptation to life problems. In its fundamental assertion that discovery and understanding lead to psychic transformation, this remarkable hypothesis of Freud remains a guiding principle in all analytic-based therapies. The focus on penetrating through (by analysis of them) defenses to hidden contents remains the approach of many analytic therapists, but others focus more on the immediate experience of their patients with them (the here and now of “us”) to gain crucial information. They give precedence to recognizing and interpreting the relational interaction that is and has developed in the dyad.

My focus includes both attending to the relational interaction and broadening the range of focus beyond it because I believe patients include far more in the message as delivered than a dyadic
communication. The principal difference that has led me to abandon the archaeological metaphor as my guide is my belief that to search for what is behind the message as delivered or what is hidden by it denigrates its communicative value. To find the needle in the haystack treats the hay as only an impediment. My approach is to seek all the meaning a patient and I can extract from the messages we are sending each other. This approach allows therapists to be equally attentive to all sides of the patient’s communication. After all, each message contains mixed elements of what a person consciously wants the listener to know, what a person unconsciously wants the listener to know (they often are not the same), what a person consciously doesn’t want the listener to know, and what a person unconsciously wants to hide from the listener (including himself) or to deceive him about. By conceptualizing communication in this way, that “the message contains the message,” both the hay and the needle are explored and yield equally important information about the patient and the dyadic relationship.

The therapist’s listening priorities that derive from “the message contains the message” begin with what a patient can acknowledge that she wants to be telling. The explicit communication may involve a feeling, an event, a dream, a complaint, a request. It may be in the form of an organized story, fragments of loose associations, chatty time fillers, long silences, emotional storms, or contemplative reflective observations about self or others. Therapists’ listening priority extends beyond being an attentive faithful recorder of the delivered message to attempt to track a theme unfolding as the session or sessions progress. Developing an intuitive sensing of a theme or motivational story about self with others involves integrating the explicit message of consciously intended communication with an implicit message of unconsciously intended communication.

An expensively dressed, successful professional woman wore pantyhose with rips and snags as a message to her therapist of the feeling of neglect from childhood she still experienced every day. A man who prided himself on his affability and positive orientation to his treatment would start to shake his foot in annoyance if he felt his therapist did not respond as quickly as he wished. A man who regarded himself as timid would raise his eyebrows in contempt and disdain as he described his troubled relations with superiors. Gestures, facial expression, vocal tone, eye contact or aversion, grooming, clothing, posture, perspiration, body tension, odor, and gait are all omnipresent elements of implicit communication that are being absorbed directly or subliminally by an attentive therapist. A therapist may recognize the implicit message as an augmentation of the explicit message or as a contradiction to it. His awareness of either explicit or implicit communication may, at times, emerge more from focusing on his own emotional responses than from observation of the patient.

Arthur Harris was a patient whose adventurous young adult years gave him interesting experiences to relate. A major complaint was that although he easily attracted women, before long their interest in him faded and the affairs petered out. In the middle phase of his analysis, I could follow his associations from within his perspective for the first 10 or 15 minutes of the session, during which he would report significant events or dreams. Then my attention would drift off. My attempts to explain my flagging responsiveness to his explicit or implicit message were unproductive. When I turned to introspection, I failed to relate it to any conflictual response on my part to the content of his associations or to him personally. During one session, I connected the drifting of my attention to an experience I remembered having when I sat with my children watching a TV show in which I had only a distant interest. I would attend to the TV show enough to talk about it with them, but otherwise, I would think of my own thoughts. Within a few moments, Arthur mentioned (as he had previously) that when he came home after work he turned the TV on, made dinner, and let the evening drift away without getting to work on his long overdue tax-refund claim. Cued by my association, I asked him about his reference to turning on the TV. He described a state of mind in which he would begin to listen to the news, and then the TV would become a general background blur that he would tune in and out of awareness. His recent girlfriend had complained about it for a while but then said nothing more.

Once this drifting state of mind came into focus for us, we were able to relate it to his use of alcohol and marijuana—not to enhance
his experience (as he had claimed), but to produce this sense of being with another in a state of remoteness and drift. Stimulated by dream images of furniture placement in his childhood apartment, he began to recall a seemingly innocuous scene, which served as a nodal point (a model scene, see chapter 7) for our joint effort to reconstruct significant family relationships and their effect on him. In this scene, he was sprawled out on the floor with the TV on in front of him. His mother was sitting behind him, on the other side of the room, knitting or reading. His father had gone to work, leaving him, as he saw it, to keep his lonely, depressed mother company. In desultory fashion, he watched TV while flipping a rope, imagined to be a cowboy’s lariat, over a chair. There was no conversation between him and his mother; the only sounds came from the TV. His attention was dominated by anger-filled fantasies of heroic battles. A mood of depressed remoteness, irritability, and mutual withholding characterized the exchange. An appreciation of this scene provided welcome entry into the reenactment that we had cocreated in such a puzzling fashion. We had unconsciously drifted into the roles of two people similar to his mother and him passing time in a desultory state while the TV (his droning speech) played in the background. The message indeed contained the message, but, to decode it, I had to go beyond what I could recognize from either his explicit or implicit communication. In retrospect, I believe that earlier, more perceptive appreciation of his vocal tones, body posture, and breathing might have provided clues to the message he was unconsciously communicating. In any event, I began to discover the message contained in (not hidden by) the message as delivered via his dream images and our cocreated model scene.

Freud’s archaeological metaphor does apply to some extremely obscure symptoms. These symptoms contain the message as an artifact of traumatic occurrences in the individual’s past life. These experiences remain as physiological revenants that preceded or escaped symbolic representation so that the symptom stands alone as both message and container. An example comes from the treatment of Mrs. G.

Mrs. G’s therapy centered on her phobic symptoms, her depression, and her hypersensitivity to anxiety. She described a symptom that was unique in my experience. Her mouth would be held open as if to yawn but, unlike a yawn, she would not inspire air. Instead, she would try to get her mouth to close. We spoke of this as a yawn for lack of a better designation and related it to a response to mounting anxiety. Yet this coupling with anxiety struck me as unsatisfactory because I couldn’t determine why this particular response should occur rather than any of her other responses to anxiety.

Mrs. G became generally able to associate to and master anxiety. Her “yawn” disappeared or, more accurately, did not occur (neither of us being aware of its absence). Then, during the final months of her lengthy therapy, Mrs. G was telling me an anecdote about her new baby and her five-year-old daughter. She seemed rather comfortable, and I was listening with my attention easily placed within her state of mind. She described feeding the baby a bottle, with her daughter looking on and asking if she could help. Somewhat reluctantly, Mrs. G answered “yes” and gave her the baby and the bottle. After turning away for a moment, she looked back to see the baby in some distress because the five-year-old feeder had let the bottle press too deeply into the baby’s mouth. Mrs. G proceeded to describe her reason for bringing up this anecdote. Initially she had been ready to react with a panicky yell. She was pleased that she had been able to get control of herself and simply help her daughter reposition the bottle properly. As she talked, I basked somewhat in her pride of mastery over her inclination to panic and her implied appreciation of me as the parent-therapist who had helped her to do so. Involuntarily, without conscious thought, I found myself opening my mouth and feeling the sensation of a nipple thrust into it too far to suck in or push out. I repeated to her this aspect of her description before asking her about my conjecture that her so-called yawning symptom was a somatic memory of a nipple thrust too far into her mouth. Before I could verbalize my question, she reproduced the symptom for the first time in several years.

The construction we made was based on a great deal of information about her early life. A premature baby, she had spent two months in an incubator before coming home. This gap probably interfered with the attachment between mother and infant, which was also attenuated by the mother’s general anxiety and preoccupation with her
own mother’s chronic physical illness. We postulated that her mother, pulled by this concern, had at times turned over aspects of Mrs. G’s care to Mrs. G’s older sister. Whatever difficulties had occurred, especially mechanical ones of a too-intrusive nipple, may have been aggravated by the mouth sensitivity of this premature child, plus a degree of weakness in thrusting the bottle away. What was most fascinating to me was that dream material related to this experience appeared only after the exploratory work. Work with this material led to associative links to conflicts over impingement. Yet dreams prior to this construction, viewed retrospectively, did not reveal that the bodily registry had received a symbolic representation, as far as I could discern. The symptom alone had contained the message.

In more usual therapeutic exchanges, patients fill the receptive openness of the session with an issue or issues they believe will help them gain a desired goal. In the opening moments of a session, sometimes in a seemingly casual aside, as in the clinical example to follow, patients often convey an implicit message. The opening message and the entire dialogue that ensues between patient and therapist can be looked on as a text that can be scanned to bring forward overt or embedded themes that organize the message as a whole. The text that allows therapists to illuminate and track themes as they wax and wane is not limited to the message as delivered by the patient but involves the totality of the interchange and the therapist’s ongoing introspection, inference making, and interventions. The text is not simply a patient’s message combined with a therapist’s message: she said plus I said plus she said. The text of an ongoing exploratory therapy is shaped by the relatedness the pair has achieved as evidenced by the conversational and conceptual space they offer each other and the hints and cues they communicate.

CLINICAL EXAMPLE

Sylvia is a married woman with one child. Because of a collagen disease requiring steroids, she has had to give up her profession. This change in her life aggravated her tendency to be somewhat reclusive and to be dismissive of aversive feelings. Behind her avoidant pattern lay traumatizing problems with both parents, which had been intensified by her divided loyalties after their divorce.

Sylvia announces the theme of the hour in her opening comment about missing her daughter on her first day of school. Here the message is packaged in the social convention of an entry comment not meant explicitly to be the business of the session. I have found that such “social” comments often are highly pertinent, like an opening chord in a musical composition before the formal theme is announced. Naturally, the motif significance of “missing” can only be appreciated later in the hour when missing reappears in several different contexts. Also noteworthy is the difference between the opening mention where Sylvia talks explicitly about missing her daughter, and the later references, where missing must be inferred implicitly as Sylvia disconnects herself from the emotional experience.

Tracking a transcript of a therapy session differs from tracking an authored text. A text authored by a single person tends to present themes in a relatively linear fashion for better comprehension. The therapeutic transcript of necessity introduces strong nonlinear elements in that a therapist’s spoken or unspoken interventions introduce a constant influence, leading themes emanating from the patient to wax or wane. The extent of the influence at any moment is unpredictable in that small encouragements may have considerable effect at one moment and none at another, and small failures to comprehend may pass unnoticed, be a minor distraction, or be a major dysjunction. While Sylvia and her therapist are each contributing to the flow of the theme about missing and the subtheme of coldness and anger, together they cocreate an atmosphere that transcends the immediate exchanges. The message of the session contains the unfolding of messages expressing both missing and coldness themes and a created ambiance of generally moving along together, trying to follow each other’s leads and include each other’s point of view.

PATIENT: First day of school—D (seven-year-old daughter) is very excited—I’m going to miss her but that’s OK. She is happy to be back with her friends.

THERAPIST: So, she got off OK this morning.
PATIENT: Yeah, everything went fine—she was so happy.
THERAPIST: That's good.

PATIENT: This weekend was weird. I got my steroids on Friday and I was just off this weekend—hyper as hell and then I crashed suddenly on Sunday and I got down and hyper and mean.
THERAPIST: Tell me about that—what happened?

PATIENT: I just wasn't very nice.
THERAPIST: To M (husband)?

PATIENT: And D sometimes—I just got frustrated.
THERAPIST: Was there anything especially upsetting?

PATIENT: No, just how I felt.
THERAPIST: Do you usually have that kind of reaction to the steroids?

PATIENT: Not usually that bad—but I always can tell when I've had the shot. But we did have couples counseling last night, which wasn't a good idea.
THERAPIST: Why is that?

PATIENT: Well, I really hurt his feelings—poor guy.
THERAPIST: Well, tell me.

PATIENT: Well, we talked about the phone—he has a habit of calling me up in the middle of the day from work and putting me on hold for hours—so I just hang up.
THERAPIST: So you get pretty pissed off about being forgotten?
[The analyst illuminates the contained message by identifying the affect involved in hanging up—being pissed off—and the source—being forgotten.]

PATIENT: Yeah. Also I don't want to call him. When he's gone, he's gone—but when he's home, he's home.
THERAPIST: Can you tell me about those feelings?

PATIENT: Well, when he's at work doing his own thing, I feel disconnected—he thinks that we are each just doing our own thing but are still connected. When people aren't there, I put them in a funny place in my brain.
THERAPIST: What's that funny place like?

PATIENT: I don't know—they are gone—you don't see them or think about them, so I don't want to call them.
THERAPIST: So I guess the phone calls disturb your effort to keep them in that funny place.

PATIENT: Right!
THERAPIST: So what happens to your feelings for him during these phone calls?

PATIENT: Well, it depends—but he usually ends up putting me on hold.
THERAPIST: So what is that feeling?

PATIENT: Well, disturbed—by being put on hold. It's similar to saying goodbye to my family—it used to be different, but now I just put them in that place and they are gone.
THERAPIST: So at some point it was very hard until you developed this place?

PATIENT: Yeah, the first few years.
THERAPIST: And you really missed them during this period? [Through the reference to saying good-bye, Sylvia returns to the theme of missing that the therapist identifies precisely.]

PATIENT: Yeah, a little is okay—I just overdo it.
THERAPIST: And how do you overdo it?

PATIENT: You're there but not there, so instead of integrating it into my life it upsets the balance. [Pause] [During this pause, the therapist had to consider whether Sylvia was moving the therapist's absence into the foreground in her shift to the
personal pronoun "you" or whether the foreground is occupied by the pressure of her memory of missing her family of origin.] 

**therapist:** It sounds like you feel that you have gotten too upset by this in the past—by the family separations. [Going back and forth between parents and then leaving Europe where her family lives and she grew up.]

**patient:** Maybe . . . I don’t know. I don’t want to not function, so I keep things very separate—I think I’m a little overorganized.

**therapist:** When you say that you keep things separate, do you mean the practical and the emotions? [In her response, Sylvia moves away from the past to return to the present with her current family, and the therapist shifts with her.]

**patient:** When my family is there I interact with them, when they are not I don’t.

**therapist:** So they go into a sort of cold storage? [The therapist is trying to demonstrate that the message includes an understated affective thread first by his phrasing of “too upset” and “practical and the emotions” and then by the evocative metaphor of “cold storage.”]

**patient:** Yeah, M got very upset about this.

**therapist:** What was it that you said?

**patient:** Well, that I did not want him to call me during the day.

**therapist:** Did he understand any of what we are talking about today?

**patient:** No, but do you get it? [Sylvia now calls on the therapist directly to do more than ask exploratory questions. She directly requests that he convey his understanding of her explicit and implicit message.]

**therapist:** Well, I think so. It seems like the upset that you experienced during separations has led you to develop this place—this cold storage where you keep people and that this place allows you to function—essentially go about your business without feeling the absences so acutely. And it seems your ability to keep M in this place is disturbed by these phone calls, which in themselves are frustrating because he ends up putting you on hold while he attends to business. The end result leaves you feeling that it would almost be better not to talk to him during the day and just wait till he’s home because that is the way you use to cope with separations. Does that seem right so far? [Sensing that he is giving Sylvia a somewhat complex explanation, the therapist pauses before going further to give her a chance to agree or modify.]

**patient:** Yeah. That seems right.

**therapist:** It also seems that there is this feeling that your ability to put people in this place—“out of sight, out of mind”—makes you wonder if you’re a bit coldhearted. [Reassured that Sylvia believes they have achieved an adequate mutual understanding, the therapist invites Sylvia to reflect on the cost to her of obliterating the image of people she cares about—being coldhearted—a concern she had expressed in the beginning of the session as being mean and hurtful to M.]

**patient:** Yeah, I guess it’s part of why I don’t call people as much—because it upsets things.

**therapist:** It upsets keeping them in this place [pause], and I would imagine it makes it tough to take them back in after the phone call.

**patient:** No, I’m pretty good at it actually [crying]. [At this point, the message contained in the message of Sylvia’s tears is unrevealed. Does she feel moved by the sadness of separation? Does she feel hurt by an implied criticism of her as coldhearted? Is she sad because of the loneliness of her withdrawal?]

[Pause]

**therapist:** Tell me, do you think you might have done the same thing with your father when you missed him? [With the disconnect that follows Sylvia’s crying, the therapist might have attempted to explore the meaning of her tears. Instead, he uses
his association to attempt to reopen the issue of missing by selecting her father, whom she lost twice, first through her parents’ divorce and second by moving from Europe.]

PATIENT: Probably—I don’t know.
THERAPIST: Well that would make some sense—it does sound like a technique that was born of some real emotional pain. [Sensing the need signaled by Sylvia’s intellectual “probably—I don’t know” to shift back and respond to Sylvia’s emotion, the therapist reconnects by acknowledging the source of her “funny place” as “real emotional pain.”]

PATIENT: Yeah—so how do I get rid of it?
THERAPIST: So it is something you want to get rid of?

PATIENT: Yeah I think so.
THERAPIST: Because of the way it makes you feel about yourself?

PATIENT: That and because I would like to keep better contact with people, and people are probably hurt by it.
THERAPIST: Have people said things to you about it?

PATIENT: Well, my oldest sister wants me to call even when things are not going on.
THERAPIST: But that would mean keeping her out of this place.

PATIENT: Right. Not that I don’t want to—I just find it difficult.
[Alonger pause]
[Sylvia had asked directly for helpful advice—“how do I get rid of it?”—and the therapist had parried her request. He might have recognized and possibly opened for discussion this interplay in which he answered one question and dodged another. Instead, he took up an earlier theme that had been left incomplete.]
THERAPIST: So you felt pretty bad about hurting M’s feelings last night? [An attempt to fill out the reference to hurting her husband’s feelings from earlier in the session.]

PATIENT: Yeah, because he was so upset that he couldn’t sleep.
THERAPIST: How did you think he was hearing what you said to him?

PATIENT: That I don’t care about him. [Pause] How do you think I can make it better for him?
THERAPIST: Well, do you think you could tell him about what we talked about today—explain to him that this is how you manage your feelings during separations?

PATIENT: Yeah, because it’s not like I don’t care.
THERAPIST: No, I don’t think so—just the opposite if anything.

PATIENT: That I care too much?
THERAPIST: I think that the intensity of how much you care about people, how you attach to people, drove you to develop this technique. [The therapist had made several attempts to approach the portion of Sylvia’s message about mean and hurtful from the standpoint of her being coldhearted. The disruptions that followed may have indicated Sylvia’s response to have been more one of feeling accused than of being invited to explore. The therapist now shifts his approach to his reading of the message as indicating the intensity of her posotive caring as the source of her putting people in the “funny place” in “her brain.”]

PATIENT: I think you’re right. [Pause] It does help to talk about it. It’s bothered me for a long time.
THERAPIST: Well, I think the way you have been thinking about it reinforced this idea of you being a coldhearted bitch.

PATIENT: Well, I know I’m not, but people think I am.
THERAPIST: Which really upsets you.

PATIENT: Yeah, but I feel like I don’t have any choice to do it before it’s done to me.
THERAPIST: How do you mean?
PATIENT: If I do it first, then I don't have it done to me.

THERAPIST: So have other people done this to you?

PATIENT: I don't know because of this mechanism. I think maybe I overuse it—a little bit is OK because it provides me with a little self-protection, but I think I take it too far, and it probably interferes with my relationships with people. [Sylvia is now able to be more reflective, “I think I take it too far,” and more open to exploring.]

THERAPIST: So maybe it feels like it keeps you from getting closer to people? [The therapist now moves from the part of the message he has emphasized, Sylvia’s coldness, to her emphasis on her loss of connection.]

PATIENT: Sure it does, because to be closer to someone you have to have them in your life, even if they are not there.

THERAPIST: Um-hm.

[Moderately long pause with Sylvia seeming to be comfortably thoughtful]

[During this reflective silence, the analyst recognized that the pattern of a call to connect during a period of absence fit an experience between Sylvia and himself when Sylvia had been away from therapy.]

THERAPIST: Tell me, during our summer break, was this a technique that you used?

PATIENT: Not so much while I was in Europe, but I did use it on the trip to California.

THERAPIST: And how did it go?

PATIENT: You were dead—I mean gone. I thought talking in between would help, but it didn't. [Through her metaphor, “dead,” Sylvia integrates the two themes of protecting herself against the pain and anguish of missing and the antagonistic coldness, the freezing to death in cold storage of the abandoner.]

THERAPIST: Were you aware of how that contact between trips affected you?

PATIENT: Well, you were gone.

THERAPIST: So talking between trips only upset things?

PATIENT: I guess so. But part of it is right because you were gone—but it only got worse.

THERAPIST: And do you think I went further back into cold storage during the California trip?

PATIENT: Right—but it was OK then because I didn't have to miss you—you were gone. [An additional theme contained in the message about missing was not brought into the foreground. Sylvia could say she felt OK about consciously missing her daughter because she could envision the little girl “happy to be back with her friends.” By contrast, Sylvia implies that, unlike her daughter, she does not feel she has been lovingly placed among friends. Moves in her childhood and adult life triggered a belief that she was left unprotected among strangers. She indicates she has felt too upset about abandonment and absorbed in self-protection to open herself to contact and friendship.]

I chose this clinical exchange partially because it is representative of commonplace communications. Nothing dramatic occurs, and nothing dramatic is discussed. Yet when the message containing the message is examined closely, the richness of its complex texture can be recognized. The theme of missing, once identified, helps to give unity to the entire communication. The richness of the message as delivered, however, derives for the many subthemes of past and present experiences that are touched on and from the nature of the interchanges between Sylvia and the therapist. For the most part, they work closely together, but at times he is pushing her to deal with the impact of her withdrawal. The message contained in the message of his linguistic choices, such as “coldhearted bitch,” reflects his intensifying the issue he is hoping she will be more willing to explore. Thus, the message contains Sylvia’s explicit and implicit communications to him and to herself, his explicit and implicit communications to her and to himself, and the overt and covert pulls and tugs being enacted between them.
REFLECTIONS ON WORDS

The exploratory psychotherapies are about words and relationships. A skeptic might say, “Well, so is life, so what distinguishes therapy?” The communication during exploratory therapy depends on a unique combination of words and relating. The words and the emotions they convey and elicit when exchanged between two people who have no other integral connection with each other makes it possible for a unique relationship to form. The relationship as it forms provides the safety needed for the words of both therapist and patient to convey more directly the thoughts and feelings of each. The relationship as it forms and shifts provides itself a centrally rich source for exploration of what is transpiring between them that requires words to carry out.

Their relationship can bring patient and therapist together with safety, humor, and the sharing of pain and joy. An interpenetration of mind/body states often is achieved through implicit nonverbal communication, but wisdom about one another is enhanced by words. A therapist identifying and designating a feeling or motive a patient is groping to recognize provides the patient with an illuminating focus that the dyad can use to map a whole realm of experience. The theme of “missing” in the session with Sylvia is one example. In another example, I helped a patient to identify that in a series of actions he was taking, the common goal was revenge. Once identified, “revenge” provided a handle to crystallize and organize his thinking. Alternatively, words can form buttresses against organizing thinking if they are used to concretize experience. As an example, a young boy had suffered the painful humiliation of an auditory processing disorder in preschool. Subsequently, he resisted all efforts his parents and teachers made to help him by insisting that he was stupid. This word, having delusionlike intensity and rigidity, offered no opening for consideration. Only his talents for athletics lay outside the wall of impenetrable resistance that consolidated around his universal answer of “No. I’m too stupid!”

What, then, is the distinction between “revenge,” which as a designator opened a patient’s realm of experience to recognition and discussion and “stupid,” which closed down on consideration of past and present experience? First, “revenge” filled the patient’s desire to conceptualize his experience and motives with clarity. Second, revenge became useful for therapist and patient to use as a metaphor to link past and present experiences. In contrast, “stupid” had no metaphoric ambiguity for the boy. It was as concrete as if it were a physical weapon used to beat him, and he was using it both to fend off and to wound others. Only through the nonspecific aspects of a therapy relationship and the initially concrete, repetitive use of play could its metaphoric use as a communicative word be restored. A therapist’s sensitivity to the nuances of words, and the behavioral communications that accompany them, helps to move understanding from the limitation of concrete usage to the flexibility of metaphor.

In this chapter, I offered the guideline of utilizing as fully as possible the message as delivered. In chapter 5, I will consider further the nature of verbal communication. A patient’s narrative account of her experience may be full of those orienting details and specific information that allow for easy comprehension. Unfortunately, a patient’s descriptions often are either too terse or too discursive for a therapist’s adequate understanding. Filling the narrative envelope is then needed for progress to be made.