**Listening Psychodynamically**

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*There are no conflicts of interest for this episode*

This is the beginning of a series on psychodynamic therapy, one of the most evidence-based psychotherapies for most mental disorders including anxiety, depression, and personality disorders such as BPD. Our approach will focus on components that work across psychotherapy modalities (sometimes called common factors).

In today's episode of the podcast, we will be discussing the skill of listening psychodynamically. Listening as a therapist or psychiatrist increases connection with the patient by regarding attachment (the interpersonal emotion) and looking for what is strong and adaptive about the patient. For adaptive reasons, memories that are traumatic are often guarded by fear, shame, self-hatred, and many other types of defenses, both conscious and unconscious. Increased connection allows the patient to feel more at ease to tell their story. The shame, self-guilt, self-disgust, and fear of not being enough or being found out melts as we listen for the adaptive reasons behind thoughts and actions. When someone feels connected in the midst of their most distressing memories and thoughts, they will feel less alone and isolated.

We all want to feel heard and understood. As mental health providers, growing in this area is a gift to our patients. It is quite possible that one of the biggest struggles people face is to not feel heard and understood enough. Good listening is a gift, something unusual. Being heard, being truly understood, or understood more fully, is a yearning that we hope this episode gives you as we share some practical techniques.

If some of the concepts are new for you, I recommend listening to this episode several times and even discussing the novel components with other professionals. Listening in this way will take everything you have. Although we value it, and love doing it, it will bring you into contact with emotions and fatigue that will stretch you in new ways. You will yourself need someone to give you this gift, as well.

# Listening: An Active Process

- Let the patient be the authority on their life and you be the student.
- Aristotle said that hearing contributes most to the growth of intelligence and hearing is crucial for receiving communication (Jackson, 1992; "On the Soul").
- "Listening in a professional capacity is a disciplined, meditative, and emotionally receptive activity in which the therapist's needs for self-expression and self-acknowledgement are subordinated to the psychological needs of the client" (McWilliams, 2004 p 133).
    - This means that we are listening in a way that is rare in this day and age.

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- Not listening for your own needs, but primarily for the clients' needs and subordinating your own, which is a meditative task.

- "Most of the ways that therapists talk during the clinical hour are intended to demonstrate that they are listening" (McWilliams, 2004 p 134).
    - Dr. Puder says the majority of his talk is to show that he has been listening. And not just listening in the here and now moment of the client, but listening across sessions and showing deeper levels of empathy that are experienced as pleasurable.
- Listen to their moment-to-moment change in emotions.
    - Try to enter a bit into their feelings, be present with them, mirror the emotion, use their own words, ask them to find their own words.
    - If we do not understand why they are sad, we should stay with it and ask them more questions, having them deepen our understanding of it. Once they feel that we truly understand, their affect will change. When people feel heard, deeply understood, it is pleasurable.
    - If we do therapy right, it allows a patient to explore themselves: "The appropriateness of any intervention or therapeutic stance should be judged by the criterion of whether it increases the patient's ability to confide, to explore more and more painful self-states, and to expand access to more intense and more discriminated emotional experience–in other words, to elaborate the self" (McWilliams, 2004 p 135).
    - Shame: When a patient looks down, it is a possible indication of shame.
        - It is not that they are continuing to explore things they know they want to share, but things they did not even have access to until you listened in a way that reduced shame and fear and, therefore, allowed them to elaborate and to talk about themselves in deeper ways.
        - Dr. Puder says it is hard to express in an audio monologue what he might say because it is intuitive and it is real. It is a real relationship. But the gist is that he says something like:
            - "It is understandable that this is really hard to talk about."
            - "You are entitled to have a difficult time talking about this."
            - "I can understand why talking about this must be difficult."
            - "Perhaps as you talk about this you feel uncomfortable."
        - Try to find the adaptive function:
            - "I hear switching to a new doctor is hard. I think that is a common experience. I think it is adaptive to be hesitant at first in what you share. We are just getting acquainted and it's early in our working together."
        - Be aware and very cautious when asking "why" questions. Why questions are likely to arouse the same defensive, emotional reactions that occurred

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when the patient, as a child, was asked "Why did you do that?". At times, "Why?" can communicate disapproval. For example, you ask, "Why do you feel that?" and they say, "I DON'T KNOW! Aren't you the doctor?!" Many experts suggest never asking why.

- Anger/Frustration:
  - “Would you say, as you mention this, that you feel frustrated?”
  - Find the adaptive function: “Your anger here seemed to have the goal to protect you and your family.” “Your anger likely kept you alive!"
  - People feel guilt about being angry. Guilt is the turning of anger on oneself.
  - With anger, listen for the goal that existed before the anger came up. Anger is the energy to overcome the obstacle. Anger is adaptive and life saving.
  - We hear thousands of comments like “don’t be angry” that might be keeping us from consciously experiencing anger. This is why shame often surrounds anger.
    - Someone who has a high amount of shame surrounding anger may score very low in the N2 Anger/Hostility subdomain of neuroticism. Whereas, they may score average or above average in everything else in the neuroticism domain. They could also be high-trait agreeable, where it is hard to differentiate themselves from others or harder to get in touch with their desires/emotions. A lot of patients come in without much access to a conscious understanding of anger.
  - They may feel anger towards us. That is also good, but hard to express.
  - Anger often seeks to control. When the anger is not pointed at overcoming the obstacle, listen to where it is pointing.
    - Reaction formation: Defense, where the impulse is pointed in the opposite direction. For example, instead of being angry towards your partner, you do something good for them. The defense is adaptive and helpful and should not be shamed and pointed out in a way that would make the person feel worse for having it.
    - Having compassion for the defense itself is important and seeing the defense as adaptive and the role of the defense. It can be adaptive to have anger. Not feeling upset about them having those defenses is very important.
- Sadness
  - Sadness is often associated with the loss of something. This could be the loss of a loved one, an ideal, a dream/aspiration. Let’s say there was a goal someone had and the anger was no longer able to move them past

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the obstacle towards the goal. They would need to grieve the loss of this thing—grieve the loss of the ideal family that they desired to create or grieve the loss of finding that perfect partner. There are a lot of different types of grief that could come up.
        - We are not trying to put on someone else what isn't there, we are observing what is there. We are allowing the patient to teach us and help us understand on a deeper level what is going on.
            - "Perhaps you are feeling sad as you say this?"
        - Find the adaptive function: "It makes sense that you feel sad here. I think crying and feeling sad shows how much you valued your dad and, therefore, the loss hurts that much more."
        - When we cannot overcome the obstacle, we often need to grieve the loss of the goal we desired.
    - Disgust
        - "I am wondering if you feel disgusted or revulsion here?"
        - "I hear you feel disgusted…"
        - Find the adaptive function: "Feeling disgusted by how your sisters turned on you and cast you out of the family makes sense; it sickens you to see the level of their resentment and bitterness."
        - If the person feels a revulsion (which is another word Dr. Puder likes to use for disgust) towards something, could that something be poison in their mind or in their body? People will feel disgust towards different things and that can be important to listen to.
    - Fear
        - "I hear a deep concern or perhaps fear regarding this"
        - "Might there be a deep concern or perhaps fear regarding this?"
        - Find the adaptive function: "After your traumatic event, it makes sense that you would no longer want to put yourself in that situation, so it sounds like you are trying to protect yourself."
            - How is it helping/protecting them? Sometimes when the fear response is really intense, they may dissociate, get lightheaded, and disconnect; that could also be adaptive. Maybe it is not adaptive in the moment that it happens, but, historically, it may have been adaptive.
            - Maybe they are feeling fear when they describe anxiety. Or it could be excitement, but they call it anxiety/fear.
        - As we listen to someone who says they have "anxiety," this might actually be excitement.
    - Pain

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- When we see pain, it is a visceral manifestation of emotional content. This is usually in the context that Dr. Puder sees it. It is very helpful to be present with someone in the midst of pain. Dr. Puder uses the example of when his kids get hurt, he thinks about how he can be present with them. He focuses on holding them and gives them words to help describe the feeling. Moving to help them is powerful.

## Listen for resistance

- Focus on what content they are resistant or avoidant to talk about.
  - Dr. Puder does not particularly like the term "resistance." While it is the classical psychodynamic word, a patient might define resistance as anything that is moving them away from moving forward in life or anything that is moving them away from discussing certain content. Instead of seeing resistance as a negative thing, he perceives that it is helpful to talk about and focus on the content they are resisting talking about.
  - For example, they may feel something that is inside of them, if they were to speak it out loud, would cause you to think less of them and they would have incredible shame. So they feel resistance in sharing it. I find it so much more helpful to talk about the difficulty of talking about things and how they might perceive me in hearing the content of what they are about to say and then to empathize with the distress of that. When the patient can feel okay having apprehension talking about something, they can see that we are working together, and they are not alone in the midst of the difficulty of talking about something.
  - It is hard to feel shame and togetherness at the same time. Togetherness reduces shame. It is hard to feel lonely and connected at the same time. So, if we are connecting, the patient will feel less lonely and less shame in the here-and-now of the therapeutic moment. That is really hard to get in self-help books or poor therapy—another person present with you in a way that is togetherness, close, listening… for you.
  - Often these patients have felt so much judgment that sharing anything critical with us or things they consider shameful is stifled by the intensity of their fear of judgment from you. Over time, we learn that patients are so much like us.
  - They may imagine that we think critically of them, but our goal is to understand, holistically, the completeness of their life in a way that is not condemning or judgemental. It is the opposite. We are trying to see how they are doing the best they can, given the circumstances they have

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experienced. There is a lot of courage and bravery in all of our patients. We should not just say things for the sake of saying them. We should never say something we do not believe. But we should try to be as honest to our own internal experience as possible. This is where we have to do our own work. If we are being triggered, it is 100% necessary to work through the things that are triggering factors for us.

- Observe that defenses (sublimation, reaction formation, intellectualization), although they reduce anxiety, may misrepresent reality.

## Listen to and notice recurrent themes and patterns

- Point out common patterns.
- Example: If everytime you say something to the patient, he says "No, that's not it," thank them for correcting what you misunderstood. Maybe empathize with the difficulty of their experience of you not getting it right; of you not understanding them perfectly.

## Listen to developmental themes

- Before verbal language comes, connection is non-verbal; right brain to right brain nonverbal attunement.
  - Emotional attunement.
    - It is moving attunement. There are movements we do together. For example, before children are verbal there is a lot that can be communicated in a nonverbal way. It is unfortunate that some adults think connection with a child does not start until after they can talk. We can mirror and connect in a nonverbal way; and most importantly, kids *want* to!
- Assume an attitude of "reverie," like a good maternal object, receiving toxic stuff from patients and then giving it back to them in a detoxified form (Wilfred Bion).
- Create a "holding" place for patients in which they have a transitional or play space (Donald Winnicott).
  - A nonverbal attachment emotional response is often very black and white. It is a very strong anger when it comes out. It sounds different. It is best to attune without getting into your left brain. Example: “It is very distressing to think I never loved you.” “It is very distressing to think that I am being critical of you.” That is the medicine for the attachment distress.

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## Listen to the patient's idiosyncratic meaning

- "It is as though he listened and such listening as his enfolds us in a silence in which at last we begin to hear what we are meant to be." - Lao-Tzu
  - The listening brings forth the self. The child is pretty far from their emotional desire and as we attune to the emotion, the child becomes more able to see the emotion or desire in themselves. They feel less shame around emotion or desire. They feel it more freely and feel it when you are not around. They feel it more consciously in a way that is not distressing, which really helps the self come forward.
- Everything that is said has meaning. Nothing is trivial. Sequences are connected and thoughts and feelings are connected.
  - Imagine approaching someone with the mindset that what they say has meaning. Inevitably they will feel meaningful. They will feel that their thoughts are important and are there for a good reason.
- Omissions (what is not said) in the patient's stories and memories are important.

## Listen to the patient's interpersonal relationships

- How was their relationship with their primary caregivers growing up? Their relationships with friends? Their relationships with past therapists? Their relationship with coworkers or bosses? How do they attach? Feel connected? What happens in the lapses of attachment? What happens in the midst of intimacy?
  - So much of life is connection. So much of life is interpersonal intimacy. So much of the success of the work we do with patients will be on the meaningfulness of future relationships or the ability to connect with more people in a more meaningful way, leading them to have richer friendships and relationships.
    - Consider, the nature of abuse is to isolate and to make the victim fully immersed in the singular relationship with the abuser and to create a space where all of the psychological needs of the abuser are met while none of the victim's needs are met. The abuser becomes the sole source of attachment and that allows for the abusive control. Abusers isolate.
    - Imagine the opposite of that—that the patient may have more fruitful and meaningful relationships with a multiplicity of people. These new relationships and new connections can be celebrated.

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- If a patient enters into an abusive relationship, often, the abuser will work to split the therapist and the patient, because the abuser wants to be the only one connecting with them. They will work to tear the patient away from the family and isolate them. Until we are aware of that abusive dynamic it is hard to stop it.
- Also, listen to the interpersonal relationship they have with us. It is important because as we build trust and connection and take away loneliness when talking about the past, that trust and loneliness for those traumas will be experienced differently. Imagine bringing about a memory and inserting a loving person. Schema therapy does that directly. It happens differently in different therapies. I think what is important is that we have trust and connection while they are talking about the memory. And if the memory causes a trauma, dissociation, and/or shame, they will often, in the midst of the memory, have challenges in the interpersonal experience with us and with the sharing of the trauma. This is really where the work of therapy is very unique.
- A more dynamic focus would be the ability to talk about the transference in a way that decreases shame/anxiety.

## Listen to what is going on in the therapy relationship

- Dr. John Tarr (Dr. Puder's long term mentor): "I participate, I respond, I react to my patient and his or her verbal and non-verbal communications. At the same time, I observe what's going on, what the patient is saying and what he or she is not saying--evidences of anxiety. I become aware of what I am feeling and thinking, and where, if anywhere, the interchanges are going. I am participating and observing and wondering how best to formulate to the particular patient what I observe."
- Listen in a way that notes what the patient is *trying to say* about your relationship.
- Patient: "I feel lonely even when I am with people." Doctor: "Do you feel lonely here with me now?" Patient: "No, I feel you understand me somewhat." Doctor: "I want to know if there are any times where you feel more lonely in our sessions. It will be valuable to help me understand what is going on between us."
    - Consider the use of "somewhat." What would make the interaction feel more comprehensive? Where are the gaps between what has been said and where they are not being felt and understood?

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- "My work, during this arduous first year, consisted of containing my own distress sufficiently that I could provide an environment in which Ruth could continue to tell her story" (McWilliams, 2004 p134-5).
  - Hearing the stories of some patients may cause us distress. We often listen to very troubling content. Managing our own distress efficiently could be the main task of the work together. Getting some good supervision and therapy of our own goes a long way to help.
  - Think about the therapy relationship as essential to the goals of the treatment and it makes it easier to weather through the storms of the ups and downs of a person's life for longer term work. This cannot so much be taught, as it has to be experienced firsthand. For many of these things have to be experienced and processed with a trusted mentor or coach.
  - If you are experiencing distress and do not have a supervisor or therapist, reach out to a colleague. Process through the distress.
- "Are you feeling comfortable talking with me? Is there any way I could make it any easier for you to be frank and open?" (McWilliams, 2004 p 137)

## Listen to the exploration of fantasy life and dreams

  - In psychodynamic theory we value fantasy and dreams because they give a glimpse into the unconscious. They give us a glimpse into what is going on at a deeper level. We want to pay attention to the details and emotion, the way they tell the dream or tell the fantasy, the emotions they feel in the here and now about telling the dream. We want to focus on decreasing any shame they feel about telling us the fantasy or dream. We want to focus on helping the patient free-associate the dream or fantasy when a particular image or something comes up. What does that mean? Or what else comes to their mind as they think about that?
- Listen to the content of the dream (both details and emotions), the way they tell the dream, and the emotion they feel in the here and now about telling the dream.
- Focus on decreasing any shame they might feel in telling you about fantasies or dreams.
- Focus on helping the patient free-associate particular portions of the dream/fantasy.
- If they have positive feelings towards us this may also be distressing. It can be helpful to explore those feelings with words, as well. Positive transference is part of what makes good therapy work, but other times it is distressing or overwhelming.

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# Further reading:

McWilliams, N. (2004). *Psychoanalytic psychotherapy: A practitioner's guide*. Guilford Press.

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