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The Art of Listening

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Introduction

We are pleased to introduce two new on-line features to our professional community: The Monograph and The Salon. These innovative, virtual venues are available to AAPCSW members for publishing and disseminating our writing electronically. Accessible on our website, both venues promote AAPCSW and encourage members who have not written papers for presentation to do so.

The monograph appears as a compilation of articles on a single specialized subject. Our premier issue, The Art of Listening, serves as a vehicle for larger exposure of papers presented at our 2015 conference of the same name.

This material may be used freely in the spirit of open access for teaching, discussion with colleagues and personal use as long as attribution to the AAPCSW monograph and its authors is included.

Comprising various subjects and writing modalities, The Salon is designed to function as a virtual gathering space for members, a place where thoughts may be easily shared. It offers opportunity for reflection on and expansion of ideas and associations generated by having attended or presented at our national and local conferences and workshops.

We are excited about our inaugural issue of each venue and look forward to receiving future submissions. Please contact us with any questions you might have. Comments may be sent to: administrator@AAPCSW.org.

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The Art of Listening to Couples Diagnosed with Dementia

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Abstract

Dementia is a complicated disease. It impairs brain function and assaults human capacity and identity. It is said to rob the afflicted person of his or her self. A diagnosis of dementia creates fear in the bravest and humility in the most arrogant. However, the challenges created by dementia are more than the loss of cognitive functioning. The challenges are, paradoxically, in the damage to relationships and social support networks, which are the best interventions to moderate the symptoms of fear, anxiety, and decline. In this paper we suggest that the art of listening to the stories of couples diagnosed with dementia helps to preserve relationships, and we suggest that a psychodynamic sensibility of empathic appreciation facilitates a gentler course of treatment that emphasizes coping with relational shifts and personal loss. A framework based on relational psychodynamic concepts and attachment is used to describe the dynamics discerned from couples' narratives.

The Art of Listening to Couples Diagnosed with Dementia

The shift to a relation-centered psychoanalytic treatment parallels the shift from person-centered to relation-centered health care. Management of an illness happens in a network of relationships (Spira & Kenemore, 2002). The application of relational psychodynamic ideas to couples with dementia is clearly limited in the literature. This paucity of scholarship is surprising in light of the long-time recognition that supportive intimate relationships can provide a buffer against stress and emotional disturbance (Berg & Upchurch, 2007; Hirshfield, in Keady & Nolan, 2003).

However, the reintroduction of intersubjectivity and interpersonal approaches to clinical practice should extend to a new understanding of the experience of living with an illness like dementia.

Concepts like attachment (Bowlby, 1969), narrative coherence (McAdams, 2006; Fonagy & Target, 2007), mutuality (Aron, 2001), and relationality (Mitchell, 2000) have become familiar in psychodynamically informed papers that describe the dynamic between clinicians and clients, but also in the scant literature on the dynamics of couples and families affected by mental or physical illnesses (Horowitz, 2012). Horowitz (2012) proposes a potential benefit to understanding psychodynamic relationships with clients who have severe mental illness. He believes that understanding a client's communications and behaviors would best be achieved in the relational dynamic.

The use of relational therapy with couples challenged by dementia is vital. There is recognized reciprocal influence between the experience and management of illness and interpersonal relationships. With an illness that diminishes a sense of personal identity, the endurance of relational strength can mitigate the sense of loss. The people in a relationship create a way of experiencing the illness together, not just separately. Strengthening a relationship as a valuable means for maintaining one's identity may mitigate the sense of personal loss associated with cognitive decline.

The Context of Dementia

Dementia involves the irreversible and progressive decline of cognitive functioning—

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thinking, remembering, and reasoning—in addition to causing changes in behavior that interfere with a person’s ability to be independent in his or her daily life. Dementia ranges from an early, mild stage, when it starts to affect a person’s abilities, to an advanced stage, when the person is completely dependent on others for his or her most basic needs (National Institute on Aging, 2015). There are many causes of dementia, all resulting in brain cell death.

Alzheimer’s disease is the most common form of dementia for people over the age of sixty-five. Other dementias include Lewy body dementia, frontotemporal disorders, and vascular cognitive impairment. Many individuals have a combination of two or more disorders; for example, Alzheimer’s disease and vascular cognitive impairment often occur together (Rahimi & Kovacs, 2014).

Individual and Family Perspectives

Over the past ten to fifteen years there has been increasing evidence detailing the subjective experience of living with cognitive changes. Documentation regarding the subjective experience of dementia has included autobiographical (Davies & Gregory, 2007; Ingersoll-Dayton, et al, 2013) and exploratory interviews (McGovern, 2011; Ryan, Bannister, & Anas, 2009). Studies have found that persons with dementia can provide accurate and meaningful information about their experiences. Other studies (Kuosa, Elstad, & Normann, 2015; Menne, Kinney, & Morhardt, 2002) have found that individuals with dementia wish to continue the lifestyle that they have become accustomed to, maintaining their long held beliefs and values, contributing to society, and fighting to hold on to their autonomy and independence for as long as possible.

There is a general consensus that caring for a person with dementia is challenging for caregivers. In the 1970s, the focus of concern was on the caregiver. The notion of “caregiver burden” was developed to describe the increased health risks, emotional strain, and financial worry that accompany their work (Gwyther & George, 1986; Pearlin, Mullan, Semple, & Skaff, M. M. 1990). Sabat (1994) warned that this relationship could cause the caregiver to believe that his or her charge’s dementia is more advanced than it actually is. This would limit the caregiver’s ability

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to recognize the cognitive capacities retained by the person with dementia.

When a diagnosis of Alzheimer's disease is made, patients often find themselves excluded from relationships, a social disenfranchisement (Kitwood, 1997; Beard & Fox, 2008). The lives they organized around multiple roles and identities are reduced to "Alzheimer's patient." This process of depersonalization is in part a defense against the pain of seeing a loved one deteriorate. However, in *Living the Labyrinth*, Diana Friel McGowin's 1993 memoir about living with early-onset Alzheimer's disease, she described the personal experience of being: "...every molecule seems to scream out that I do, indeed, exist, and that existence must be valued by someone!"

Recognition by others is essential for people with dementia to sustain a sense of self worth. For therapists, understanding the interpersonal aspect of dementia requires an appreciation of a patient's relationships as they existed before the onset of the disease. It is important for clinicians to understand the complexity of these relationships, their preexisting dynamics, strengths, and vulnerabilities (Davies & Gregory, 2007). Acknowledging that the relationship as a unit is impacted by the disease shifts the emphasis of therapy from the caregiver and the patient individually to the dynamic between them.

Early in the process of the disease, both the patient and his or her caregiver are confronted with the beginning of progressive losses that indicate significant changes to come in their capacities and roles. Keady and Nolan (2003) present a way to observe the interactions of couples by considering the characteristics of their past relationship. The authors describe potential styles of interaction, including "working together" (facing the issues jointly), "working alone" (recognizing the presence of disease but concealing the symptoms), "working separately" (both partners exerting great effort, with one concealing the symptoms while the other one becomes more vigilant), and "working apart" (having little interaction about the disease). The couples who work apart may have already been in a poor relationship at the time of diagnosis. As the condition progresses, such relationships are at risk for further deterioration, with the caregiving spouse feeling trapped (Keady

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& Nolan, 2003).

The various ways that couples manage dementia, from early stages to later stages of the disease, can be understood through psychodynamic formulations, including styles of attachment, interactional dynamics, and the construction of their narratives.

Dyadic Interactions and Attachment

Internal models of attachment affect the enduring emotional bonds between significant others (Bowlby, 1969). Well-being in caregiving and care-receiving can be understood by looking at the attachment styles of each person in the dyad.

Secure attachments may facilitate acceptance of the changes caused by the progression of dementia, while insecure attachments are associated with avoidance, potential isolation, lowered self-esteem, and depression (Morse, Shaffer, Williamson, Dooley, & Schulz, 2012; Cooper, Owens, Katona, & Livingston, 2008; Ingebretson & Solem, 1998). Secure attachments are associated with Keady and Nolan's (2003) formulation of working together. Both parties acknowledge the disease and rely on the strength of their relationship to cope with uncertainty. Ingebretson and Solem (1998) describe three types of messages in relational interactions that are indicative of insecure attachments: anxious attachment, exaggerated self-sufficiency, and compulsive caring. Each of these internal models reflects conflict between the wishes and expectations of one of the partners. The couple has to find a way to care for the spouse with dementia, a relationship beyond the illness, and self-care. These styles of insecure attachment may reflect problematic relational histories, like what Keady and Nolan call "working apart" (2003).

Attachment styles are associated with caregiving as well as with coping with stress (Nelis, Clare & Whitaker, 2013; Kokkonen, Cheston, Dallos & Smart, 2014). In fact, attachment reactions are activated at times of vulnerability and stress, such as the progression of a chronic illness like dementia (Nelis, Clare & Whitaker, 2013). When the loss of an attachment object occurs, as in the unavailability of a spouse with dementia, anxiety and anger can be activated.

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Piiparinen and Whitlatch (2011) note that a focus on the experience of loss affects the ability of a couple to integrate the emotional costs of dementia. According to Keady and Nolan (2003), couples who characteristically work together are able to rely on the strength of their relationship to manage changes. Such secure attachment helps partners cope with and accept the diminished capacities of the spouse with dementia; they can respond with less impact on self-esteem and on the endurance of the relationship. Insecure attachment styles are more likely to result in extreme reactions, such as avoidance or compulsive clinging, both of which interfere with empathic connections (Ingebretson & Solem, 1998).

Relational Dynamics

Attempts to describe relational well-being have been made in a small body of literature on the dynamic interactions of couples. Hellström, Nolan, and Lundh's (2007) study looks at the effects of dementia on the daily functioning of a couple. Their qualitative analysis revealed that working on the "sustainability of couplehood" helped to maintain and enhance the quality of both partners' lives.

The character of relational interaction can be understood through Mitchell's framework of relational dynamics (2000). He describes "four basic modes" of interaction. The first is "non-reflective behavior"; that is, ways of knowing and understanding one another that evolve from reliable and consistent patterns of behavior and form the basis of secure attachment. Couples therefore co-construct daily patterns of behavior in their interactions; their exchanges have a reciprocal influence upon each other.

Bretherton (1991) notes that the expectations partners have for each other are based on earlier "contracts" in the relationship. These contractual arrangements are often unspoken but reflect patterns of attachment. Relationships that are deeply affected by the loss of individual independence that comes with dementia may forget the strength of these patterns of attachment; however, couples that rely on well-established patterns of interaction, despite the changes created by the illness, seem to sustain open communication, including conversations about the disease (Radcliffe, Lowton &

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Morgan, 2013).

Mitchell's second mode of relationality is the "permeability of affect"—"the shared experience of intense affect across permeable boundaries"—and it can be both a strength and a source of conflict for a couple. Someone's affective resonance with his or her partner can be a window onto the affective experience of the other. However, while this enables greater empathy, it can also elicit a defensive disengagement from the person in order to avoid the pain of the shared emotion. In listening to couples, astute clinicians may hear and observe the affective filters that each partner employs. As couples tell their stories, listeners should interpret signs of permeability or disengagement. The way that these affective responses manifest in extreme behaviors is similar to the themes of compulsive caring or self-sufficiency described by Ingerbretson and Solem (1998). These responses also correspond with Keady and Nolan's description of couples who "work alone" or "work separately" (2003).

Mitchell's third relational dynamic is the "organization of experience into self-other configurations. He writes that we imbue others with specific traits so that they play specific roles that satisfy our needs and expectations. In couples where one partner has dementia, this is a complicated dynamic. It is probable that partners will retain perceptions of each other from prior to the onset of dementia, postponing the acceptance of the reality of the disease's symptoms and progression. For instance, a spouse may explain her partner's dementia-related emotional bluntness and withdrawal as typical of his personality, typical of a man who was always preoccupied with work or other considerations. Normalization of symptoms enables partners to forestall the reality of change. As the individual with dementia needs more care, the spousal caregiver often finds him or herself managing the tasks of daily life more than the emotionally expressive aspects of the relationship. Some partners resist a self-perception of caregiver. However, many are surprised to recognize that the relationship may have always been organized around roles of caregiving and care receiving.

Early in the illness, the diagnosed person is quite capable of engaging in life activities and

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sustaining a sense of agency. The process of gradually reducing expectations of capability and of accepting changes in the relationship is challenging. O'Shaughnessy, Lee, and Lintern (2010) reported that participants in their study grieved the loss of their spouses as "adults"—the qualities the person had brought to the relationship—in addition to the loss of their own sense of self as it related to their spouse. Changing expectations and contracts is particularly difficult when one spouse needs the other to be consistent in a particular role in order to feel safe. Letting go of expectations as opposed to letting go of the relationship is an important option to consider in the couples' interactions. Similarly, Mitchell's (2000) final interactive dynamic, "intersubjectivity," describes a relationality that recognizes the contributions of both partners to the creation of the relationship; "mutual recognition of self-reflective agents." Mitchell's framework of relational interactions provides an alternative to understanding a couples' interactions based on limited verbal interactions.

The intersubjective view, when applied to couples with dementia, relies on meaning-making that includes verbal, nonverbal, and embedded processes (McGovern, 2011), which include the first relational dynamic in Mitchell's hierarchy, "non-reflective processes."

Consideration of all four of these interactional dynamics changes the view of the relationship from one that depends solely on cognitive processes, and it forces practitioners to reconsider how couples with dementia communicate and resolve problems.

Listening to the Narrative

Narratives of relationships are shaped by the complexity of intrapsychic, interpersonal, and sociocultural dynamics (McQuaide, 1999). Some of the ideas previously described enable us to define the sources of strength of an enduring relationship, as well as barriers to it. Exploring the dynamics of the couples through the stories they tell allows clinicians to respond with empathetic understanding. This is enhanced by understanding of attachment styles and relational dynamics. Asking for and hearing stories that illuminate and create the relationship can provide an opportunity for couples and

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clinicians to see how the relationship provides care for both partners. This can assist them in managing their challenges.

Scherrer, Ingersoll-Dayton, & Spencer (2014) used narrative storytelling techniques to help couples find meaning and strength in their shared lives. They were able to build a “team of witnesses” who saw the individuals and the couple as more than a diagnosis of dementia. A growing scholarship on the stories of couples facing dementia reveals that the coherence of the narrative is the most important predictor of the longevity of the relationship. For instance, Ingersoll-Dayton et al. described a five-week intervention for individuals with dementia and their spouses/partners. This “Couples Life Story Approach” focused on helping the couples communicate, reminisce about the story of their relationship, find photographs and mementos of their past, and, finally, develop a book incorporating the memories. The authors found that this approach highlighted the couples’ strength and resilience. This intervention helped to create a coherent story by exploring the subjective experience of the diagnosis on the person with dementia as well as on their relationship.

Hellstrom, Nolan, and Lundh (2005) reported on a storytelling project in which the couples described their reciprocal and complementary roles in maintaining enduring aspects of both their relationships and of their individual contributions to the shaping of their life together. Facilitating storytelling is a means of recognizing each person’s part in the relationship. The stories couples tell can then help a clinician to understand the dynamics of couples challenged with dementia.

This kind of narrative gerontology has been a source of study that is compatible with a psychodynamic approach. The empathetic narrative listener hears both the resilience and the patterns of conflict in a couple’s story, and its context and content show what can help them ensure continuity and endurance in their relationship. Much of what turns different people into a “we” is the mutual recognition of their strengths and weaknesses (Oppenheimer, 2006). Couples create together the meaning of illness as well as the processes by which they will manage the inevitable losses they will experience (Radcliffe, Lowton, & Morgan, 2013). This appreciation of couplehood rather than

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personhood provides an alternative to the deficit model of neurocognitive decline (Graham and Bassett, 2006). Psychodynamic sensibilities help clinicians help the couples to meet the long-term challenges of living with a difficult disease by making meaning out of their relationship.

Mitchell (2000) and McQuaide (1999) state that the goal of therapy is not to cure a disease but to sustain a relationship. The focus on the relationship as instrumental in the experience of dementia makes intuitive sense, since caretaking takes place in a relationship. McQuaide (1999) suggests the potential uses of psychodynamic questions for helping clients to deconstruct negative narratives. The couple's life experience, then, is not focused on loss and deterioration. The inevitable losses of dementia are viewed through the lens of a full life story. This process helps couples to mourn losses and also appreciate the sometimes forgotten strengths that have enabled them to endure hardship. Once the clients have told their story, further questions from the therapist can help them recognize the ambivalence and conflicts that may interfere with moving forward.

One experience common to the stories of couples with dementia is the fear and ambivalence about changing roles, from autonomy to dependency or from dependency to autonomy. Many couples prioritize the preservation of old roles and the powerful retention of early experiences. McQuaide (1999) writes that early in the disease process it helps to have conversations with more participation from the person with dementia.

Couples who engaged in a mutual recognition of the diagnosis and openly discussed their concerns were most productive in reinforcing their bonds of affection and appreciation, and in accepting uncertainty (O'Shaughnessy, Lee, & Lintern, 2010; Keady & Nolan, 2003). Marital partners often experience gratification by caregiving. This satisfaction is enhanced by the encouragement of the development of the couple's story or narrative.

Later in the disease, an essential role of the partner without dementia is to take over telling the story for the couple, having the knowledge and memory of the whole story. "When dementia brings loss of language, coordination, and memory, as with a fragmented image, the knowledge

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preserved in the relationship can allow the gaps to be partly filled in” (Oppenheimer, as cited in Morhardt & Spira, 2013, p. 39).

Particular attention should be given to the dynamic interactions of couples from the earliest points of diagnosis to the latest stages of the illness. While there are practical considerations, the clients that have engaged in mutual support and recognition of the strength of their relationship tend to fare better than those that see no alternatives.

Conclusion

Work with couples challenged by dementia is anything but linear. However, the awareness of the knowledge of interactive relational dynamics emphasizes the impact of the disorder on the relationship and the impact of the relationship on the disorder. Listening to couples challenged with a diagnosis of dementia is indeed an art. The listener must suspend judgment and evaluation and listen for the subtext of strength and endurance. It is worth noting, although outside the scope of this paper, that the listener’s own attachment style and affective permeability influences the understanding of the couple’s dynamics. Often there is a prescribed perspective—one focused on deficit and loss—offered in good faith by professionals. This may prevent recognition of the potential for continued quality of life and pathways to continued fulfillment through the relationship. Listening to the voices of the relationship supports a position of strength and resilience that outlives the illness.

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Habits of Mind, Habits of Heart: The Art of Listening

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Abstract

Over the years, psychoanalysts and mental health professionals have stressed the importance of listening, yet many of us sometimes find it difficult to listen well to our patients. The importance of good listening was recognized long before psychoanalysis or psychotherapy. Since the Axial Age (600–500 BCE) there has existed a noteworthy history of thoughtful scholarship on listening. This essay includes a brief review of the history of listening, a classification of some of the most troublesome impediments to it, and an example that illustrates my own listening difficulties.

Throughout are suggestions for those aspiring to be better listeners.

*Those unmindful when they hear, for all they make of their intelligence,
may be regarded as the walking dead.*

—Heraclitus (circa 500 BCE)

“Don’t just do something, sit there. Listen, be curious. Be open to experience. Be open to the patient’s inner experience and to your own.” These admonitions came stridently from one of my earliest postgraduate supervisors as I was beginning to learn the art of psychoanalysis. Yet despite her relentless passion and conviction, which resonate in my mind to this very day, it has taken me my entire career to begin to grasp the meanings and consequences underlying her exhortation.

In this paper we will explore basic questions related to the age-old conundrum of *how we learn to listen*: What does it mean to listen well? What are the consequences of not listening well? Does a lifetime of practice only begin to teach us how to listen to our patients, or ourselves? And how are listening and the therapeutic use of words related in practice?

The Popularity of Therapeutic Listening

Television’s Dr. Frasier Crane began his radio show by announcing, “Seattle, I’m listening.” His catchy opener exemplifies the primacy of listening that has developed in the psychotherapeutic community. In the analytic literature, much has been written about listening and listening skills. There are countless titles in which *listening* is central, for example: *Listening with the Third Ear* (Reik, 1983), *Listening to Listening* (Faimberg,⁶ 2005), *Listening Perspectives* (Hedges, 1983), and *Listening to Affect* (Fishman, 1996). A quick look at titles on the psychoanalytic archive Pep Web revealed 174 books, chapters, or articles in which the term *listening* was prominent. Clearly, *listening* continues to be an essential and vital topic for

psychoanalytic discussion.

Freud and Psychoanalytic Listening

Although Freud kept his clinical guidelines to a minimum, as if he didn't want to contaminate our listening abilities by offering too much guidance or direction (Ellman, 1991; Gay, 1987), he certainly had instructive things to say about how to sit with and listen to the patient. His comments about listening are a gift to us all. In his *Recommendations to Physicians Practicing Psychoanalysis* he described the mindset and stance the analyst must maintain in an analytic session, speaking of the “calm, quiet attentiveness” which he called “evenly suspended” or “evenly hovering attention” (1912,p. 111). Freud's (1913) instructions to patients are also intended to promote evenly hovering attention with respect to their emerging associations, thoughts, and feelings: “So say whatever goes through your mind. Act as though . . . you were a traveller sitting next to the window of a railway carriage . . . [etc.]” (p. 135). These instructions teach *both* analysts and patients how to listen more carefully—how to listen to the demands and yearnings of the unconscious. Freud's emphasis on free association and the necessity of a neutral stance (evenly hovering attention) were more on target than they have been given credit for being.

Listening Before Freud

We know that Freud and Western psychoanalysts were not the first to emphasize the importance of careful listening. The fundamental role of listening is found in many ancient written records, dating back more than 2,500 years. The philosopher Heraclitus, an exemplar of the Axial Age (600–500 BCE)—an era of major advances in science and philosophy around the world—wrote persuasively about the importance of listening while cautioning his students about the difficulties associated with effective listening. Here are some of Heraclitus's thoughts in verse fragments

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translated by Haxton (2001):

The Word proves
Those first hearing it
As numb to understanding
As the ones not heard.

Yet all things follow from the Word.

For wisdom, listen
Not to me but to the Word,
And know that all is true.

Those unmindful when they hear,
For all they make of their intelligence,
May be regarded as the walking dead.

People dull their wits with gibberish,
And cannot use their ears and eyes.

Many fail to grasp what they have seen,
And cannot judge what they have learned,
Although they tell themselves they know.

Yet they lack the skill
to listen or to speak (pp. 3–7).

Although there are many ideas in these fragments, the gist of it is that it is difficult to listen well. Also implied are warnings about some of the impediments to good listening. Heraclitus is concerned about how readily we jump to conclusions about what we've heard.

In the same time period, the Chinese humanistic thinker, Lao Tse, addressed the importance of listening and the inherent conflict that exists between listening and speaking (Waley, 1968). In the very first lines of the *Tao Te Ching*, Lao Tse¹ questions the role of language and its function in enabling us to differentiate one thing from another. For the most part, these lines suggest that language serves more of a limiting function than a helpful one. As language selects objects from the undifferentiated realm and names them, it also creates distance from—a

separateness from—the Unvarying Way: “The Way that can be told (spoken of) is not an Unvarying Way; The names that can be named are not unvarying names” (p.141).

This cautionary note permeates Taoistic thought and other religious philosophic movements of the Axial Age, including Buddhism. We must note the limitations of naming, we must be cautious when we express something. The *Tao Te Ching* essentially claims that in our attempts to use words, we can never get it just right. Words simply attempt to set forth or illuminate the ineffable. This cautionary note is reinforced later by Lao Tse in lines from Chapter LVI: “Those who know do not speak; Those who speak do not know” (Waley, 1968, p. 210).¹

From Lao Tse, we get not only his cautionary note about the dangers of speaking (especially thoughtless speech), but also implications about the role of listening. Our main job is to listen—and to listen carefully—so we can be open to experience, to The Way. To be at home with self, other, and the world, “Don’t speak, but listen.”

Moving Forward in Time

More recently in the West there has been the tradition of the Trappist monastic order, exemplified by Thomas Merton who wrote voluminously about how essential it is to remain *in the quiet*, in silence, in listening (Pennington, 2005). The Trappist monk listens for the voice of God, for directions from God, for communion with God. Other religious groups also go into quiet retreat and prayer for lengthy periods, including Benedictine, Eastern Orthodox, and Jewish mystical sects, as well as the Eastern meditative traditions. For example, in a presentation at the

1 The actual authorship of the *Tao Te Ching* is uncertain. Muesse (2007) argues that “most scholars believe that early Daoists created Laozi [Lao Tse] to provide an author for the Daodejing [Tao Te Ching] and a counterpart to Confucius” (p. 105).

2015 American Association for Psychoanalysis in Clinical Social Work (AAPCSW) conference, Paul Cooper concentrated on Soto Zen Buddhism along with the profound role that “just sitting” (*shikantaza*) plays in personal development and spiritual growth. Cooper writes about the salubrious effect of the radically open, all-inclusive, non-dualistic thinking found in Soto Zen (2014, p. 3). It’s an approach to both the inner and outer worlds that could only improve our listening abilities.

Given such a long history of focus on the necessity of sensitive, appropriate listening—including specific instructions on how to be quiet, how to observe, how to be attentive to stimuli emerging from within and without—how can it be that listening continues to be so difficult for so many of us? Do we confuse *good listening* with *merely hearing*? What obstacles get in the way of my listening better?

Barriers to Effective Listening

As a psychoanalyst, I need to listen sensitively, patiently, and skillfully every moment of every day in my practice. Nonetheless, I have arrived at the sobering, if not troubling, realization that I don’t always do it well. Moreover, I have come to believe there are many reasons I have a difficult time listening well in general—and with certain patients in particular. My difficulties notwithstanding, I admit to vowing before most sessions to listen as carefully, prudently, respectfully, and as nonjudgmentally as possible. I have big plans. Honorable and ethical aspirations to be sure, but I almost always fail. Why?

Trying to honestly and objectively analyze my shortcomings, I have arrived at a typology of at least five contributors to my faulty listening.

One: The Intrusion of the Quotidian

Quotidian aspects of daily life can burst onto my mental landscape: car to the shop, budget for the clinic, what's for lunch, thinking about a transferential glitch with the previous patient, hurtful things that were said, etc. Any or all of this annoying detritus can be taken into a session or emerge unimpeded midway through. We can make a conscious effort to set this everyday debris aside, but it often creeps back in. Yes, we might tell ourselves that this is a good thing; there is meaning in it all. For example, we could say these seemingly random associations evidence a subtle or nuanced *tuned-in-ness* to unconscious information emanating from the patient. Ideally, we might be experiencing a kind of *reverie* in those moments such as that discussed by Ogden (1994), Green (1975), and others. But might we also rightly worry that this kind of association is more about ourselves than it is about the patient? How do we ever know? We may be inclined to think that it's about the patient and what is going on that very moment *with this particular patient*. Maybe it's a reflection of the analytic third—that uniquely generated shared subjectivity that emanates from the synthesis of two individual subjectivities working so closely together. “It has to be about something going on between the patient and me,” we think, “it must be a reflection of meaningful relational dynamics occurring between us.” This is often true and, potentially, it can be both instructive and helpful to understand how this phenomenon works. Nevertheless, I will reluctantly suggest that this may not always be the case. Occasionally, then, I have to ask myself: Are these simply distractions deriving from my own psychology?

Two: Blinded by Theory

Another problem is that I sometimes take my favorite theories into the consulting room with me. As much as I know this to be inadvisable, I can't seem to help it. I've been known to say to myself: “This is my Kleinian patient, this is my Kohutian patient, or this dynamic is best

understood through Bion or Winnicott.” This kind of self-prompting or stereotyping isn’t quite as disruptive these days as it used to be. Our dearly held and jealously guarded theories affect us in pernicious ways in the therapy process. They establish a lens through which we view the patient’s narrative, serving to keep us away from the raw truth of the patient’s experiences. Despite an academic understanding of this conundrum and previous writings on the topic (Miller, 1995), my favorite theoretical notions will occasionally rear their heads, interfering with my capacity to be present with patients, blocking my ability to listen to what *they* are saying. Grotstein (2007) offered a partial explanation of this perennially puzzling stumbling block when he proposed that the analyst’s favorite and deeply held theories are often formulated for the purpose of staving off death—keeping thoughts of their own deaths, the reality of their own deaths, at bay. This is a proposition worthy of consideration as we reflect upon the limiting effects of our theories.

Three: Led Astray by Desire

Oddly, a third problem I encounter is my desire to help. My wish to help the patient can be quite an impediment, and undoubtedly gets in the way of good listening. It could be said that the *wish to help* privileges the therapist’s agenda over the patient’s, eclipsing the deeper associations coming from the patient’s unconscious. Our instinctive wish to help can keep us from listening—from sensing into our patients’ most confounding issues, and from tuning in to the depth of their pain. Although this point has been made by Alonso (1985), Luepnitz (2013), and others, and is one that I have made frequently with supervisees, it is unquestionably very difficult to heed. Confounding this problem, I suspect, is the fact that those of us who have chosen this profession have done so because we are helpers by nature. And yet, these same yearnings *to be of assistance to the other* can often keep us from listening as well as we might. As assiduously as I attempt to adhere to the “no hope, no help” tenet, I frequently violate it. I am

thinking of a patient who in session just the other day, said: “Now, let me finish this thought. Just listen. Don’t be positive; don’t try to help. Just listen.” I was appropriately cautioned, if not chided by her. However, I must admit that I said to myself: “Who, me, the one who propounds the tenet of *not having hope*? Who, me, the one who decries the petty American focus on optimism and happiness? How could this be?”

Four: Aesthetic Perturbations

The fourth stumbling block to better listening is likely more idiosyncratic than the others. It seems that my ears are acutely sensitive to sound, to music, and, of course, to the tonality of the spoken word. Years of listening to classical music, listening to books and lectures on tape, and listening to patients have made me particularly sensitive to—and sometimes critical of—the affective tones in a patient’s voice. When sitting with patients, I am keenly tuned into the sounds of their voices and to the words they select to articulate inner experiences.

For example, if the voice sounds too anxious, whiny, sharp, flat, pleading, insistent, demanding, apologetic, obsequious, etc., it can be distracting. I need to let the voice, the tone, fall over me, permeate me, saturate me. And then, much later, maybe I will let it inform an interpretation...or maybe not. Be quiet, I tell myself. Listen. Wait. What will the next utterance be? What will the tone be? What about the word choice? Just what will emerge from this silence? What will the patient’s next word be? I’m thinking of the cautionary note from Taoism here: the Way that can be named is not the Way. Yet the patient has to try to name *it*—that which seems so unnamable. Listen for the specific words chosen, I say to myself. Don’t be put off or offended. Just listen. How are words selected to express inner experiences, feelings, thoughts? Are they deliberately chosen? How is the right word to break the silence selected—that word that is placed

into the space between us? What is the affective coloring of the word? “Listen to just this word,” I say to myself, “what is it trying to express?”

Five: The Analyst’s Resistance

A fifth dynamic that gets in the way of sound analytic listening is the analyst’s *reluctance* to go deeper into the material. We can simply call it the analyst’s resistance. Upon further analysis, this stumbling block is most likely the foundational underpinning of the previous four. It’s our job to go to these difficult places with people. Instead, we often are afraid to hear the truth in what the patient has to say—especially when it pertains to death or to something even more dreaded than death.

Grotstein (2000) discussed these frightening possibilities and named them: the encounter with the infinite bizarre object, a confrontation with infinity—with chaos, “phantasies of an infinite proliferation of protoaffects” (p. 67), an encounter with “O.” Most likely it is in anticipation of an encounter with any one of the aforementioned demons (the infinite, the unnamable, chaos) that *our* hard won, overused defenses kick into gear. We resist. We delve into theory; we rationalize; we think of something else. This tendency seems to rear its head more forcefully when we sense something even more unspeakable than death is in the room.

You may think I overstate my case, but I would argue otherwise. We know that many of our patients have had profound, deep traumas—maybe even ones passed on from generation to generation (Faimberg, 2005)—traumas they can’t even begin to fathom let alone formulate. Sometimes they are in such deep pain and they really don’t know why. Yet this anguish brought them into treatment and keeps them coming back. At least some part of the patient is inviting us to encounter the ineffable chaos, the infinite dread within him. Listening to such profound pain,

listening for its roots, for how deep it runs, is sometimes just too painful for any of us. Lacan's (1981) notion of the Real, that place of unnamed, unprocessed trauma, comes to mind, along with Bion's (1970) conceptualization of the dark and formless "O."

Even a nascent, emerging awareness of this unspeakable chaos can be too much to bear for either patient or analyst. Though we may not feel the full extent of it consciously, at an unconscious level we sense how deep it goes. We might name it as merely an aspect of countertransference. I'm afraid this is too simplistic. If we are attentive at these moments, we might claim we are tuned into—or responding to—an experience of projective identification.

Irrespective of our formulation, we are locked into something mutually and interactively painful. To listen to and sense into the patient's pain at these critical moments demands that we give up our own construction of reality and begin to have an immediate experience of something that might be too painful for us to bear. Yet this is what we are called to do. We must experience the patient's psychic world in all its rawness—in all its vividness. Yes, we have to go into their intense, horrific pain in all its floridness, in all its abjectness. We may even have to experience how disorganized and psychotic the patient's inner world really is as we risk dissolving into an infinite abyss of nonmentation ourselves. In doing so, we'll likely experience our own infinite terror and nameless dread, our own fear of disorganization—our own fear of breakdown. No wonder it is hard to listen well.

An Example of Flawed Listening

With these five impediments to effective listening in mind, I can readily distinguish a fairly typical analytic session from a clinical situation in which these concerns could arise. Most of the time when I do listen better, I seem to be able to create a space where the patient feels heard, has room to say what's on her mind, and has the space to let those dreaded associations

come to the fore. When this happens, patients are appreciative and can sometimes articulate why being listened to in this way is helpful (cf. Miller, 2000). The sense of efficacy surrounding these optimal listening moments makes it even more imperative that we try to understand clinical situations that are confounded by flawed listening.

Curiously, a handful of patients challenge my listening abilities. Anticipating their arrival in my consulting room causes me an apprehension that is both noxious and overwhelming. I am convinced in these moments that I do not want to see them. When anticipating these sessions, I am filled with a sense of nameless dread and infinite terror. An overpowering sense of uncanny apprehension strikes me for moments, for minutes, as I anticipate entering the consulting room to spend an hour with them. Here is a look at one of these confusing, confounding clinical riddles.

Reflections Upon the Analyst's Reverie: Silent, Ineffable, Horrifying

Although it is utterly irrational, I dread seeing him. Despite having had a very satisfying and productive session with my previous patient, dread emerges. The dread comes to the fore as I pause in anticipation, as I begin to make my mental transition to this next patient. Vivid thoughts of not going into the room come to mind. Maybe he'll cancel. I would rather go home, sleep, run away, run a marathon. I don't want to do it. I feel like I'm one of Indrahabad's prisoners waiting to be mangled, then eaten alive by a tiger if I'm unlucky enough to open the wrong door. No, the image of this particular annihilation scenario is too vivid, too structured. What I fear has no crystallized image attached. It is vague, uncertain, and horrifying. More to the point is an image of a hospital situation (maybe a hospice), a feeling of waiting for the most awful verdict imaginable. Is it cancer? Is he/she now dead? My loved one is dead! Am I dying? No, it's something more incomprehensible than this, more horrific. It is truly unimaginable, unnamable.

The patient comes in. I am full of apprehension and dread. Oh no, why didn't he cancel?

He lies down. I listen. He doesn't talk. I wait for the silence to be broken. I sometimes think I will butt in before he says anything, before he speaks the unspeakable. What to do? Do I say "shut up" or "don't talk"? I'm sure I have said this to myself subvocally? Do I say it to him? Will it slip out? Have I already said it? Does he know what I'm thinking? The patient is quiet. Do I speak prematurely and redirect the content of the session to something more acceptable to me? Shall I introduce content that *I* want to hear, that I am *able* to hear? I know I can make it sound plausible, maybe even profound. The old diversion tactics do work. "What's up with this?" I ask myself. I suspect I want to keep him from speaking the unspeakable. At the same time, I am fairly confident that he won't. I know quite well how hard it is for him to say anything with emotional depth to it. I know he won't speak the ineffable, the unformulated, but still fear he will. Whatever it is—the trauma, the infinite dread, whatever it is that's not being spoken—must truly be worse than death itself.

Upon occasion an image of Odysseus of ancient Greece comes to my mind while sitting with this patient. In those moments it strikes me that I might need to be more like the indefatigable, storied Odysseus who asked his mates to strap him to his ship's mast so that he could listen to the song of the sirens without being seduced or killed by them (Hamilton, 1942, p. 310). What a courageous, yet necessary move on his part. Perhaps I need to be made to listen in a similar fashion. What will it take? Can I be *forced* to listen to the birth of the Word in the soul of the other? Do I need to be strapped to the mast, suffer multiple knocks on the head, or engage in daily, if not hourly, self flagellation?

Now, back to the consulting room musings. Next thought: maybe he will terminate the analysis before *it* is spoken. Would I experience that as relief? If he were talking about death itself, I know I would be alright. If he were talking about dying, I think I could deal with that.

Whatever it is, though, he can't speak it. What keeps the words from emerging, from being born? "Please say them," is my inner plea. And, "Please don't," is the competing thought. Are these his resistances at work, or are they mainly mine? Does he sense my resistances? Do his defenses resonate with mine and mine with his? What is this misalliance, this collusion that is occurring between us? Is it our special version of the analytic third? Is it some intractable enactment of mutual dissociation (cf. Stern, 2010), or perhaps it reflects some unspeakable, unformulated trauma or loss that I've not yet grieved? Ah, maybe that's what is going on. Something is keeping the right words, the veridical words from being spoken. Is it that the words can't be spoken, or that the words being spoken are not being heard adequately, or correctly by me?

So what is getting in the way? What is it that is waiting, lurking in his shadowy background? What is there in his unconscious and in my unconscious that is causing so much resistance? What kind of unspoken, unmentionable trauma did he experience? And how might this resonate with something going on inside me? Will this all begin to resolve with the patient when I resolve something within myself? Did someone in his family (perhaps someone in my family) experience a profound trauma that has never been talked about but was passed on uncannily? Was there some huge, indescribable loss, some unspeakable trauma (with a parent, a family member, an intimate friend)? Were they victims of the Holocaust, slavery, or some secret pogrom? Who was tortured, murdered? What keeps it from being spoken? What is it that is being communicated to me that makes it so hard for me to truly listen? Is this bastion being mutually constructed?

Thoughts of Bion's "O" and Lacan's Real again come to mind. Ah, but even these thoughts distract me from being present; they distract me from my effort to listen for that unspeakable pain, that unprocessed trauma, festering at the edge of the real. There is a horrific, dark void, a formless emptiness, an insurmountable nothingness, dread, abject terror. Something lurks

underneath the surface that portends a fate worse than death. And, it is frightening, terrifying.

Ah, but he does come in and he lies down. And after he is there for a while, he finally speaks. And when I listen to what is spoken, as the fabric of silence is torn, as the words come forth, when I listen to the sounds that break through and become words, I hear words that are both heady and intellectualized. There is a tone of voice that is empty, vacant, devoid of affect. Are these words representative of what is inside him? What is it that is hanging around in the dark inner void that's waiting to come forth? What are the haunting feelings that are waiting to be formulated, yearning to be put into words, anxiously longing to burst forth from the depth of his anguished soul? Yet the words he has available don't seem to begin to represent it. The words fail, at least for the moment. His words fail, my listening fails, at least for this session. We wait. I try to listen better. We both try to speak, to listen. And then the session is over.

However, we'll come back to it all again next session. And I will likely approach this next session with the same apprehension, the same terror, the same yearning to move into it—and, unfortunately, with the simultaneous tendency to avoid. It is as if I must remind myself again and again to be as emotionally present as I can be, and to listen to him with all my sensory capacities engaged. Does this mean I'm trying too hard to help? I know I want to be of help. I tend to believe I must urge myself to recommit to his therapy, to him, to the unspoken trauma. I must re-up, recommit before each session, at the beginning of each session, at each moment in each session. Can either one of us bear what must come forth: the ugliness, the messiness, the awful feelings, the inadequate words? Will we be blinded or deafened by the truth when it appears? We're both afraid. Maybe we'll just sit with the feelings of the moment, resistances and all, for just a while longer. And do it again and again.

Yes, I do pay attention to my reverie while sitting with this patient. I listen to myself as

well as to him. I observe my fleeting associations, I observe the images and nagging preoccupations that come to mind. Sometimes there are images of huge spans of blackness, of empty space, of an infinite abyss. Other times my image is of being alone on a stark, dry expanse of desert dunes, and occasionally it is of dark foreboding hellish nothingness, unbearable aloneness. These images usually emerge when the words aren't there. Can I put some of this into words? Do I dare? I try. No luck, no success. So far, to no avail. We are both moored in an expanse of dry, painful emptiness. We'll try again next session.

Some Final Thoughts

We end with the big question: Are there remedies or solutions to these kinds of perplexing listening problems? Is there more that can be done to improve our listening stances? Must we keep in mind, in our efforts to do so, this lingering background presence of unprocessed trauma, unformulated grief and terror lurking at the edge of awareness? What about just sitting quietly with the patient and listening? We can't be in a hurry. Can we simply sit with the patient in the quiet, perhaps with a Taoistic sensibility, in a way that respects the precariousness and subtlety of every moment? We need not avoid the tension in the air; we can sense into it; we might want to relax into it. Let's continue to sit with a feeling of awe in each listening moment. Sometimes just listening without speaking is all we can do. During those times we'll simply appreciate the awesomeness of the void, the enigma of the undifferentiated realm. Let's wait; let's listen. Let the words emerge from the void—from the soul. Odysseus begs: don't untie me from the mast, I want to listen. When and how will the sirens call? When will the silence of the void be ripped open? The fabric of the void is eventually rent with the word. The word comes forth. I am sitting alert and ready—open to whatever words emerge from the void; I'm listening for tonality and for meanings, both on the surface and deeper. In that respect, each word becomes a new beginning,

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an *act of creation*, giving new resonance to the biblical phrase “In the beginning was the word.”

Each word as a new event, a new utterance set in time, with patients trying once again to put language to the ineffable. We listen, we are open to the word. Let the words emerge.

Each one of them a carrier of meaning. Hear them? Try to understand them?

Maybe someday I’ll get it right. But, if the words miss the mark, or if I don’t get their essential communication, let it go. Be open to the next utterance.

I believe this approach to listening is consummately relational, albeit relational in a deep, quiet, unconscious, often unspoken way. It is dialogical in the truest sense of the term: the meeting of two subjectivities, two minds, engaged together in a mutual effort. This is so whether words are being articulated *or* we continue to sit in the quiet. And when words are used, it seems clear that the words break the spell of the void, they differentiate the undifferentiated matrix, something is created. Psychological truth is trying to be formulated. We listen; we practice listening. As we engage in this effort, time and time again, we invariably become more open to the other, to the experiences and subtle vicissitudes of the other. A new kind of receptivity to the other develops as we practice this quiet approach. And of course, as we continue to develop this open, welcoming, evenly hovering stance, we tend to find that increasingly generous habits of heart and soul become accessible to us, the devoted listeners.

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**The Ultimate Empathic Moment:
Listening as Death Draws Near**

*A Personal Tribute to Jean Sanville
(12/6/1918 – 11/4/2013)*

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The Ultimate Empathic Moment: Listening as Death Draws Near

A Personal Tribute to Jean Sanville

(12/6/1918–11/4/2013)

*To live in
this world
you must
be able
to do three things:*

*to love what
is mortal; to
hold it
against your
bones knowing
your own life
depends on it;
and, when the time comes to let it go,
to let it go.*

—Mary Oliver (*In Blackwater Woods*)

Who ARE You, Again?

I remember, in a very direct and personal way, the first time I began to witness the decline of Jean’s mind and cognition. Initially, as I arrived at her home in the Brentwood Hills overlooking the sprawling metropolis of Los Angeles, things felt the same. Her blue-gray Lexus was parked in the carport; the tall, wooden front door was unlocked because she and her caregiver Norma were expecting me. The rich aroma of rice and vegetables cooking greeted me as I entered the expansive space of her dining room. I saw the familiar figure of a petite woman with coiffured white hair and bright, sparkling blue eyes sitting at the table, looking through some mail, as she often did. But when she looked up at me I could see that something was different. She smiled as I entered and greeted her, but then, in a quiet and curious way, she asked, “Who are you, again?”

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There was a lot of water under our bridge by this time. I had known Jean for some twenty years as a psychoanalytic mentor and as a personal friend, so my reply came naturally, “Oh Jean, it really doesn’t matter what my name is.... I know your heart and you know my heart, and that’s all that really matters.” She sat back in her chair and pointed her finger at me, saying, “You know, I really like you.” I responded in a wholehearted and natural way, “Well, you know, I really like you too.” In this moment, some of Jean’s mind was beginning to fade, but the essentials remained. It was the beginning of a way of meeting and connecting beyond words, constructs and feelings, a way of sensing each other’s felt experience, given whatever was unfolding, visit-to-visit, moment-to-moment.

Interestingly, the deeper aspects of my relationship with Jean began some twenty years ago when I asked her to be on my dissertation committee at the Los Angeles Institute and Society for Psychoanalytic Studies (LAISPS) for my Ph.D. thesis, “When Death Knocks on the Analytic Door.” At that time, one of my control cases, a woman I had been seeing four times weekly for several years, was suddenly diagnosed with a terminal illness. I wondered, early in my training, how analysis continued in the face of death. I sought Jean’s mind and heart as an anchor in my own explorations as a clinical social work/ psychoanalyst while adjusting to the modifications and changes in the therapeutic frame that are imposed by such circumstances. A more flexible frame that allowed for phone sessions, home or hospital visits, use of didactic information, handling of missed appointments, and utilization of physical contact was not the method that I was taught early in my psychoanalytic training. While my role and previous experience as an oncology social worker had prepared me for the terrain of death and dying, I was uncertain how psychoanalysts handled such circumstances. Did the analysis continue?

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What were the countertransference responses? Were there resources that guided analysts' ways of working at this edge? Did analysts change as a result of working so intimately with death? How did death as an end point affect analysts' ways of working with other kinds of endings in psychoanalytic treatment? Were psychoanalysts able to "learn from the dying patient?" These were some of the questions and explorations that initially brought Jean and me into dialogue and quickly deepened our bond. The "Who Are You" question was more personal and relational early in our acquaintance and continued to present itself, especially when words and cognitions began to fail.

Poetry and Play: "This Is Part of How I Think"

*The body dies; the body's
beauty lives. So evenings die,
in their green going, A wave,
interminably flowing.*

—Wallace Stevens (*Peter Quince at the Clavier*, 1923)

Jean lived in the play space that she so often wrote about. When asked "what was your pathway to becoming a social work/psychoanalyst," in an interview for the book *The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville* (1999), she replied, "the job of the clinical social worker psychoanalyst is to foster the reparative intent...and ultimately, the reparative intent is to make things better." She emphasized in her teaching and writing that the social worker psychoanalyst should lend herself to the patient's growth purposes, rather than estimate the degree or kind of sickness that another has suffered. Jean stressed that the goal of treatment was more about removing obstacles to

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ongoing development than focusing on the notion of a “cure.” With a mischievous grin and conviction in her voice, Jean espoused the idea that the capacity for playing is and has been a characteristic of the entire mammalian species.

According to Jean, “play itself is hard to define, but the closest synonym may be freedom” (Edward & Sanville, 1996). I experienced Jean’s freedom of self-expression in many of our conversations and dialogues. Often she was willing to think aloud, pose questions and remain curious; be open to the process and not attached to the outcome. In one of our conversations, she reflected that when the therapist had the capacity “not to understand,” the patient had the opportunity to educate the therapist. I remember her playfully asking me, “how do *you* think we become enlivened rather than unsettled by ‘not knowing?’” And in the fluidity of conversation, she gently led me to the realization that healing only really becomes possible when we can find each other in collaborative ways within the relationship.

Jean paused often and seemed to take delight in not anchoring her attention on an opinion or fixed view. Often, it felt like words and ideas were emerging as she spoke as if speaking while thinking was a form of play. The converse was true as well. Jean listened deeply, often pausing and leaning her body toward me as if to feel my words with her body and not only rely on what she heard. This form of play opened space for me to be more of myself as well as to be more with her.

A favorite film of hers, *The Amazing Newborn* (1957), demonstrated nearly sixty years ago how newborns are able to visually reach out for their mothers’ eyes and respond in rhythm to their voices. This film contradicted existing theories about infant cognition because it demonstrated a primary mutual connection between mother and child from the

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very beginning of life.

Jean often said that she experienced an “allergic reaction” to anything that resembled dogma. She cautioned that interpretation is used more to convey the therapist’s *limits* in understanding rather than to supply an answer. Jean’s way of knowing was informed by her direct felt experience in the clinical encounter as well as by her favorite poet, Wallace Stevens. She is quoted as saying, “poetry, and Wallace Stevens’s poetry in particular...this is part of how I think. Our theories are really ‘notes towards a supreme fiction’...which happens to be one of Stevens’s best-known poems” (Edward & Rose, 1999). Jean encouraged openness and directed attention to that which lies beyond what is seen or grasped in the moment. Indeed, our understandings kept changing and evolving.

One of Jean’s favorite and often repeated quotes was “life begins in dialogue and psychopathology can be seen as a derailment of dialogue” (Spitz, 1964). Essentially, when we do not feel seen or understood, something gets derailed and can feel crazy. As time went on in my relationship with Jean, I wondered what form our dialogue would take as words got lost? In the final years and months of her life, our foundation of poetry and play carried us through this fog when dialogue became less accessible.

Often, we would play with some of the images from my photography of tribal peoples from remote places in the world. In the beginning, she would ask many questions and was very curious about their customs and ways of life. When words failed, she would simply look, really look at the images with a sense of wonder and smile. When her thoughts became less fluid, we would play with poems, each reading aloud the poems that spoke to us most deeply.

Eventually, when Jean was less able to read poems, I would bring poems to read to

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her. On an earlier occasion, being fluent in Spanish, Jean translated a poem, “The Explosion,” by Nobel Prize–winning Spanish poet Vicente Aleixandre. It is a long poem, but one stanza that really stands out, especially now, is: “all the light in the universe suddenly gathers, suddenly in a whole lifetime/...unrolls and unfolds/like a huge wave, like a huge light that lets us look on each other at last.” Indeed, Jean often felt like such a light, even when things grew dark.

One of the many things that grew and strengthened in me as a result of this illuminating and endearing relationship with Jean was my own way of listening. In the clinical encounter, I steadily moved away from “doing psychoanalysis” to a more personal way of “practicing psychoanalysis,” and becoming less afraid of that. More and more, I began to trust my own direct and felt experience. I allowed my bodily sensations, breath, hearing, and reveries to really speak to me. This expanded my capacity to listen to what needed to be opened, touched, and released within myself as well as in another person. I felt the integration of both psychoanalytic knowledge and intuitive wisdom.

Indeed, the art of listening and mindful engagement is something that we practice to get enough out of the way to really see what is here, and what arises in us in response to THAT. Like the verse in the Wallace Stevens poem, listening becomes a wave that is “interminable flowing.” It becomes not only how we practice psychotherapy, but how we connect to the deeper parts of ourselves.

In her paper “Traversing the Caesura: Transcendent Attunement in Buddhism and Psychoanalysis” (1995), Concetta Alfonso, a clinical social worker and Zen practitioner, introduced the idea of “transcendent attunement.” She suggests becoming attuned to the existential dimension of life, even the sacred component that takes us beyond the

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theoretical or conceptual realms. Transcendent attunement reminds us of our interconnectedness and interrelatedness that transcend perceived boundaries of separateness. Like the words of the thirteenth-century Persian poet Rumi:

*Out beyond ideas of wrongdoing and
rightdoing, there is a field. I'll meet
you there.*

*When the soul lies down in
that grass, the world is too
full to talk about.
Ideas, language, even the phrase "each other" doesn't make sense.*

These words and the idea of transcendent attunement ultimately opened to me the way of being with Jean at the very end.

Dying as a Labor: Of Love, of Surrender, of Letting Go, of Releasing the Body

The first step to the knowledge of the wonder and mystery of life is the recognition of the monstrous nature of the earthly human realm as well as its glory, the realization that this is just how it is, that it cannot and will not be changed.... So if you really want to help this world, what you will have to teach is how to live in it. And that no one can do who has not himself learned how to live in the joyful sorrow and sorrowful joy of the knowledge of life as it is.

—Joseph Campbell

Having had the experience of working with people who were close to death, it was not new to me to see Jean at the end, her body, now a shell, so tiny, holding labored, irregular, and difficult breaths, even with the assistance of oxygen. Her hair was flat

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with little white strands framing her face; her mouth was open; her skin translucent; her eyes closed. I could see that death was near. It felt like I was already with a corpse... YES, a corpse with breath and a beating heart.

Jean's physical form...

changing...transitioning.

Numbering

Breath, sounding loud...deliberate, yet

measured Bones, covered with a thin

blanket of luminous skin A body,

dissolving...

I arrived at Jean's house in the early afternoon of Saturday, November 2 just two days before she died. It did not escape my attention that my own mother had passed on this very day fourteen years earlier. In addition to being my esteemed mentor and beloved friend, Jean had also felt like a mother to me. I reflected on the inscription that she had written on my copy of the book *The Social Work Psychoanalyst's Casebook: Clinical Voices in Honor of Jean Sanville*. It read: "To Karen—the daughter I wish I'd had." I had told her on numerous occasions that, indeed, she was to me the mother that I had found and recognized. She loved me like a daughter. I loved her like a mother. We both needed that.

I was led to her bedroom where Jean's sister and niece, after brushing a moist cotton swab around her open lips, had made a few body adjustments. They remained at the bedside for a few moments, and then allowed us to be alone, without interruption.

Initially, I touched her hand, in this moment, so frail and transparent, and I spoke her name: "Jean, it's me, Karen, I'm here now, next to you. It is a sunny November day and Alice,

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Julie, Norma, and Elsie are taking *such* good care of you. It's good to be here now and feel the care...to feel the love. I hope you can feel that too."

I then became quiet, now holding her hand with both of my hands as if I were holding all of her. Feeling my arm next to hers, skin touching skin. Noticing her skin, so soft and paper thin. Seeing this tiny physical being, yet still holding a tender presence.

I began breathing with her, following her breath to see what it felt like in *my* body to breath like this with her.

Short breath. Fast breath. Labored breath.

It was a meditation and it took me to a reverie of being in labor close to twenty years earlier when I gave birth to my son. My own felt experience of when breath and body felt so beyond me, of feeling the contractions before they registered their arrival on the instruments that were attached to me, of huge waves of unbelievable pain crashing down on me, of having no idea how women could possibly have the strength to scream while in labor, of each and every contraction absorbing my breath and taking over my body. Each wave, feeling larger than the last, arrived faster and faster, my body, no longer feeling like me/mine, something so much *bigger*, this body in an unknown zone, in a deep and tumultuous cyclone of movements, the memory of experiencing myself then, more like a passenger in this birth process, this labor of love and surrender that took me on the most wild and unforgettable ride of my life.

This felt experience and body memory became a means for making deeper contact with Jean. An experience was opening up where I was not only with Jean, but also with deeper parts of my own knowing of suffering. We touch another's suffering more directly when we can touch our own...

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Open hearted connection...

One quivering body and heart responding to another quivering body and heart.

I was feeling a deeper compassionate presence—a being able to feel, be honest about, and support awareness of my own pain so that I could really stay present and witness Jean’s pain, without backing away, staying right there, right there in the midst of *all* of it. I began free-associating out loud as if I were reading a poem:

“Jean, your body is entering labor...

You are shedding this shell of a body that *no longer* serves you... It won’t be much longer now...you are *almost* there...

Remember Kahlil Gibran’s poem ‘*when the earth shall claim your limbs, then shall you truly dance...*’

Freedom is within sight, Jean...it’s okay...it’s really okay... Your body is releasing itself...let it be...let it be...let it be... Just love...just love...just THIS love, right here...right now...

It’s how we rock ourselves like babies...

Just rock ourselves in this little, temporary cradle of a body... And the way we learn to speak to the deepest parts of ourselves... This language of the heart...

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The way we learn to feel
sensations in the body With
curiosity...kind attention
And hold things as they are...for WHAT
they are... Which are
changing...changing...always changing...
ALL of this FREES us...
Doesn't it, Jean?"

These were my final moments with Jean. Her family, who had been so respectful and accommodating, commented that Jean had seemed calmer after our visit together. They invited me before leaving to share a special Filipino dessert that was prepared by her caregivers. It was one of Jean's favorites, fried banana strips.

For that brief afternoon, which was imbued with a timeless quality, I felt as if I had been living inside of "The Explosion," that Vicente Aleixandre poem that Jean had read to me some time ago:

I know all this has a name: to be given life.

*Love isn't a bomb bursting, though at the same time
that's really what it is*

It's like an explosion that lasts a whole lifetime.

*It comes out of that breakage they call knowing
yourself, and then it opens wider and wider,*

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*colored like a quick cloud of sunlight that rolls
through time and floats up and up until it ripens
in the passage of life,
so that an afternoon becomes all existence, or better: all
existence is like one long afternoon,
like a roomy afternoon full of love, where
all the light in the universe suddenly gathers, suddenly in a whole
lifetime,
until at last it's full, it's all formed and ripened at the top
and from there the fullest light comes down, the light
that unrolls and unfolds
like a huge wave, like a huge light that lets us look on each other at last.*

We've gone all over the soul's smallest details.

Yes, we're the lovers who fell in love one afternoon.

We've gone over that soul so slowly, always surprised

to find it still larger in the morning.

The same way that afternoon lovers, lying there,

uncovered, go over and over their glowing body,

absorbed in themselves,

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*and in that afternoon all the light comes out and
bursts and grows, and it's been an endless afternoon of
love,
and then later they're lost in the dark, and now they'll
never see each other again, they'd never
recognize each other...*

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The Salon

**Beyond Mentoring:
The Evolution of Generativity, Collaboration and
Reciprocity**

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Abstract

At the March 14, 2015 AAPCSW conference, *The Art of Listening: Psychoanalytic Transformations*, I co-presented a paper—"Finding Meaning in What is Spoken and Unspoken in the Therapeutic Hour"—with Joyce Edward, a woman I have known and valued for over twenty-five years. Afterward, in attending several other conference presentations, I was particularly struck by two other panels that also discussed the dyadic relationship and mirrored some of the experiences that Joyce and I had shared in our paper. Generational differences appeared to dissolve as generativity flourished and connections evolved. We stimulated, supported, and enriched each other's lives even, at times, after death.

One presentation that particularly engaged me was *The Ultimate Empathic Moment: Listening as Death Draws Near*, a posthumous homage to Jean Sanville written and movingly read by Karen Redding. She described a twenty-year relationship beginning when Jean served on her doctoral dissertation committee. Jean helped Karen to transform herself from an oncology social worker into a psychoanalyst capable of continuing analytic treatment with a patient facing death. Their relationship, one in which she knew "Jean as both a psychoanalytic mentor and personal friend" (Redding, p. 2), shifted over time as their bond deepened. Jean underscored this relational tie in a book inscription: "To Karen—the daughter I wish I'd had" (Redding, p. 7).

The other paper, "The Simultaneous Treatment of a Mother and a Daughter and Its Synergistic Effect on Their Growth and Development," jointly presented by Diana Siskind and Susan Sherman on March 13, 2015, portrayed a special working relationship that developed over many years. Diana was the mother's therapist. Susan, the daughter's therapist, was an experienced child therapist who viewed the very accomplished and experienced Diana as her

mentor. Over the years, they became trusted colleagues who helped one another, especially in the treatment of this mother-daughter pair. They believe the success of their work was related to the respectful, easy, and open way in which their relationship allowed them to share important aspects of their treatments with each other. Therapists and patients alike grew simultaneously from this unique collaborative experience.

In this paper I will address, largely through the medium of emails and references to clinical writing and presentations, the particular relational journey that Joyce Edward and I have traveled. Although brief, pertinent references regarding supervision and mentoring will be included, the material presented is not meant to be comprehensive.

The Beginning

I remember hearing my social work field-placement supervisor at Pederson Krag Center praising a presentation given by Joyce Edward. I subsequently read many of her papers and attended her workshops; I admired Joyce from afar. When I began psychoanalytic training in 1989, I requested her as my first supervisor. The tone of my responses to her early supervision can be heard in the following excerpt from our co-authored paper:

Each week I brought process recordings from sessions with Lynn, the patient I would later present as my case study for the New York School of Psychoanalysis and Psychoanalytic Psychotherapy. I was in my forties, only a year out of New York University's MSW program and just starting my own psychotherapy. I was a "newbie" in many ways. [Lynn related an incident in which her mother was too ill to accompany her and her father on a day trip. She loved being alone with her strong handsome dad.] My responses focused on my patient's mother, minimizing the father's importance in my patient's life. As I recall, Joyce said something like:

"Little girls love their fathers, [a primary] love object, the Oedipal struggle....For some reason you did not explore this with her. Might you have some ideas about why you didn't? You know, your patient can only go as far as you can."

I'm shocked. I tell myself I never experienced this kind of love for my father. I feel inept clinically and deficient in achieving an important psychological milestone. The next supervision session one week later begins: "It's really hard for me to come for supervision, the commuter traffic is fierce at 5 PM and the distance to your office is making it too difficult for me to continue."

"What's wrong?" she asks, seeing through me immediately.

“I feel like I can’t keep up with you,” I reply.

“It’s my job to stay where you are, not your job to keep up with me,” she responds.

My initial response was to run, not to explore. Joyce heard the latent content, my struggle and resistance. I needed to deal with my feelings of inadequacy as well as my feelings of competition. I was used to being in control and had been experienced and knowledgeable in my previous professional career as a clinical nurse practitioner. Joyce’s careful and skillful guidance, as well as my own analysis, enabled me to become keenly aware that listening is limited by the unconscious as well as by transference interactions, including those within the supervisory arena.

Gerald Schames (2006) posits:

In supervision, positive and negative feelings about being a learner and being a teacher are filtered through both parties’ childhood experiences, and then enacted through displacement and projection in presentations of clinical process.... The transference relationship that develops between a supervisee and a supervisor often provides the first, best information about what is unsaid and unsayable in supervisees’ relationships with patients; more accurate and more vivid than even the most detailed case report

(Schames, p. 417).

Supervision and Mentoring: a Brief Discussion

Psychoanalyst Sandra Buechler illustrated that death alters but did not end her relationship with Ralph Crowley in “A Letter to My First Analytic Supervisor” (2009): Did you know that we would still be talking to each other? After you died you took up a permanent place in what I like to call my “internal chorus.” I see it as essential that candidates audition their supervisors and others for inclusion in this chorus. In training (I hope) we internalize some of our relationships to our analyst, supervisors, and others for inclusion in this chorus. These voices can make even the loneliest clinical moments less painful.... Ideally, analytic training can provide graduates with an array of internalized mentors who guide, support, and inspire them in their loneliest hours, enabling them to bear vicariously traumatic, conflict-laden, and other painful exchanges (Buechler, p. 425).

Joyce and Sheila: Writing Together

Our writing history began when I submitted a paper to the Clinical Social Work Journal regarding my work with HIV-infected patients at a mental health center. It was reviewed by three readers then reviewed again. Each time reviewers gave either highly scathing or complimentary responses. Jean Sanville, who was editor at the time, was supportive, but the paper was not accepted for publication.

Joyce suggested that I submit it for consideration to *The Reader*, a proposed publication whose mission was to help social work students understand the value of psychoanalytic theories. She encouraged me to keep working on my paper, “Psychoanalytic Therapy with the HIV-Infected Person,” and it was eventually included as a chapter in the retitled book *Fostering Healing and Growth: A Psychoanalytic Social Work Approach* (1996),

which was co-edited by Joyce and Jean. I'd almost given up but Joyce's encouraging advice, "let it rest over the summer then pick it up and work on it once again," helped me to persevere.

Ellen Ruderman in "As Time Goes By: Life Experiences and Their Effects on Analytic Technique" (2002) evokes similar support through identification with her mentors:

My motivation to take my former presentations and convert them into publishable articles to share with my mental health colleagues struck me as a positive identification with my deceased mentors. They, too, had given much of themselves in teaching and later writing for the mental health professional community (Ruderman, p. 505).

Mentorship is, of course, not confined to academic and clinical disciplines. A salient literary example cited in *Thomas Wolfe: A Writer's Life* by biographer Ted Mitchell (2013) taken from *The Letters of Thomas Wolfe to his Mother* (1956) concerns Wolfe's relationship with his teacher Margaret Hines Roberts:

A major influence upon Wolfe's life, Mrs. Roberts nurtured his talent as a writer and awakened in him a love for fine literature.... Because of Mrs. Roberts's affection and compassion for the young, awkward Wolfe, she became the invincible mentor he called the "mother of my spirit" (Mitchell, p. 17).

In the interest of showing and not just telling, I've included examples of e-mail correspondence between Joyce Edward and me from June 1993 until March 2015 that illustrate the nature of mentoring that I received:

June 23, 1993

Dear Joyce,

I have enclosed a copy of my paper "Psychoanalytically Oriented Psychotherapy with the HIV Infected Person" to be considered for publication for the *Reader*. I am very grateful for your time and effort on my behalf. I would like to meet with you to discuss revisions if possible. The third reviewer seemed to feel, as had one of the reviewers from the *Clinical Social Work Journal*, that the paper was not acceptable. It is surprising that such strong and differing reactions are stimulated. It does make me more aware of the pitfalls in publishing; certainly it contributes to some anxious feelings about the process. Your continuing encouragement and support has really been so helpful. I don't know if I am capable of supporting this work with theory strong enough or clear enough but would like to try.

Warmest Regards, Sheila

January 1, 1994

Dear Sheila,

I have just received Jean's thoughts about your paper and am sending them on to you along with my own. As you can see we both are very pleased with what you have done, though we have to ask you to revise a bit more. I hope our suggestions are clear enough but you can of course call me for any clarification you may need.

This will be the last rewrite, which I am sure you are pleased to hear. We will do whatever editing is necessary from here on.

Sheila I am so glad you kept at this. It will be a fine addition to the book and I

think you will find it very satisfying to have your good work published for others to learn from.

Warmly, Joyce

December 26, 1994

Dear Joyce,

Enclosed is a revised submittal of my paper for the *Reader*. I want to thank you so much for all of the time and kind consideration you have extended to me in the editorial help you have provided. I feel that I have learned so much through this process. Let me know if there is anything else I can do to improve this paper. I would be happy to continue to work on it.... Even if I am unable to be included I feel honored to have been asked to try and to receive so much assistance from both you and Jean.

Warmly, Sheila

January 30, 1995

Dear Sheila,

About a week ago I sent my comments on your paper to Jean. We usually review the papers independently, then exchange ideas, and then pull our thoughts together. I am sure you would like to be done with this and we would like very much to have it completed. Thank you so much Sheila for all the hard work you have done. You are so sweet to keep thanking us, but it is you that have put in all the effort and time.

Fondly, Joyce

August 23, 1995

Dear Colleague,

I have just spoken with Judy Cohen the production editor of Jason Aronson. She advises me that they have finished copy editing the book.

You will be pleased to hear that Ms. Cohen was quite positive about the book. They are planning to release it in hard cover by the beginning of March.

Cordially,

Joyce Edward, Jean Sanville

Co-editors

Changing Relationship

The first time I experienced a shift in our writing relationship occurred when Joyce asked me to edit a chapter of her book *The Sibling Relationship: A Force for Growth and Conflict* (2011). What an honor it was to have come full circle, to contribute something of value to the person who had midwived me through so many writing projects. This shift continued when I invited Joyce to present a paper, "Some Psychoanalytic Reflections On Friendship," for a weekend conference entitled *Therapeutic Passages, Midlife and Beyond* (October 24–26, 2014), co-chaired by Linda Sherby and me for New Directions, a postgraduate training program at the Washington Center for Psychoanalysis that combines writing and modern psychoanalytic perspectives. Attendees were bowled over by Joyce's intelligence, creativity, curiosity, and obvious happiness in my accomplishments. Part of my introduction for her included what has become for me a meaningful quote from her chapter "Listening, Hearing and Understanding" in *Fostering Healing and Growth* (1996):

Just as it is difficult for the patient to speak freely, so is it difficult for the therapist to listen openly. As a fellow human being, the therapist shares certain phenomena. That

which we cannot as therapists attend in ourselves, frequently becomes difficult to comprehend in our patients (Edward and Sanville, p. 25).

As I opened the conference proceedings, introduced speakers, and presented a paper, I noticed Joyce *kvelling* (a Yiddish expression close to my heart which means beaming with pride) as she sat in the audience, just as my mother had some thirty years earlier.

Our friendship intensified as we collaborated on a paper, "Finding Meaning in What Is Spoken and Unspoken in the Therapeutic Hour." In my introduction I said:

I realized that although our writing styles differ, our writing process is quite similar. When the spirit moves us and as the deadline approaches, we can't stop reshaping and rewriting. We are, however, in good company, Justice Ruth Bader Ginsburg showed evidence of sharing our obsession when she nodded off at a State of the Union address, in part, because she had been up writing throughout the night before. "My pen was hot," she said (*The New York Times*, February 22, 2015, p. 6). Our pens have also been hot.

A few days later I received an email:

March 16, 2015

Dear Sheila,

It was such a joyful rewarding experience sharing with you before, during and after our talk. You are like a reward for my efforts as a teacher and supervisor. It is such a pleasure to see one's students not only stand beside you but move even further ahead. Your paper was such a testimony to your development as a clinician and as a writer.

Lots of love, Joyce

Despite our pleasure in our joint writing venture we decided not to submit our paper

for journal publication. Even though the clinical material had been disguised, I felt that asking for permission to publish from the particular patients I'd written about might impact the treatment negatively. Instead, I obtained informed consent from my colleagues Susan Sherman, Diana Siskind, and Karen Redding, and asked Joyce for permission to include excerpts of our paper, e-mails, and experiences at conferences in order to submit this as the first Salon paper for the AAPCSW monograph pertaining to *The Art of Listening: Psychoanalytic Transformations* (March 2015).

Joyce Speaks

April 15, 2015

Dear Sheila,

I just finished reading your most recent draft of "Beyond Mentoring" and liked it very much; I have a few thoughts about it. When the young writer-to-be asks for help from their more experienced and published mentor, who has a name in the field as Jean, Diana and I have had, might she somehow be unconsciously seeking permission to begin to move into their mentor's place? In other words may this involve certain Oedipal issues? At the same time might one consider that the older clinician's need for generativity could play a role in their responsiveness to their supervisee or mentoree, perhaps for a relationship that can in some way replace a relationship with separating children? Let me say that while I was reading the paper I thought about how long ago it has been since you asked if I would take a look at a paper you were writing? With little help from me you went on to present that paper at several meetings and in time it was published. Since then you have spoken and written and significantly enriched

our literature. Now I send my drafts to you, as I recently did with the paper on Friendship. In a space of twenty years we have gone from teacher and student, mentor and mentee, and finally to collaborators, all the while forging a strong and meaningful friendship. What began as a relationship between an older and younger woman, an experienced and inexperienced clinician, focused on clinical concerns and projects has become a rich reciprocal and inspiring relationship.

Much love, Joyce

A Letter to My Supervisor, My Mentor, My Dear Friend

July 15, 2015

Dearest Joyce,

You are an invincible mentor, *a mother of my spirit*, a peer and a dear friend. We are able to relate to each other sans the baggage and weight of familial responsibility, which frees us up, in some ways, to be more present and available to each other. After my mother's death I missed being a daughter but our relationship allows me to feel some of that with you even though you balk at my helping too much.... Even though autonomy, competency, and separation-individuation issues dribble in we are able to treat these events with humor and kindness. Joyce, you continue to be a big part of my writerly evolution and an ongoing role model for my professional identity.

With much love, Sheila

Closing Remarks

The examples and references in this paper have concerned mentoring and supervision relationships that have evolved into what I call *Beyond Mentoring*; positive growth-promoting and enriching associations which have led to loving friendships sprinkled with the best aspects of familial connections. Much is left to explore in terms of how and why these or any particular relationships become more meaningful than others; temporality, geographical nearness, stage of life, and temperament are some probable variables. I enthusiastically invite my colleagues to contribute to an ongoing dialogue on this topic in a subsequent issue of the Salon portion of the AAPCSW monograph.

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