

# 1 Listening to the Patient

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## Listening: The Key Skill in Psychiatry

It was Freud who raised the psychiatric technique of examination – listening – to a level of expertise unexplored in earlier eras. As Binswanger (1963) has said of the period prior to Freudian influence: psychiatric “auscultation” and “percussion” of the patient was performed as if through the patient’s shirt with so much of his essence remaining covered or muffled that layers of meaning remained unpeeled away or unexamined.

This metaphor and parallel to the cardiac examination is one worth considering as we first ask if listening will remain as central a part of psychiatric examination as in the past. The explosion of biomedical knowledge has radically altered our evolving view and practice of the doctor–patient relationship. Physicians of an earlier generation were taught that the diagnosis is made at the bedside – that is, the history and physical examination are paramount. Laboratory and imaging (radiological, in those days) examinations were seen as confirmatory exercises. However, as our technologies have blossomed, the bedside and/or consultation room examinations have evolved into the method whereby the physician determines what tests to run, and the tests are often viewed as making the diagnosis. So can one imagine a time in the not-too-distant future when the psychiatrist’s task will be to identify that the patient is psychotic and then order some benign brain imaging study which will identify the patient’s exact disorder?

Perhaps so, but will that obviate the need for the psychiatrist’s special kind of listening? Indeed, there are those who claim that psychiatrists should no longer be considered experts in the doctor–patient relationship, where expertise is derived from their unique training in listening skills, but experts in the brain. As we come truly to understand the relationship between brain states and subtle cognitive, emotional, and interpersonal states, one could also ask if this is a distinction that really makes a difference. On the other hand, the psychiatrist will always be charged with finding a way to relate effectively to those who cannot effectively relate to themselves or to others. There is something in the treatment of individuals whose illnesses express themselves through disturbances of thinking, feeling, perceiving, and behaving that will always demand special expertise in establishing a therapeutic relationship – and that is dependent on special expertise in listening (Clinical Vignette 1).

All psychiatrists, regardless of theoretical stance, must learn this skill and struggle with how it is to be defined and taught. The biological or phenomenological psychiatrist

**Clinical Vignette 1**

A 28-year-old white married man suffering from paranoid schizophrenia and obsessive–compulsive disorder did extremely well in the hospital, where his medication had been changed to clozapine with good effects. But he rapidly deteriorated on his return home. It was clear that the ward milieu had been a crucial part of his improvement, so partial hospitalization was recommended. The patient demurred, saying he didn’t want to be a “burden”. The psychiatrist explored this with the patient and his wife. Beyond the obvious “burdens” of cost and travel arrangements, the psychiatrist detected the patient’s striving to be autonomously responsible for handling his illness. By conveying a deep respect for that wish, and then educating the already insightful patient about the realities of “bearing schizophrenia”, the psychiatrist was able to help the patient accept the needed level of care.

listens for subtle expressions of symptomatology; the cognitive–behavioral psychiatrist listens for hidden distortions, irrational assumptions, or global inferences; the psychodynamic psychiatrist listens for hints at unconscious conflicts; the behaviorist listens for covert patterns of anxiety and stimulus associations; the family systems psychiatrist listens for hidden family myths and structures.

This requires sensitivity to the storyteller, which integrates a patient orientation complementing a disease orientation. The listener’s intent is to uncover what is wrong and to put a label on it. At the same time, the listener is on a journey to discover who the patient is, employing tools of asking, looking, testing, and clarifying. The patient is invited to collaborate as an active informer. Listening work takes time, concentration, imagination, a sense of humor, and an attitude that places the patient as the hero of his or her own life story. Key listening skills are listed in Table 1.1.

| <b>Table 1.1 Key Listening Skills</b> |   |
|---------------------------------------|---|
| Hearing                               | <ul style="list-style-type: none"> <li>Connotative meanings of words</li> <li>Idiosyncratic uses of language</li> <li>Figures of speech that tell a deeper story</li> <li>Voice tones and modulation (e.g., hard edge, voice cracking)</li> <li>Stream of associations</li> </ul> |
| Seeing                                | <ul style="list-style-type: none"> <li>Posture</li> <li>Gestures</li> <li>Facial expressions (e.g., eyes watering, jaw clenched)</li> <li>Other outward expressions of emotion</li> </ul>   |
| Comparing                             | <ul style="list-style-type: none"> <li>Noting what is omitted</li> <li>Dissonances between modes of expression</li> <li>Intuiting</li> </ul>  |
| Reflecting                            | <ul style="list-style-type: none"> <li>Attending to one’s own internal reactions</li> <li>Thinking it all through outside the immediate pressure to respond during the interview</li> </ul>   |

The enduring art of psychiatry involves guiding the depressed patient, for example, to tell his or her story of loss in addition to having him or her name, describe, and quantify symptoms of depression. The listener, in hearing the story, experiences the world and the patient from the patient's point of view and helps carry the burden of loss, lightening and transforming the load. In hearing the sufferer, the depression itself is lifted and relieved. The listening is healing as well as diagnostic. If done well, the listener becomes a better disease diagnostician. The best listeners hear both the patient and the disease clearly, and regard every encounter as potentially therapeutic.

## The Primary Tools: Words, Analogies, Metaphors, Similes, and Symbols

To listen and understand requires that the language used between the speaker and the hearer be shared – that the meanings of words and phrases are commonly held. Patients are storytellers who have the hope of being heard and understood. Their hearers are physicians who expect to listen actively and to be with the patient in a new level of understanding. Because all human beings listen to so many different people every day, we tend to think of listening as an automatic ongoing process, yet this sort of active listening remains one of the central skills in clinical psychiatry. It underpins all other skills in diagnosis, alliance building, and communication. In all medical examinations, the patient is telling a story only she or he has experienced. The physician must glean the salient information and then use it in appropriate ways. Inevitably, even when language is common, there are subtle differences in meanings, based upon differences in gender, age, culture, religion, socioeconomic class, race, region of upbringing, nationality and original language, as well as the idiosyncrasies of individual history. These differences are particularly important to keep in mind in the use of analogies, similes, and metaphors. Figures of speech, in which one thing is held representational of another by comparison, are very important windows to the inner world of the patient. Differences in meanings attached to these figures of speech can complicate their use. In psychodynamic assessment and psychotherapeutic treatment, the need to regard these subtleties of language becomes the self-conscious focus of the psychiatrist, yet failure to hear and heed such idiosyncratic distinctions can affect simple medical diagnosis as well (Clinical Vignettes 2 and 3).

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### Clinical Vignette 2

A psychiatric consultant was asked to see a 48-year-old man on a coronary care unit for chest pain deemed “functional” by the cardiologist who had asked the patient if his chest pain was “crushing”. The patient said no. A variety of other routine tests were also negative. The psychiatrist asked the patient to describe his pain. He said, “It’s like a truck sitting on my chest, squeezing it down”. The psychiatrist promptly recommended additional tests, which confirmed the diagnosis of myocardial infarction. The cardiologist may have been tempted to label the patient a “bad historian”, but the most likely culprit of this potentially fatal misunderstanding lies in the connotative meanings, each ascribed to the word “crushing” or to other variances in metaphorical communication.

### Clinical Vignette 3

A psychiatrist had been treating a 35-year-old man with a narcissistic personality and dysthymic disorder for 2 years. Given the brutality and deprivation of the patient's childhood, the clinician was persistently puzzled by the patient's remarkable psychological strengths. He possessed capacities for empathy, self-observation, and modulation of intense rage that were unusual, given his background. During a session, the patient, in telling a childhood story, began, "When I was a little fella...". It struck the psychiatrist that the patient always said "little fella" when referring to himself as a boy, and that this was fairly distinctive phraseology. Almost all other patients will say, "When I was young/a kid/a girl (boy)/in school", designate an age, etc. On inquiry about this, the patient immediately identified "The Andy Griffith Show" as the source. This revealed a secret identification with the characters of the TV show, and a model that said to a young boy, "There are other ways to be a man than what you see around you". Making this long-standing covert identification fully conscious was transformative for the patient.

In psychotherapy, the special meanings of words become the central focus of the treatment.

### How Does One Hear Words in This Way?

The preceding clinical vignettes, once described, sound straightforward and easy. Yet, to listen in this way, the clinician must acquire specific yet difficult-to-learn skills and attitudes. It is extremely difficult to put into words the listening processes embodied in these examples and those to follow, yet that is what this chapter attempts to do.

Students, when observing experienced psychiatrists interviewing patients, often express a sense of wonder such as: "How did she know to ask that?" "Why did the patient open up with him but not with me?" "What made the diagnosis so clear in that interview and not in all the others?" The student may respond with a sense of awe, a feeling of inepititude and doubt at ever achieving such facility, or even a reaction of disparagement that the process seems so indefinable and inexact. The key is the clinician's ability to listen. Without a refined capacity to hear deeply, the chapters on other aspects of interviewing in this textbook are of little use. But it is neither mystical nor magical nor indefinable (though it is very difficult to articulate); such skills are the product of hard work, much thought, intense supervision, and extensive in-depth exposure to many different kinds of patients.

Psychiatrists, more than any other physicians, must simultaneously listen symptomatically and narratively/experientially. They must also have access to a variety of theoretical perspectives that effectively inform their listening. These include behavioral, interpersonal, cognitive, sociocultural, and systems theories. Symptomatic listening is what we think of as traditional medical history taking, in which the focus is on the presence or absence of a particular symptom, the most overt content level of an interview. Narrative-experiential listening is based on the idea that all humans are constantly interpreting their experiences, attributing meaning to them, and weaving a story of their

lives with themselves as the central character. This process goes on continuously, both consciously and unconsciously, as a running conversation within each of us. The conversation is between parts of ourselves and between ourselves and what Freud called “internalized objects”, important people in our lives whose images, sayings, and attitudes become permanently laid down in our memories. This conversation and commentary on our lives includes personal history, repetitive behaviors, learned assumptions about the world, and interpersonal roles. These are, in turn, the products of individual background, cultural norms and values, national identifications, spiritual meanings, and family system forces (Clinical Vignette 4).

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#### Clinical Vignette 4

A 46-year-old man was referred to a psychiatrist from a drug study. The patient had both major depression and dysthymic disorder since a business failure 2 years earlier. His primary symptoms were increased sleep and decreased mood, libido, energy, and interests. After no improvement during the “blind” portion of the study, he had continued to show little response once the code was broken, and he was treated with two different active antidepressant medications. He was referred for psychotherapy and further antidepressant trials. The therapy progressed slowly with only episodic improvement. One day, the patient reported that his wife had been teasing him about how, during his afternoon nap, his snoring could be heard over the noise of a vacuum cleaner. The psychiatrist immediately asked additional questions, eventually obtained sleep polysomnography, and, after appropriate treatment for sleep apnea, the patient’s depression improved dramatically.

It seems that three factors were present that enabled the psychiatrist in Clinical Vignette 4 to listen well and identify an unusual diagnosis that had been missed by at least three other excellent clinicians who had all been using detailed structured interviews that were extremely inclusive in their symptom reviews. First, the psychiatrist had to have readily available in mind all sorts of symptoms and syndromes. Second, he had to be in a curious mode. In fact, this clinician had a gnawing sense that something was missing in his understanding of the patient. There is a saying in American medicine designed to focus students on the need to consider common illnesses first, while not totally ignoring rarer diseases: when you hear hoofbeats in the road, don’t look first for zebras. We would say that this psychiatrist’s mind was open to seeing a “zebra” despite the ongoing assumption that the weekly “hoofbeats” he had been hearing represented the everyday “horse” of clinical depression. Finally, he had to hear the patient’s story in multiple, flexible ways, including the possibility that a symptom may be embedded in it, so that a match could be noticed between a detail of the story and a symptom. Eureka! The zebra could then be seen although it had been standing there every week for months.

Looking back at Clinical Vignette 3, we see the same phenomenon of a detail leaping out as a significant piece of missing information that dramatically influences the treatment process. To accomplish this requires a cognitive template (symptoms and syndromes; developmental, systemic, and personality theories; awareness of cultural perspectives),

a searching curious stance, and flexible processing of the data presented. If one is able to internalize the skills listed in Table 1.1, the listener begins automatically to hear the meanings in the words.

## Listening as More Than Hearing

Listening and hearing are often equated in many people's minds. However, listening involves not only hearing and understanding the speaker's words, but attending to inflection, metaphor, imagery, sequence of associations, and interesting linguistic selections. It also involves seeing – movement, gestures, facial expressions, subtle changes in these – and constantly comparing what is said with what is seen, looking for dissonances, and comparing what is being said and seen with what was previously communicated and observed. Further, it is essential to be aware of what might have been said but was not, or how things might have been expressed but were not. This is where clues to idiosyncratic meanings and associations are often discovered. Sometimes, the most important meanings are embedded in what is conspicuous by its absence.

There appears to be a biogrammar of primary emotions that all humans share and express in predictable, fixed action patterns. The meaning of a smile or nod of the head is universal across disparate cultures. The amygdala and the inferior temporal lobe gyrus have been identified as the neurobiological substrate for recognition of and empathy for others and their emotional states. Further research has identified that these parts of the brain are, on the one hand, prededicated to recognizing certain gestures, facial expressions, and so on, but require effective maternal–infant interaction in order to do so (Schore, 2001). All of this is synthesized in the listener as a “sense” or intuition as to what the speaker is saying at multiple levels. The availability of useful cognitive templates and theories enables the listener to articulate what is heard (Clinical Vignette 5).

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### Clinical Vignette 5

A 38-year-old Hispanic construction worker presented himself to a small-town emergency department in the Southwest, complaining of pain on walking, actually described in Spanish-accented English as “a little pain”. His voice was tight, his face was drawn, and his physical demeanor was burdened and hesitant. His response to the invitation to walk was met by a labored attempt to walk without favor to his painful limb. A physician could have discharged him from the emergency department with a small prescription of ibuprofen. The careful physician in the emergency department responded to the powerful visual message that he was in pain, was beaten down by it, and had suffered long before coming in. This recognition came first to the physician as an intuition that this man was somehow more sick than he made himself sound. A radiograph of the femur revealed a lytic lesion that later proved to be metastatic renal cell carcinoma. To hear the unspoken, one had to be keenly aware of the patient's tone and how he looked, and to keep in mind, too, the cultural taboos forbidding him to give in to pain or to appear to need help.

As has been implied, not only must one affirmatively “hear” all that a patient is communicating, one must overcome a variety of potential blocks to effective listening.

## Common Blocks to Effective Listening

Many factors influence the ability to listen. Psychiatrists come to the patient as the product of their own life experiences. Does the listener tune in to what he or she hears in a more attentive way if the listener and the patient share characteristics? What blocks to listening (Table 1.2) are posed by differences in sex, age, religion, socioeconomic class, race, culture, or nationality? What blind spots may be induced by superficial similarities in different personal meanings attributed to the same cultural symbol? Separate and apart from the differences in the development of empathy when the dyad holds in common certain features, the act of listening is inevitably influenced by similarities and differences between the psychiatrist and the patient.

| Table 1.2 Blocks to Effective Listening |   |
|---|---|
| Patient–psychiatrist dissimilarities    | Race<br>Sex<br>Culture<br>Religion<br>Regional dialect<br>Individual differences<br>Socioeconomic class |
| Superficial similarities                | May lead to incorrect assumptions of shared meanings  |
| Countertransference                     | Psychiatrist fails to hear or reacts inappropriately to content reminiscent of own unresolved conflicts |
| External forces                         | Managed care setting<br>Emergency department<br>Control-oriented inpatient unit                         |
| Attitudes                               | Need for control<br>Psychiatrist having a bad day   |

Would a woman have reported the snoring in Clinical Vignette 4 or would she have been too embarrassed? Would she have reported it more readily to a woman psychiatrist? What about the image in Clinical Vignette 2 of a truck sitting on someone’s chest? How gender and culture bound is it? Would “The Andy Griffith Show”, important in Clinical Vignette 3, have had the same impact on a young African-American boy that it did on a Caucasian one? In how many countries is “The Andy Griffith Show” even available, and in which cultures would that model of a family structure seem relevant? Suppose the psychiatrist in that vignette was not a television viewer or had come from another country to the USA long after the show had come and gone? Consider these additional examples (Clinical Vignette 6).



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### Clinical Vignette 6

A female patient came to see her male psychiatrist for their biweekly session. Having just been given new duties on her job, she came in excitedly and began sharing with her therapist how happy she was to have been chosen by her male supervisor to help him with a very important project at their office. The session continued with the theme of the patient's pride in having been recognized for her attributes, talents, and hard work. At the next session, she said that she had become embarrassed after the previous session at the thought that she had been "strutting her stuff". The therapist reflected back to her the thought that she sounded like a rooster strutting his stuff, connecting her embarrassment at having revealed that she strove for the recognition and power of men in her company, and that she, in fact, envied the position of her supervisor. The patient objected to the comparison of a rooster, and likened it more to feeling like a woman of the streets strutting her stuff. She stated that she felt like a prostitute being used by her supervisor. The psychiatrist was off the mark by missing the opportunity to point out in the analogous way that the patient's source of embarrassment was in being used, not so much in being envious of the male position.

It is likely that different life experiences based on gender fostered this misunderstanding. How many women easily identify with the stereotyped role of the barnyard rooster? How many men readily identify with the role of a prostitute? These are but two examples of the myriad different meanings our specific gender may incline us toward. Although metaphor is a powerful tool in listening to the patient, cross-cultural barriers pose potential blocks to understanding (Clinical Vignettes 7 and 8).

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### Clinical Vignette 7

A 36-year-old black woman complained to her therapist (of the same language, race, and socioeconomic class) that her husband was a snake, meaning that he was no good, treacherous, a hidden danger. The therapist, understanding this commonly held definition of a snake, reflected back to the patient pertinent, supportive feedback concerning the care and caution the patient was exercising in divorce dealings with the husband.

In contrast, a 36-year-old Chinese woman, fluent in English, living in her adopted country for 15 years and assimilated to Western culture, represented her husband to her Caucasian, native-born psychiatrist as being like a dragon. The therapist, without checking on the meaning of the word "dragon" with her patient, assumed it connoted danger, one of malicious intent and oppression. The patient, however, was using "dragon" as a metaphor for her husband – the fierce, watchful guardian of the family – in keeping with the ancient Chinese folklore in which the dragon is stationed at the gates of the lord's castle to guard and protect it from evil and danger.



### Clinical Vignette 8

In a family session, a psychiatrist from the South referred to the mother of her patient as “your mama”, intending a meaning of warmth and respect. The patient instantly became enraged at the use of such an offensive term toward her mother. Although being treated in Texas, the patient and her family had recently moved from a large city in New Jersey. The use of the term “mama” among working-class Italians in that area was looked upon with derision among people of Irish descent, the group to which the patient was ethnically connected. The patient had used the term “mother” to refer to her mother, a term the psychiatrist had heard with a degree of coolness attached. What she knew of her patient’s relationship with her mother did not fit in with a word like mother; hence, almost out of awareness, she switched terms, leading to a response of indignation and outrage from the patient.

Even more subtle regional variations may produce similar problems in listening and understanding.

Psychiatrists discern meaning in that which they hear through filters of their own – cultural backgrounds, life experiences, feelings, the day’s events, their own physical sense of themselves, nationality, sex roles, religious meaning systems, and intrapsychic conflicts. The filters can serve as blocks or as magnifiers if certain elements of what is being said resonate with something within the psychiatrist. When the filters block, we call it countertransference or insensitivity. When they magnify, we call it empathy or sensitivity. One may observe a theme for a long time repeated with a different tone, embellishment, inflection, or context before the idea of what is meant comes to mind. The “little fella” example in Clinical Vignette 3 illustrates a message that had been communicated in many ways and times in exactly the same language before the psychiatrist “got it”. On discovering a significant meaning that had been signaled previously in many ways, the psychiatrist often has the experience: “How could I have been so stupid? It’s been staring me in the face for months!”

Managed care and the manner in which national health systems are administered can alter our attitudes toward the patient and our abilities to be transforming listeners. The requirement for authorization for minimal visits, time on the phone with utilization review nurses attempting to justify continuing therapy, and forms tediously filled out can be blocks to listening to the patient. Limitations on the kinds and length of treatment can lull the psychiatrist into not listening in the same way or as intently. With these time limits and other “third-party payer” considerations (i.e., need for a billable diagnostic code), the psychiatrist, as careful listener, must heed the external pressures influencing the approach to the patient. Many health benefit packages will provide coverage in any therapeutic setting only for relief of symptoms, restoration of minimal function, acute problem solving, and shoring up of defenses. In various countries, health-care systems have come up with a variety of constraints in their efforts to deal with the costs of care. Unless these pressures are attended to, listening will be accomplished with a different purpose in mind, more closely approximating the crisis intervention model of the emergency room or the medical model for either inpatient or outpatient care. In these settings, the thoughtful psychiatrist will arm himself or herself with checklists, inventories, and scales for objectifying the severity of illness and response to treatment: the ear is tuned only to measurable and observable signs of responses to therapy and biologic intervention (Clinical Vignette 9).

### Clinical Vignette 9

An army private was brought to the emergency room in Germany by his friends, having threatened to commit suicide while holding a gun to his head. He was desperate, disorganized, impulsive, enraged, pacing, and talking almost incoherently. Gradually, primarily through his friends, the story emerged that his first sergeant had recently made a decision for the entire unit that had a particularly adverse effect on the patient. He was a fairly primitive character who relied on his wife for a sense of stability and coherence in his life. The sergeant's decision was to send the entire unit into the field for over a month just at the time the patient's wife was about to arrive, after a long delay, from the USA. After piecing together this story, the psychiatrist said to the patient, "It's not yourself you want to kill, it's your first sergeant!" The patient at first giggled a little, then gradually broke out into a belly laugh that echoed throughout the emergency room. It was clear that, having recognized the true object of his anger, a coherence was restored that enabled him to feel his rage without the impulse to act on it. The psychiatrist then enlisted the friends in a plan to support the patient through the month and to arrange regular phone contact with the wife as she set up their new home in Germany. No medication was necessary. Hospitalization was averted, and a request for humanitarian dispensation, which would have compromised the patient in the eyes of both his peers and superiors, was avoided as well. And, with luck, the young man had an opportunity to grow emotionally as well.

With emphasis on learning here and now symptoms that can bombard the dyad with foreground static and noise, will the patient be lost in the encounter? The same approach to listening occurs in the setting of the emergency department for crisis intervention. Emphasis is on symptom relief, assurance of capacities to keep oneself safe, restoration of minimal function, acute problem solving, and shoring up of defenses. Special attention is paid to identifying particular stressors. What can be done quickly to change stressors that throw the patient's world into a state of disequilibrium? The difference in the emergency room is that the careful listener may have 3–6 hours, as opposed to three to six sessions for the patient with a health maintenance organization or preferred provider contract, or other limitations on benefits. If one is fortunate and good at being an active listener–bargainer, the seeds of change can be planted in the hope of allowing them time to grow between visits to the emergency department. If one could hope for another change, it would be for a decrease in the chaos in the patient's inner world and outer world.

### Crucial Attitudes That Enable Effective Listening

The first step in developing good listening skills involves coming to grips with the importance of inner experience in psychiatric treatment and diagnosis. The advent of modern diagnostic classifications has been responsible for enormous advances in reliability and accuracy of diagnosis, but their emphasis on seemingly observable phenomena has

allowed the willing user to forget the importance of inner experience even in such basic diagnoses as major depressive disorder. Consider the symptom “depressed mood most of the day” or “markedly diminished interest or pleasure” or even “decrease or increase in appetite”. These are entirely subjective symptoms. Simply reporting depression is usually not sufficient to convince a psychiatrist that a diagnosis of depression is warranted. In fact, the vast majority of psychiatric patients are so demoralized by their illnesses that they often announce depression as their first complaint. Further, there are a significant number of patients who do not acknowledge depression yet are so diagnosed. The clinician might well comment: “Sitting with him makes me feel very sad”.

The psychiatrist must listen to much more than the patient’s overt behavior. There are qualities in the communication, including the inner experiences induced in the listener, that should be attended to. The experienced clinician listens to the words, watches the behavior, engages in and notices the ongoing interaction, allows himself or herself to experience his or her own inner reactions to the process, and *never forgets that depression and almost all other psychiatric symptoms are exclusively private experiences*. The behavior and interactions are useful insofar as they assist the psychiatrist in inferring the patient’s inner experience.

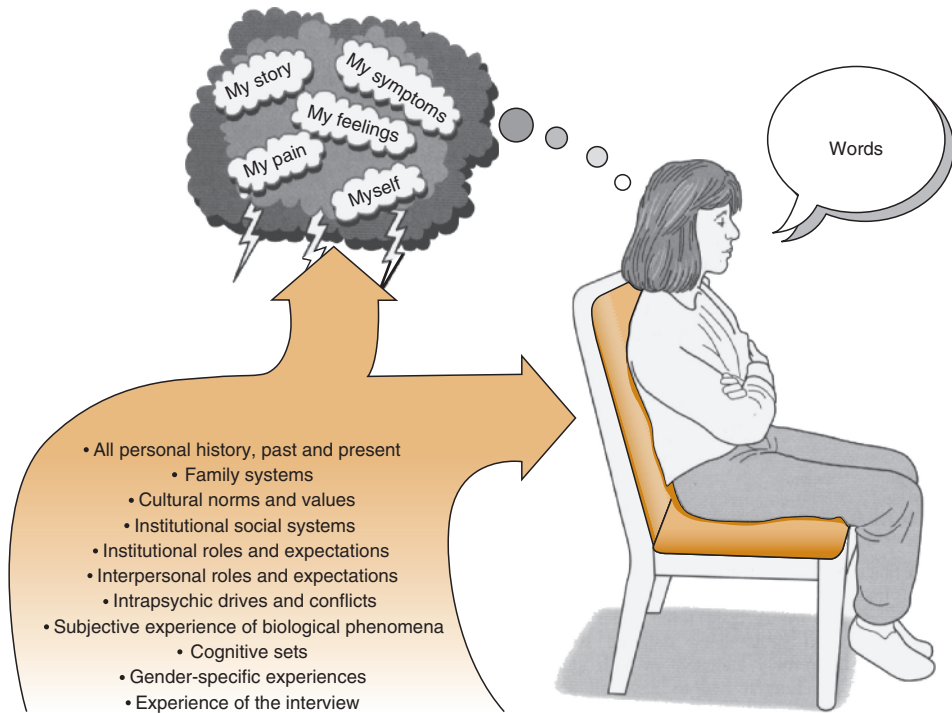
Therefore, to convince a clinician that a patient is depressed, not only must the patient say she or he is depressed, but the observable behavior must convey it (sad-looking face, sighing, unexpressive intonations, etc.); the interaction with the interviewer must convey depressive qualities (sense of neediness, sadness induced in the interviewer, beseeching qualities expressed, etc.). In the absence of both of these, other diagnoses should be considered, but in the presence of such qualities, depression needs to remain in the differential diagnosis.

Even when we make statements about brain function with regard to a particular patient, we use this kind of listening, generally, by making at least two inferences. We first listen to and observe the patient and then infer some aspect of the patient’s private experience. Then, if we possess sufficient scientific knowledge, we make a second inference to a disturbance in neurochemistry, neurophysiology, or neuroanatomy. When psychiatrists prescribe antidepressant medication, they have inferred from words, moved into inner experiences, and come to a conclusion that there is likely a dysregulation of serotonin or norepinephrine in the patient’s brain.

As one moves toward treatment from diagnosis, the content of inner experience inferred may change to more varied states of feelings, needs, and conflicts, but the fundamental process of listening remains the same. The psychiatrist listens for the meaning of all behavior, to the ongoing interpersonal relationship the patient attempts to establish, and to inner experiences as well.

Despite all of the technological advances in medicine in general and their growing presence in psychiatry, securing or eliciting a history remains the first and central skill for all physicians. Even in the most basic of medical situations, the patient is trying to communicate a set of private experiences (how does one describe the qualities of pain or discomfort?) that the physician may infer and sort into possible syndromes and diagnoses. In psychiatry, this process is multiplied, as indicated in Figure 1.1.

It was widely assumed that development, and problems related to development, effect the inner experiences of various affects. Does, for example, a person with borderline personality disorder experience “anxiety” in the same qualitative and quantitative manner in which a neurotic person does? What is the relationship between sadness and



**Figure 1.1** *Finding the patient* (Kay and Tasman, 2006).

guilt and the empty experiences of depression? This perspective underlies the principle articulated in text after text on interviewing that emphasizes the importance of establishing rapport in the process of history taking. It is incredibly easy for the psychiatrist to attribute to the patient what she or he would have meant and what most people might have meant in using a particular word or phrase. The sense in the narrator that the listener is truly present, connected, and with the patient enormously enhances the accuracy of the story reported.

Words that have been used to describe this process of constant attention to and inference of inner experience by the listener include interest, empathy, attentiveness, and noncontingent positive regard. However, these are words that may say less than they seem to. It is the constant curious awareness on the listener's part, that she or he is trying to grasp the private inner experience of the patient, and the storyteller's sense of this stance by the psychiatrist that impel the ever more revealing process of history taking. This quality of listening produces what we call rapport, without which psychiatric histories become spotty, superficial, and even suspect. There are no bad historians, only patients who have not yet found the right listener.

It is well established that two powerful predictors of outcome in any form of psychotherapy are empathy and the therapeutic alliance. This has been shown again and again in study after study for dynamic therapy, cognitive therapy, behavior therapy, and even medication management. The truth of this can be seen in the remarkable therapeutic success of the

**Table 1.3** Attitudes Important to Listening

|   |
|---|
| <p>The centrality of <i>inner experience</i></p> <p>There are no bad historians</p> <p>The answer is always inside the patient</p> <p>Control and power are shared in the interview</p> <p>It is OK to feel confused and uncertain</p> <p>Objective truth is never as simple as it seems</p> <p>Listen to yourself, too</p> <p>Everything you hear is modified by the patient's filters</p> <p>Everything you hear is modified by your own filters</p> <p>There will always be another opportunity to hear more clearly</p> |
|---|

“clinical management” cell of the National Institutes of Mental Health Collaborative Study on the Treatment of Major Depression. Although the Clinical Management Cell was not as effective as the cells that included specific drugs or specific psychotherapeutic interventions, 35% of patients with moderate to severe major depressive disorder improved significantly with carefully structured supportive clinical management alone (Elkin *et al.*, 1989).

Helpful psychiatric listening requires a complicated attitude toward control and power in the interview (see Table 1.3). The psychiatrist invites the patient/storyteller to collaborate as an active informer. He or she is invited, too, to question and observe himself or herself. This method of history taking remains the principal tool of general clinical medicine. However, as Freud pointed out, these methods of active uncovering are more complex in the psychic realm. The use of the patient as a voluntary reporter requires that the investigator keep in mind the unconscious and its power over the patient and listener. Can the patient be a reliable objective witness of himself or herself or his or her symptoms? Can the listener hold in mind his or her own set of filters, meanings, and distortions as he or she hears? The listener translates for himself or herself and his or her patient the patient's articulation of his or her experience of himself or herself and his or her inner world into our definition of symptoms, syndromes, and differential diagnoses, which make up the concept of the medical model.

Objective–descriptive examiners are like detectives closing in on disease. The psychiatric detective enters the inquiry with an attitude of unknowing and suspends prior opinion. The techniques of listening invoke a wondering and a wandering with the patient. Periods of head scratching and exclamations of “I’m confused”, or “I don’t understand”, or “That’s awful!”, or “Tell me more”, allow the listener to follow or to point the way for the dyad. Finally, clear and precise descriptions are held up for scrutiny, with the hope that a diagnostic label or new information about the patient's suffering and emotional pain be revealed.

It is embarking on the history taking journey together – free of judgments, opinions, criticism, or preconceived notions – that underpins rapport. Good listening requires a complex understanding of what objective truth is and how it may be found. The effective psychiatrist must eschew the traditional medical role in interviewing and tolerate a collaborative, at times meandering, direction in which control is at best shared and sometimes

wholly with the patient. The psychiatrist constantly asks: What is being said? Why is it being said at this moment? What is the meaning of what is being said? In what context is all this emerging? What does that tell me about the meaning of and what does it reflect about the doctor–patient relationship?

## Theoretical Perspectives on Listening

Listening is the effort or work of placing the therapist where the patient is (“lives”). The ear of the empathic listener is the organ of receptivity – gratifying and, at times, indulging the patient. Every human being has a preferred interpersonal stance, a set of relationships and transactions with which she or he is most comfortable and feels most gratified. The problem is that for most psychiatric patients, they do not work well, but the psychiatrist, through listening and observing, must understand the patient. Beyond attitudes that enable or prevent listening, there is a role for specific knowledge. It is important to achieve the cognitive structure or theoretical framework and use it with rigor and discipline in the service of patients so that psychiatrists can employ more than global “feelings” or “hunches”. In striving to grasp the inner experience of any other human being, one must know what it is to be human; one must have an idea of what is inside any person. This provides a framework for understanding what the patient – who would not be a patient if he fully understood what was inside of him – is struggling to communicate. Personality theory is absolutely crucial to this process.

Whether we acknowledge it or not, every one of us has a theory of human personality (in this day and age of porous boundaries between psychology and biology, we should really speak of a psychobiological theory of human experience), which we apply in various situations, social or clinical. These theories become part of the template alluded to earlier, which allows certain words, stories, actions, and cues from the patient to jump out with profound meaning to the psychiatrist. There is no substitute for a thorough knowledge of many theories of human functioning and a well-disciplined synthesis and internal set of rules to decide which theories to use in which situations.

Different theoretical positions offer slightly different and often complementary perspectives on listening (Table 1.4). Each of the great schools of psychotherapy places the psychiatrist in a somewhat different relationship to the patient. This may even be reflected in the physical placement of the therapist in relation to the patient. In a classical psychoanalytic stance, the therapist, traditionally unseen behind the patient, assumes an active, hovering attention. Existential analysts seek to experience the patient’s position and place themselves close to and facing the patient. The interpersonal psychiatrist stresses a collaborative dialogue with shared control. One can almost imagine the two side by side as the clinician strives to sense what the storyteller is doing to and with the listener. Interpersonal theory stresses the need for each participant to act within that interpersonal social field.

In the object relations stance, the listener keeps in mind the “other people in the room” with him and the storyteller, that is, the patient’s introjects who are constantly part of the internal conversation of the patient and thus influence the dialogue within the therapeutic dyad. In connecting with the patient, the listener is also tuned in to the fact that parts and fragments of him or her are being internalized by the patient.

**Table 1.4** Theoretical Perspectives on Listening

| Theory           | Focus of Attention  | Listening Stance                                    |
|------------------|---|---|
| Ego psychology   | Stream of associations  | Neutral, hovering attention                         |
| Object relations | Introjects (internalized images of others within the patient) | Neutral, hovering attention                         |
| Interpersonal    | What relationship is the patient attempting to construct?     | Participant observer                                |
| Existential      | Feelings, affect  | Empathic identification with the patient            |
| Self-psychology  | Sense of self from others                                     | Empathic mirroring and affirmation                  |
| Patient centered | Content control by patient                                    | Noncontingent positive regard, empathy              |
| Cognitive        | Hidden assumptions and distortions                            | Benign expert                                       |
| Behavioral       | Behavioral contingencies                                      | Benign expert                                       |
| Family systems   | Complex forces maneuvering each member                        | Neutral intruder who forces imbalance in the system |

The listener becomes another person in the room of the patient's life experience, within and outside the therapeutic hour. Cognitive and behavioral psychiatrists are kindly experts, listening attentively and subtly for hidden assumptions, distortions, and connections. The family systems psychiatrist sits midway among the pressures and forces emanating from each individual, seeking to affect the system so that all must adapt differently.

Referring again to Clinical Vignette 3, we can see the different theoretical models of the listening process in the discovery of the meaning of "little fella". Freud's model is one in which the psychiatrist had listened repeatedly to a specific association and inquired of its meaning. Object relations theorists would note that the clinician had discovered a previously unidentified, powerful introject within the therapeutic dyad. The interpersonal psychiatrist would see the shared exploration of this idiosyncratic manner of describing one's youth; the patient had been continually trying to take the therapist to "The Andy Griffith Show". That is, the patient was attempting to induce the clinician to share the experience of imagining and fantasizing about having Andy Griffith as a father.

Existentialists would note how the psychiatrist was changed dramatically by the patient's repeated use of this phrase and then altered even more profoundly by the memory of Andy Griffith, "the consummate good father" in the patient's words. The therapist could never see the patient in quite the same way again, and the patient sensed it immediately. And Kohut would note the mirroring quality of the psychiatrist's interpretation of the meaning of this important memory. This would be mirroring at its most powerful, affirming the patient's important differences from his family, helping him to consolidate the memories. The behavioral psychiatrist would note the



reciprocal inhibition that had gone on, with Andy Griffith soothing the phobic anxieties in a brutal family.

A cognitive psychiatrist would wonder whether the patient's depression resulted from a hidden assumption that anything less than the idyllic images of television was not good enough. The family systems psychiatrist would help the patient see that he had manipulated the forces at work on him and actually changed the definition of his family.

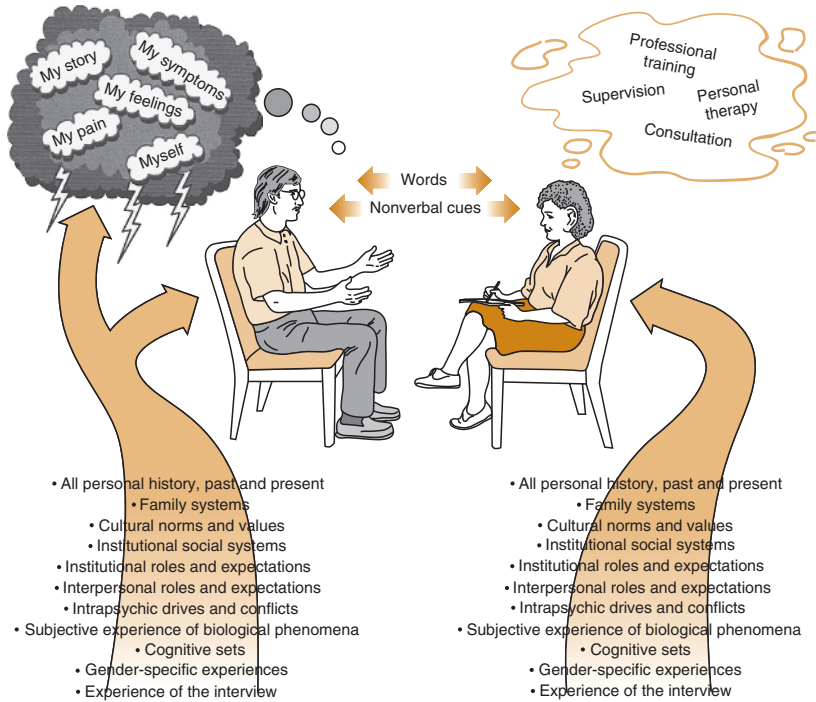
The ways and tools of listening also change, according to the purpose, the nature of the therapeutic dyad. The ways of listening also change depending upon whether or not the psychiatrist is preoccupied or inattentive. The medical model psychiatrist listens for signs and symptoms. The analyst listens for the truth often clothed in fantasy and metaphor. The existentialist listens for feeling, and the interpersonal theorist listens for the shared experiences engendered by the interaction. Regardless of the theoretical stance and regardless of the mental tension between the medical model's need to know symptoms and signs and the humanistic psychiatrist's listening to know the sufferer, the essence of therapeutic listening is the suspension of judgment before any presentation of the story and the storyteller. The listener is asked to clarify and classify the inner world of the storyteller at the same time he or she is experiencing it – no small feat!

## Using Oneself in Listening

Understanding transference and countertransference is crucial to effective listening. Tomkins, LeDoux, Damasio, and Brothers have given us a basic biological perspective on this process. However, one defines these terms, whatever one's theoretical stance about these issues. To know ourselves is to begin to know our patients more deeply. There are many ways to achieve this. Personal therapy is one. Ongoing life experience is another. Supervision that emphasizes one's emotional reactions to patients is still a third. Once we have started on the road to achieving this understanding by therapy, supervision, or life experience, continued listening to our patients, who teach us about ourselves and others, becomes a lifelong method of growth.

To know oneself is to be aware that there are certain common human needs, wishes, fears, feelings, and reactions. Every person must deal in some way with attachment, dependence, authority, autonomy, selfhood, values and ideals, remembered others, work, love, hate, and loss. It is unlikely that the psychiatrist can comprehend the patient without his or her own self-awareness. Thus, Figure 1.1 should really look like Figure 1.2. The most psychotic patient in the world is still struggling with these universal human functions (Clinical Vignette 10).

In this case, the psychiatrist was able to connect with a patient's inner experience in a manner that had a fairly dramatic impact on the clinical course. That is the goal of listening. The art is hearing the patient's inner experience and then addressing it empathically, enabling the patient to feel heard and affirmed. There are no rules about this, and at any given point in a clinical encounter, there are many ways to accomplish it. There are also many ways to respond that are unhelpful and even retraumatizing. The skilled psychiatrist, just as she or he never forgets that it is the patient's inner experience that is to be heard, also never stops struggling to find just the right words, gestures, expressions, and inflections



**Figure 1.2** *The therapeutic dyad* (Kay and Tasman, 2006).

### Clinical Vignette 10

A young man with paranoid schizophrenia had been admitted in 1979 to the hospital following a near lethal attack on his father. When asked about this incident, he became frankly delusional, speaking of the Arab–Israeli conflict, the preciousness of Jerusalem, how the Israelis must defend it at all costs. Unspoken was his conviction that he was like the Israelis, with the entire world attacking and threatening him. He believed his father had threatened and attacked him when, in fact, his father had done little more than seek to be closer, more comforting, and advising with the patient. The psychiatrist understood the patient to be speaking of that core of selfhood that we all possess, which, when threatened, creates a sense of vulnerability and panic, a disintegrating anxiety unlike any other. The psychiatrist spoke to the patient of Anwar Sadat’s visit to Jerusalem and engaged him in a discussion of how that had gone, what the outcome had been, had the threat been lessened or increased? The patient, although still delusional, visibly relaxed and began to speak much more directly about his own sense of vulnerability and uncertainty over his personal integrity and its ability to withstand any closeness. He still required neuroleptic medication for his illness; however, his violent thoughts and behaviors reduced dramatically. He was able to begin interacting with his father, and his behavior on the ward changed as well.

that say to a patient, “you have been understood”. The most clever diagnostician or insightful interpreter who cannot “connect” with the patient in this manner will miss valuable information. This issue has been addressed by writers who have pointed out how little understood are the concepts of support and empathy (Peteet, 1982).

Being human is also to be a creature of habit and pattern in linguistic, interpersonal, and emotional realms. The skilled psychiatrist listens with this ever in mind. What we see in the interview, what we hear in interactions may be presumed to be repetitions of many other events. The content may vary, but the form, motive, process, and evolution are generally universal for any given individual. This, too, is part of listening. To know what is fundamentally human, to have a well-synthesized rigorous theory, and to hear the person’s unique but repetitive ways of experiencing are the essence of listening. These skills “find” the patient in all his or her humanity, but then the psychiatrist must find the right communication that allows the patient to feel “found”.

### To Be Found: The Psychological Product of Being Heard

Psychiatric patients may be lonely, isolated, demoralized, and desperate, regardless of the specific diagnosis. They have lost themselves and their primary relationships, if they ever had any. Many therapists believe that before anything else can happen, they must be found, and feel found. They can only be found within the context of their own specific histories, cultures, religions, genders, social contexts, and so on. There is nothing more healing than the experience of being found by another. The earliest expression of this need is in infancy and we refer to it as the need for attachment. Referring to middle childhood, Harry Stack Sullivan spoke of the importance of the pal or buddy. Kohut spoke of the lifelong need for self-objects. In lay terms, it is often subsumed under the need for love, security, and acceptance. Psychiatric patients have lost or never had this experience. However obnoxious or destructive or desperate their overt behavior, it is the psychiatrist’s job to seek and find the patient. That is the purpose of listening.

If we look back to Clinical Vignette 3, wherein the phrase “little fella” bespoke such deep and important unverbally meaning, the patient’s reaction to the memory and recognition by the psychiatrist was dramatic. He had always known he was different in some indefinable ways from his family. That difference had been both a source of pride and pain to him at various developmental stages. However, the recognition of the specific source, its meaning, and its constant presence in his life created a whole new sense of himself. He had been found by his psychiatrist, who echoed the discovery, and he had found an entire piece of himself that he had enacted for years, yet which had been disconnected from any integrated sense of himself.

Sometimes objectifying and defining the disease/disorder enables the person to feel found. One of the most challenging patients to hear and experience is the acting out, self-destructive, demanding person with borderline personality disorder. Even as the prior sentence conveys, psychiatrists often experience the diagnosis as who the patient is rather than what he or she suffers. The following case conveys how one third-year resident was able to hear such a patient, and in his listening to her introduce the idea that the symptoms were not her but her disorder (Clinical Vignette 11).

### Clinical Vignette 11

The psychiatrist was working the midnight Friday to 11 a.m. Saturday shift in a Psychiatric Emergency Room. The patient was a 26-year-old woman brought in by ambulance after overdosing on sertraline following an argument with her boyfriend. She had been partying with him and became enraged at the attention he was paying to the date of a friend who was accompanying them. After being cleared medically, the patient was transferred to psychiatry for crisis intervention. It was about 4 a.m. when she arrived. She was crying and screaming for the psychiatric staff to release her. In the emergency department, she had grabbed a suture scissors attached to the uniform of the charge nurse. The report was given to the psychiatric resident that she had been a “management problem” in the medicine ER.

The psychiatrist sat wearily and listened to the patient tell her story with tears, shouts, and expletives sputtered through clenched teeth. She stated that she did not remember ever being happy, that she frequently had thoughts of suicide, and that she had overdosed twice before, following a divorce from her first husband at the age of 19 and then 8 months prior to this episode when she had been fired from a job for arguing with her supervisor. Her parents had kept her 6-year-old and 7-year-old sons since her divorce. She was currently working as a file clerk and living with her boyfriend of 2 months. She stated that she felt like there was a cold ice cube stuck in her chest as she watched her boyfriend flirting with the other woman. She acknowledged that she felt empty and utterly alone even in the crowded bar. She created an unpleasant scene and they continued to argue until they got home. Then he had laughed at her and left, stating that he would come back when she had cooled down.

The resident sat quietly and listened. He looked dreary. The night had been a busy one. She looked at him and complained, “Don’t let me and my problems bore you!” He looked at her and said, “Quite the contrary. I’ve been thinking as you speak that I know what disorder you suffer from”. With that statement, he pulled out the DSM-IV and read with her the description of the symptoms and signs of borderline personality disorder. She had been in therapy off and on since she was 16 years old. No one had ever shared with her the name of the diagnosis but instead had responded to her as if the disorder was the definition of who she was. In his listening, he was able to hear her symptoms as a disorder and not the person. And in his ability to separate the two, he was able to allow her to distance herself from the symptoms, too, and see herself in a new light with her first inkling of her own personhood.

Gender can play a significant role in the experience of feeling found. Some individuals feel that it is easier to connect with a person of the same sex; others, with someone of the opposite sex. Clinical Vignette 6 is an excellent example of this. In these days of significant change in and sensitivity to sex roles, a misinterpretation such as that early in treatment could result in a permanent rupture in the alliance. Psychiatrists vary in their sensitivity to

**Table 1.5** The Basic Sciences of Listening

|  |
|--|
| Neurobiology of primary affects<br>Universality of certain affective expressions<br>Neurobiology of empathy<br>Biological need for interpersonal regulation<br>Psychobiology of attachment<br>Biological impact of social support<br>Environmental impact on central nervous system structure and function |
|--|

the different sexes. Some may do better with those who have chosen more traditional roles; others may be more sensitive to those who have adopted more modern roles.

We now know that just as there is a neurobiological basis for empathy and countertransference, there is a similar biological basis for the power of listening to heal, to lift psychological burdens, to remoralize, and to provide emotional regulation to patients who feel out of control in their rage, despair, terror, or other feelings (Table 1.5). Attachment and social support are psychobiological processes that provide the necessary physiological regulation to human beings. A neurobiological view supports the notion of the patient's capacity to perceive empathy through the powerful nonverbal, universally understood communication of facial expressions. His research in basic human emotions sets forth the idea of their understanding across cultures and ages. It further supports the provocative idea that facial expressions of the listener may generate autonomic and central nervous system changes not only within the listener but within the one being heard, and vice versa. Indeed, the evidence is growing that new experiences in clinical interactions create learning and new memories, which are associated with changes in both brain structure and function. When we listen in this way, we are intervening not only in a psychological manner to connect, heal, and share burdens but also in a neurobiological fashion to regulate, modulate, and restore functioning. When patients feel found, they are responding to this psychobiological process.

### Listening to Oneself to Listen Better

To hold in mind what has been said and heard after a session and between sessions is the most powerful and active tool of listening. It is a crucial step often overlooked by students and those new at listening. It is necessary to hear our patients in our thoughts during the in-between times in order to pull together repetitive patterns of thinking, behaving, and feeling, giving us the closest idea of how patients experience themselves and their world. In addition, many of our traumatized patients have not had the experience of being held in mind, of being remembered, and their needs being thought of by significant others. These key experiences of childhood affirm the young person's psychological being. It is important to distinguish this kind of "re-listening" to the patient – an important part of the psychiatrist's ongoing processing and reprocessing of what has been heard and experienced – from what some may leap to call countertransference. One way of identifying this distinction would be to differentiate listening to oneself as one reviews in one's mind the

patient's story versus becoming preoccupied and stuck with one's thoughts and feelings about a particular aspect of a patient (Clinical Vignette 12).

As the verbal interaction with the patient occurs, psychiatrists may find themselves expressing thoughts and feeling in ways that may be quite different from their usual repertoire. The following case is an example.

This sort of listening to oneself in order to understand the patient requires a good working knowledge of projective identification. Projective identification is a phrase

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### Clinical Vignette 12

A second-year resident, rotating through an inpatient unit that serves the psychiatric needs of very severely ill psychotic patients with multiple admissions, dual diagnoses, homelessness, criminal records, significant histories of medical noncompliance, and, in some, unremitting psychosis, was particularly struggling with a 33-year-old white woman admitted for the 11th time since age 19. The patient invariably stopped medications shortly after discharge, never kept follow-up appointments, and ended up on the streets psychotic and high on crack cocaine. She would then be involuntarily committed for restabilization. And so the cycle would repeat itself. The resident would see the patient on daily rounds. The patient's litany was the same day after day: "I'm not sick. I don't need to be here. I don't need medicines". And regularly she refused doses.

The resident spoke often of her patient to other residents in her class and often found herself ruminating about the patient's abject lostness. She began her regular supervision hours either frustrated or feeling hopeless that anything would change with this patient because the patient flatly refused to acknowledge her disorder. The patient's level of denial was of psychotic proportions. Shortly after a particularly difficult encounter with the patient concerning her refusal to take an evening dose of haloperidol, the resident came to supervision with the report that she had awakened terrorized by dreaming the night before that she had been diagnosed with schizophrenia. She had been intensely affected by overwhelming pain, confusion, and despair as she heard the diagnosis in her dream. "IT CAN'T BE!" she screamed, waking herself with a shaking start. "I'M NOT SICK! I DON'T NEED TO BE HERE! I DON'T NEED MEDICINE!" The words of her patient echoed in her mind as her own echoed in her ears. She had taken the patient's story and words home with her and kept them in mind at an unconscious level to be brought up in her dream, the ultimate identification with the patient. How more intensely can one be empathic with her patient than to dream as if she is experiencing the same horrifying reality? The patient and resident continued to struggle, but after the dream the resident was able to approach the patient and her story from a position of understanding the patient's need to maintain a lack of awareness or absence of insight. To acknowledge the presence of the disorder was more than the patient's already fragmented ego could bear. And now the resident "heard" it.

used to describe a defense mechanism in which the patient, in an effort to master intolerably terrifying emotions, unconsciously seeks to engender them in the therapist and to identify with the psychiatrist's ability to tolerate and handle the feelings (Clinical Vignettes 13 and 14).

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### Clinical Vignette 13

A 45-year-old divorced white woman, being followed for bipolar disorder and borderline personality traits and stable for several years on lithium, was in weekly psychotherapy. During the prior weekend, she had moved into another apartment closer to her work. On the day of the move, she overslept and woke up with a start. The admonition to herself as she awoke was, "You lazy bitch! You can never manage on your own". She had earlier, as a child, experienced a mother who was needy, engulfing, punishing, hostile, critical, and dependent upon the patient. Her therapist, having some knowledge of the patient and her background, said, "Your mother is still with you. It was she in your head continuing to bombard you with derogatory statements". The same patient was often 10 or 15 minutes late for sessions, and her therapist found herself irritated at the patient's habitual tardiness. To her own surprise and enlightenment, the therapist also found herself thinking, "What a chaotic woman! She'll never manage to be here on time". She, too, had heard the voice of her patient's mother. In the next session, she wondered with her patient if she found herself wishing to place her therapist in the position of her mother, wanting at once to be engulfed and punished.

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### Clinical Vignette 14

A psychiatrist was treating a 40-year-old man who was in the process of recognizing his own primary homosexual orientation. In the course of treatment, he became enraged, suicidal, and homicidal. After one session, the psychiatrist, while driving home, experienced the fantasy that when he got home, he would find his patient already there, having taken the psychiatrist's family hostage. The psychiatrist became increasingly terrified, even outright paranoid that this fantasy might actually come to pass. The patient was a computer expert who had indeed discovered the unlisted phone number and address of his therapist. But the psychiatrist realized that this fantasy was far out of keeping with his own usual way of feeling and the patient's way of behaving and viewing him. On arriving home to discover his family quite safe, the psychiatrist called the patient and scheduled him as his first for appointment the following morning. When the patient arrived, the psychiatrist said, "You know, I think I'm only now beginning to appreciate just how terrified and desperate all of this makes you". The patient slumped down into his chair, heaved a sigh, and said, "Thank God!"



## Listening in Special Clinical Situations

### Children

Listening to younger children often involves inviting them to play and then engaging them in describing what is happening in the play action. The psychiatrist pays careful attention to the child's feelings. These feelings are usually attributed to a doll, puppet, or other humanized toy. So if a child describes a stuffed animal as being scared, the psychiatrist may say, "I wonder if you, too, are scared when..." or "That sounds like you when...". The following case is an example (Clinical Vignette 15).

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#### Clinical Vignette 15

A 4-year-old boy was brought in for psychiatric evaluation. He and his father had come upon a very serious automobile accident. One person had been thrown from the car and was lying clearly visible on the pavement with arms and legs positioned in grotesque angles, gaping head wound, obviously dead. The child's father was an off-duty police officer who stopped to assist in the extraction of two other people trapped in the car. The father kept a careful eye on the youngster who was left in the car. The child observed the scene for about 30 minutes until others arrived on the scene and his dad was able to leave. That night and for days to come, the child preoccupied himself with his toy cars, which he repetitiously rammed into each other. He was awakened by nightmares three times in the ensuing weeks. During his evaluation in the play therapy room, he engaged in ramming toy cars together. In addition, he tossed dolls about and arranged their limbs haphazardly. As he was encouraged to put some words to his action, he spoke of being frightened of the dead body and of being afraid to be by himself. He was afraid of the possibility of being hurt himself. He came in for three more play sessions, which went much the same way. His preoccupation with ramming cars at home diminished and disappeared as did the nightmares. The content of his play was used to help him put words and labels on his scare.

### Geriatric Patients

Working with the elderly poses its own special challenges. These challenges include not only the unique developmental issues they face but also the difficulty in verbalizing a lifetime of experience and feelings, and, commonly, a disparity in age and life experience between the clinician and the patient.

It is challenging to elicit the elements of a story, especially when they span generations. The elderly are often stoic. In the face of losses that mark the closing years of life, denial often becomes a healthy tool, allowing one to accept and cope with declining abilities and the loss of loved ones. The psychiatrist must appreciate that grief and depression can often be similar in some respects (Clinical Vignette 16).

### Clinical Vignette 16

A psychiatrist was asked to examine an 87-year-old white man whom the family believed to be depressed. They stated that he was becoming increasingly detached and disinterested in the goings-on around him. When seen, he was cooperative and compliant, but he stated that he didn't believe he needed to be evaluated. The patient had faced multiple losses over the past few years. After retiring at the age of 65, he had developed the habit of meeting male friends at a coffee shop each morning at 7 a.m. Now, all but he and one other were dead, and the other was in a nursing home with the cognitive deficits of primary dementia of the Alzheimer's type, preventing his friend from recognizing him when visiting. The patient's wife had died 15 years ago after many years of marriage. He had missed her terribly at first but then after a year or so he got on with his life. Several years later, he suffered a retinal detachment that impaired his vision to the point that he was no longer able to drive himself to get about as he once had. What he missed most was the independence of going places when it suited him, rather than relying on his son or grandson to accommodate him within their busy schedules. He had taken to watching televised church services rather than trouble his son to drive him to church. His mind remained sharp, he said, but his body was wearing out, and all the people with whom he had shared a common history had died. His answers were "fine" and "all right" when questions of quality of sleep and mood were asked – despite the fact that he had experienced significant nocturia. When questioned about his ability to experience joy, he retorted, "Would you be?" His youngest sister had died the year prior to the evaluation. She was 76 years old and had been on home oxygen for the last 18 months of her life for end-stage chronic obstructive pulmonary disease. He had been particularly close to her because she was only 3 years old when their mother had died. He had been her caretaker all her life.

Although he denied feelings of guilt, he said that it "wasn't right" that he had outlived the youngest member of his family. His family said that he had taken her death especially hard and was tearful and angry. The focus of his anger during the final stages of her illness was at the young doctors whom he perceived as having given up on her. After her death, it fell to him to dispose of her accumulated possessions as she had no children and her husband had preceded her in death many years before. At first, he said that he couldn't face the task. Finally, some 2 months later, he was able to close her estate. During that period of time, he had significant sleep disturbance, reduced energy, and his family often experienced him as crotchety and complaining. They and the patient attributed it to mourning her loss. However, recently he was emotionally detached, not very interested in life around him, and they found it particularly alarming that he had said to his son that he was "ready to die". What did all this mean? Was he depressed? Was he physically ill, creating the sense of apathy and disinterest? Was he grieving? He was not suicidal. He did not suffer negative thoughts about his own personhood. He was not having thoughts that he had let anyone down. Together, he and the psychiatrist decided that he was indeed grieving. This time, he was grieving for his own decline and imminent death. He, in fact, was in the final acceptance phase of that process. In a family meeting, in the discussions about the feelings of each member of the family, it became apparent that he was facing the end of life, which evoked many emotions in those who loved him.

## Chronically Mentally Ill

Listening to the chronically mentally ill can be especially challenging, too. The unique choice of words characteristic of many who have a thought disorder requires that the physician search for the meanings of certain words and phrases that may be peculiar and truly eccentric. Clinical Vignettes 1, 10, and 12 are examples of this important challenge for the psychiatric listener (Clinical Vignettes 17 and 18).

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### Clinical Vignette 17

A young man with schizotypal personality disorder and obsessive–compulsive disorder presented for months using adjectives describing himself as “broken and fragmented”. Only after listening carefully, not aided by the expected or normal affect of a depressed person, was the psychiatrist able to discern that his patient was clinically depressed but did not have the usual words to say it or was unable to discuss it.

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### Clinical Vignette 18

A 32-year-old black woman who had multiple hospitalizations for schizophrenia and lived with her mother was seen in the community psychiatric center for routine medication follow-up. Her psychiatrist found her to have an increase in the frequency of auditory hallucinations, especially ones of a derogatory nature. The voices were tormenting her with the ideas that she was not good, that she should die, that she was worthless and unloved. Her psychiatrist heard her say that she had wrecked her mother’s car 2 weeks previously. The streets had been wet and the tires worn. She had slid into the rear of a car that had come to an abrupt stop ahead of her on a freeway. Although her mother had not been critical or judgmental, the patient felt overwhelming guilt as she watched her mother struggle to arrange transportation for herself each day to and from work.

Chronically psychiatrically disabled patients may have a unique way of presenting their inner world experiences. Sometimes the link to the outer world is not so apparent. The psychiatrist is regularly challenged with making sense of the meanings of the content and changes in intensity or frequency of the psychotic symptoms.

## Physically Ill Patients

In consultations with a colleague in a medical or surgical specialty, one is evaluating a patient who has a chronic or acute physical illness. The psychiatrist must listen to the story of the patient but also keep in mind the story as reflected in the hospital records and medical and nursing staff. Then the psychiatrist serves as the liaison not only between psychiatry and other medical colleagues, but also between the patient and his or her caregivers (Clinical Vignette 19).

### Clinical Vignette 19

A 35-year-old woman was hospitalized for complications of a pancreas/kidney transplant that was completed 20 months previously. Prior to surgery she had been on dialysis for over a year awaiting a tissue match for transplantation. That year she had been forced to take a leave of absence from her job as a social worker with a local child and adolescent community center. At the time of this hospitalization, she had been back at work for only 8 months when she developed a urinary tract infection that did not respond to several antibiotics. Her renal function was deteriorating and her doctors found her to be paranoid, hostile, and labile. Her physicians dreaded going into her room each morning and began distancing themselves from her.

Psychiatric consultation was sought following a particularly difficult interaction between the patient and her charge nurse, the leader of the transplant team, and the infectious disease expert. She was hostile, blaming, agitated, circumstantial, refused further medications, and pulled out her intravenous lines. The consultation requested assistance in hospital management.

When interviewed, the patient was lying quietly in bed but visibly stiffened when the psychiatrist introduced herself. She very quickly exhibited the symptoms described in the consultation. This patient had struggled with juvenile onset diabetes since the age of 9. Despite the fact that she consistently complied with diet and insulin, control of blood sugars had always been difficult. As complication after complication occurred, she often developed the belief that her physicians thought that she was a “bad” patient. And now, the hope that her life would normalize to the point that she could carry on with her career was dashed. She felt misunderstood and alone in her struggle with long-term, chronic illness. The psychiatrist resonated with the story emotionally and listened for ways to address symptoms from a biological standpoint as well. The patient felt reassured that someone was there to appreciate the tragic turn that her life had taken.

### Growing and Maturing as a Listener

Transference/countertransference influences not only relationships in traditional psychotherapy but also interactions between all physicians and patients and is always present as a filter or reverberator to that which is heard. However, even the most experienced of listeners are not always aware of the ways in which their patients’ stories are impacted by countertransference. Patients come, too, with tendencies and predispositions to experience the listener, the other person in the therapeutic dyad, in familiar but distorted fashion. The patient may idealize and adapt to interpretations. She or he may be hostile and distrustful, identifying the psychiatrist in an unconscious way with one who has been rejecting in the past. Listening to the “flow of consciousness”, the psychiatrist discerns a thread of continuity and purposefulness in the patient’s communications. As the psychiatrist becomes more and more familiar with his or her patient, he or she will discover the

connections between threads and the meaning will become apparent. This awareness may come as a sign and symptom, fantasy, feeling, or fact.

There is an increasing recognition that to be a healing listener one must be able to bear the burden of hearing what is told. Like the patient, we fear what might be said. A patient's story may be one of rage in response to early childhood attachment ruptures or abuse, of sadness as losses are remembered, or of terror in response to disorganization during the experience of perceptual abnormalities accompanying psychotic breaks. The patient's stories invariably invoke anger, shame, guilt, abject helplessness, or sexual feelings within the listener. These feelings, unless attended to, appreciated, and understood, will block the listening that is essential for healing to take place. Every insight is colored by what the listener has known. It is impossible to know that which is not experienced. The psychiatrist comes with his or her own experiences and the experiences he or she has had with others. To listen in the manner we are describing here is another way of truly experiencing the world. The experiences include the imaginings of how it must be to be 87 years old as a patient when one is a 35-year-old doctor just finishing residency, to be female when one is male, to be a child again, to grow up African-American in a small white suburb of a large city, to be an immigrant in a new country, to be Middle Eastern when one is Western European, and so on. One comes to know by listening with imagination, allowing the words of the patient to resonate with one's own experiences or with what one has come to know through hearing with imagination the stories of other patients or listening to the thoughts or insights of supervisors (Clinical Vignette 20).

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### Clinical Vignette 20

A Jewish resident was treating an 8-year-old Catholic boy who came in one day and mentioned offhandedly that he was about to go to his first confession. The psychiatric resident made no particular note of the issue and kept on listening to the boy's play and its themes. He noted that guilt, which had been an ongoing theme, was prominent again. When he presented the session in supervision, the supervisor wondered about the connection. It emerged that there was a large gulf between the therapist and the boy. Jewish concepts of sin and atonement are different from Christian ones, and the rituals surrounding them have rather different intentions and ideas of resolution. The resident had missed the opportunity to explore the young boy's first introduction, within his religious context, to the belief in a forgiving God, a potentially important step in helping the child to resolve his ongoing struggles with guilt over his own greedy impulses.

The best psychiatrists continue all their professional lives to learn how to listen better. This may be thought of not only as a matter of mastering countertransference but of self-education. One must learn to recognize when there are impasses in the treatment and to seek education, from a colleague or, perhaps, even from the patient. Consider these two examples.

How can the psychiatrist's demeanor convey to the patient that he or she is safe to tell his or her story, that the listener is one who can be trusted to be with him or her, to worry with him or her, and serve as a helper? Much is written about the demeanor of the psychiatrist. The air, deportment, manner, or bearing is one of quiet anticipation – to receive that which the patient has come to tell and share in the telling. Signals of anticipation and curiosity may be conveyed by such statements as “I’ve thought about what you said last time”, “How do you feel about...?”, “What if...?” (Clinical Vignette 21).

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### Clinical Vignette 21

A psychiatrist began treating a Nigerian native who was suffering from posttraumatic stress disorder (PTSD) after being assaulted at work. After several sessions, the psychiatrist felt a sense of being at a loss in terms of what the patient was expecting out of their work and how the therapist was being seen by the patient. He then took several sessions to inquire of the patient about his tribe, its structure, family roles, definitions of healing, ideas of illness and wellness, etc. After this exploration, the psychiatrist adopted a different stance with the patient, heard the patient's communications very differently, and the therapy proceeded much more smoothly and comfortably to a successful conclusion.

Efforts of clarification often serve as bridges between sessions and communicate that the listener is committed to a fuller understanding of the patient. Patients have the need to experience the psychiatrist as empathic. Empathy describes the feeling one has in hearing a story which causes one to conjure up or imagine how it would have been to have actually have had an experience oneself. How does one integrate all this so that it is automatic but not deadened by automaticity? How does the psychiatrist continue to hear the “same old thing” with freshness and renewal? How does one encourage the patient with consistency, clarity, and assurance in the face of uncertainty and occasional confusion? Not by assurance that everything will be all right when things might probably not be. Not by attempting to talk the patient into seeing things the clinician's way but rather by the psychiatrist's having the capacity to hear things his or her patient's way, from the patient's perspective.

Psychiatry is one of those rare disciplines where the experience of listening over and over again allows the listener to grow in their capacities to hear and to heal. Hopefully, we get better and better as the years advance, become smoother, and develop a style that blends with our personality and training. We are renewed by the shared experiences with our patients.

To hear stories of the human condition reminds the psychiatrist that he or she, too, is human. There is time to make discoveries in the patient's stories from previous times, and maybe in previous patients. Patients will always endeavor to tell their stories. The psychiatrist continues to grow by being the perpetual student, always with an ear for the lesson, the remarkable life stories of his or her patients.

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