In Anticipation of Symposium 2014

By Sy Gers, M.D.

When I arrived early for our Tuesday morning Mount Sinai Psychotherapy Faculty Conference, Phil L, the Associate Director, said he was glad to see me because he wanted to draw my attention to the article in the Science Times that talked about mothers who were with their infants in the playground and on their smart phones, iPads or tablets and shifting their attention between their children and the screens they were watching. He said it reminded him of what I always point out in my frequent comment, ... “It’s what goes on back and forth between mother and child ... that’s what's important.” Perhaps it's because Phil has a one year old toddler at home that he doesn’t seem to have any difficulty in understanding exactly what I mean about the 'back and forth' I refer to in discussions of what goes on in psychotherapy.

On the other hand, Jeff G says he's often in agreement with many of my clinical observations, but finds that my frequent use of the phrase 'back and forth' without specifically identifying what I’m referring to is disquieting. He said that I appear to be anticipating that others will agree or accept what I say without ever defining what I actually believe, or spelling out the theory or concept upon which my psychotherapy beliefs are based. This is a valid observation.

In a discussion with my therapist, I said that I thought I should try to write up my own thoughts about what I believe was effective in psychotherapy in anticipation of my attending the Symposium 2014 on "What Works" so that what would be presented at the meeting would not influence my ideas about what is really effective in psychotherapy. My therapist and I made eye contact, and laughingly said in almost simultaneous identical speech: “There is no way that this psychoanalytic symposium is going to say anything that will influence my thoughts about what works in psychotherapy!”

I have requested that I not be introduced because when you hear what I think and believe you will know more about me than any list of accomplishments or positions that I have held in the past.

I have referred to individuals in my description by first name and capital letter because I neither sought nor received permission to use their comments or statements in my presentation.

What I expect to hear in a traditional psychoanalytically oriented discussion is ... in the beginning ... there is 'the Word!’ But that is not what we anticipate when there is the birth of a new individual. What we expect to hear is ... ‘the Sound!’ The way that we know that there is a new life starting is when we hear that first sound ... it’s ‘a cry!’ A cry for help from a totally helpless and dependent human being to a caring and helpful one, the very first back and forth that occurs is a ‘communication’. It has no words, ... it is pre-verbal, ... but it is the first means of communication available to us, ... and ... ‘it works.’ As demonstrated in Tronick’s Still Face Study with two and three month old infants ‘at play’ with their mothers, ... there is back and forth communication that involves sound, i.e. baby talk, gibberish, cooing, etc., eye contact, smiling facial expression, continued movement and activity. Until on a preset signal with the mother, all of the above communication with the child will stop as she assumes a ‘still face’ position for two minutes, with no sound, no movement, no eye contact and with only a fixed, expressionless ‘still face’ presentation instead of the previously animated and engaged mother, who now appears to be gazing off in the distance. The response of the child is dramatic. The pleasant, playful facial expression disappears and is replaced by an alarmed and distressed expression that seems about to burst into tears, or to cry out in apparent pain or discomfort, signifying that he or she has lost contact with this desired affectionately pleasant and dedicated object. In less than two minutes the calm and apparently placid infant was changed into a distraught and distressed state with seemingly apparent painful affects and feelings, agitation and crying, and an inability to be soothed or calmed, resulting from simply interrupting the back and forth communication of this infant with its caregiver. No painful, traumatic stimuli had been introduced, no sudden or disruptive or startling noises had intruded and nothing distressing was presented, ... except for the interruption of the preexisting back and forth communication that was present between the two of them. And, ... oh yes, on a prearranged signal the caregiver resumed her eye contact, smiling facial expression, pleasant baby talk and gurgling sounds and animated movements and activity, resulting in an almost immediate response by the infant to restore the
pleasant and contented status between infant and caregiver.

This preverbal back and forth communication continues to develop during our early years and goes from the almost total satisfaction of what most infants need in the beginning to more communicative forms of expression so that there develops incremental levels of interchange that are recognizable to attuned children and primary caregivers. It all starts out as non-verbal and pre-verbal communication. This is the model for what I believe is the underlying mechanism for what is the pre-verbal and non-verbal back and forth communication that produces the therapeutic effect of psychotherapy, i.e. any talk therapy. It is the basic model for what Freud later labeled as 'transference.'

It starts with a cry for help from the totally helpless individual to the able caregiver, and gradually develops over years until the establishment of verbal language, which then becomes an additional form of communication that can now be shared with a much wider audience. The primary non-verbal and pre-verbal communication remains an active form of communication along with language. Language does not replace non-verbal communication. Non-verbal communication does not become verbal communication with the development of language. BOTH continue to thrive and function, side by side through the remainder of life.

Freud pointed to our reliance on non-verbal communication in his "The Psychopathology of Every Day Life" when he noted that body language and facial expression often reveal more about truth and believability than someone's verbal communication, no matter how seriously and straightforwardly the words are presented.

Bob L continues to stress that this non-verbal model of communication does not 'go away' when verbal language develops but remains functional and significant alongside verbal communication throughout life. We use non-verbal communication to express our affective states. Our gasps, groans and sighs are not part of any language but certainly communicate to others how we feel. Facial expression alone can indicate if we are happy, neutral or sad. Our body language may show our aggressive, defensive or seductive inclinations, ... all without saying a word.

We can also see this in the non-verbal communication that is of special importance between some mothers and some of their children, between some siblings, between musicians, especially those playing in groups like string quartets or orchestras, between members of athletic teams, and between some therapists with some of their patients, ... at certain times. It is this model of the unequal interchange between a trained caregiver and someone 'being cared for' that psychotherapy relies upon for its effectiveness, ... in addition to the psychoanalytically informed language exchanged in most insight-oriented therapeutic relationships.

Jeff G had also commented that at times I appear to disparage the importance of theory in psychotherapy, and has gone on to make the point that regardless of the type or theoretical orientation of the therapy that we are providing, we must have some theoretical formulation in mind that guides what we actually do with our patients and what the intended goal might be. I believe he may have been responding to my earlier expressed observation that when we look at the broad therapeutic landscape that currently exists in society, we see psychotherapists of a variety of theoretical orientations and training, from an almost equally large assortment of disciplines ranging from psychology and social work through pastoral and other counseling orientations and theories, etc., who are sitting with patients or clients, and are engaged in providing psychotherapy, which I believe to be in some degree effective and successful. I have come to this conclusion that despite the different theoretical formulations being utilized that this therapeutic process is providing effective treatment because when I view such a treatment scene I am impressed that this diverse assortment of therapists can all be successful regardless of the theory they individually have in mind. I surmise this because despite all the differences and variations, the patients keep coming back! They must be getting something from their therapy!

I share Jeff G's view that any effective insight-oriented psychotherapy is probably derived from psychoanalytically-informed theories, regardless of the form of treatment provided. However, since not all psychotherapies are insight-oriented or psychodynamic therapies utilizing the analysis of free associations as primary source material, I still maintain that what actually takes place in effective psychotherapy is some variation of the back-and-forth interchange between the trained and motivated care-giver and the to-some-
degree needy patient. Since the needs of the individual seeking 'help' has not been specified, we might expect to find an assortment of types of treatment needs being satisfied in the form of support, providing 'how to' practical and other educational information, advice, second opinions, as well as various forms of therapy including desensitization, relaxation, cognitive, interpersonal and insight-oriented and psychodynamic informed therapies, etc. I also believe that with the assistance of 'positive transference' these treatments would be experienced as successful. As we can see from this example, my views and understanding of the use or application of 'theory' are quite different from Jeff G.'s. He uses the classical psychoanalytic model applied to non-analytic cases because certain basic principles and theories apply in other psychotherapeutic treatments, ... while my model is based more on Daniel Shore's "The First Interpersonal Relationship of the Infant" rather than Freud's Technique of Psychoanalysis. Another way of expressing this is that my theoretical model is 'pre-Freud' or a version of Shore's preverbal communication from the earliest years of life through the development of language.

I initially said that I wanted to set down my own thoughts about 'what works' before attending Symposium 2014 so that I wouldn't be influenced by what I heard at the meeting, ... but after more than 100 years since Freud defined and spelled out his theories and techniques for Psychoanalysis based in part on the analysis of the 'free associations' of patients on the couch, we find that current leaders in the field are still debating and discussing what is therapeutic and 'what works.' This is somewhat disheartening after all this time to still be questioning what works. This became another reason for me to recognize the limitations of all these verbally based theories and techniques and to focus on the preverbal and non-verbal communications that predate the use of language in chronological development, and perhaps also in importance.

Preverbal communications have been primarily affective and continue to convey the emotional aspects of our experience throughout our lives. They do not disappear or diminish in importance with the subsequent development of language, but persist in the unconscious, which is timeless, and in our everyday lives. This has been repeatedly emphasized by Bob L who has pointed to all the essential functions of our non-verbal communications and our empathic relatedness in our every day experiences, including our ability to empathize and engage a patient in psychotherapy. Child psychiatrists use 'play therapy' to treat children and adolescents rather than verbal therapies based on the analysis of free associations.

Perhaps we can come up with some fruitful findings in our search for 'what works' by expanding our field of interest to include preverbal and non-verbal communications along with the theoretical formulations derived from analysis of all those freely associated words.

I am aware that I have been considered by some as an 'anti-theory' provocateur, but my interest in 'what works' is still as active as ever. Although it is clear from what I have just written that I don't have the answer to the persistent question of 'what works', ... but I certainly continue to try to find an answer in the more clinical aspects of our work. It is with such a spirit of inquiry that I submit the following vignettes for your consideration.

Vignette – 1
My wife returned from her college reunion weekend and told me about the farewell dinner at which she was seated at the same table with the woman who had been her freshman advisor when she arrived at college. This woman was also advisor to another freshman who had a different girl as her roommate. This other roommate had been involved in a serious auto accident. The freshman advisor actually brought the girl to visit her roommate in the hospital where she was being treated for her major injuries. She also met with her when the roommate died, and continued to meet with her for a period of time afterward. I became aware that both my wife and I were crying as she told of this dinner encounter. I asked: "Why do you think we are both crying now about something that happened so long ago?" My wife dried her tears and considered why she was reacting now to this incident and said: "I don't know." After a while I ventured that I thought it was probably because it reminded her that this freshman advisor was so much more concerned and caring than her own mother. She replied: "I don't think so. I've known for a long time that my mother was more interested in herself than in me. That was one of the reasons that I was so glad to get away to college." I said: "Being aware of something unpleasant or unacceptable like that is Psychoanalysis, ... but having to say it to another human being is the beginning of 'Psychotherapy.'"
Vignette – 2
During a discussion of the merits of psychotherapy at a Psychotherapy Faculty Conference, Herb P mentioned that following the 12 Step Protocol was an essential element in achieving the therapeutic benefits of Alcoholics Anonymous meetings, especially in the opening statement: “Hello my name is so-and-so, and I’m an alcoholic.” He went on to explain that the individual has to ‘take ownership’ of his condition if the therapy was to be effective. Because of my curiosity, my wife and I attended a performance of “Bill W. and Dr. Bob”, which was playing off-Broadway at the time. It vividly portrayed how these two outwardly successful alcoholic men, who were unrelated to each other, and came from completely different backgrounds, but were able to establish a mutually beneficial relationship so that they were able over time to stop drinking, and aid and support each other through their recovery period. All of this, despite the fact that so many concerned and well-intentioned relatives and/or trained professionals at the time had been dismally unsuccessful. They started their 12 Step Program in their effort to bring their success in stopping their alcoholism to other alcoholics. However, they did NOT use the 12 Step Program to achieve their success, which hadn’t been devised until afterward.

I have no way of knowing what transpired between Bill W. and Dr. Bob, but I suspect that they established a caring, non-critical and respectful relationship with each other and were then able to tell each other the unacceptable things about themselves, that they had been aware of themselves for a long time. I believe that it was having to tell another human being what they already knew about the unacceptable things about themselves that began an effective psychotherapeutic process, that they then wanted to bring to other alcoholics, and devised the 12 Step Program.

Vignette – 3
My wife brought me an article from the Times Sunday Review Section and said someone else seemed to be saying what I had said to her previously. Because this was written by a writer, an excerpt from “Private Lives, a series of personal essays.” I am going to copy the article directly rather than attempt to summarize or condense his experience with my words. Perhaps you will better understand what I have been attempting to point out, if it is expressed by someone else in their own words.

A Bottle of Water in Brazzaville

By LAIRD HUNT JULY 17, 2013, 8:01 PM

Private Lives: Personal essays on the news of the world and the news of our lives.

Boulder, Colo.

Lately, I have been thinking of how best to talk about something that happened last year in Brazzaville, the capital of the Republic of Congo, where I was traveling, with support from the State Department, as part of a delegation of writers from the University of Iowa’s International Writing Program.
It involved a young man and a bottle of water. I had the bottle of water and the young man didn’t. I had spent the afternoon in the company of this young man, who was a participant in a writing workshop I had co-taught for a few hours in a hot, stuffy room. I had spoken directly to the young man and he had spoken directly to me.

Like his fellows, the young man was smart and passionate. The workshop was a pleasure. We talked about memory and the imagination. We did writing exercises. Many of the participants, including the young man in question, wrote about things they remembered and did not remember but imagined about the country’s recent civil war. When the workshop was over, and we had made our farewells and stepped out into the blazing Brazzaville afternoon, the State Department local staffer who was helping facilitate the event handed me a bottle of water. I opened this bottle and drank from it deeply.

Some minutes later, as we were preparing to get into our van and drive away, the young man in question, who carried a worn leather briefcase and wore smart, if now sweat-stained clothes, came up and asked the facilitator if there was something to drink; he was thirsty. The facilitator, who was holding his own bottle of water, told him there might be some bottles back inside. The way he said this was not hope-inspiring. It occurred to me to offer the young man my bottle of water, but for fear, perhaps, of seeming patronizing or overfamiliar, or of somehow insulting the facilitator who had not handed over his own bottle, or for some other reason, I did not do so.

The young man smiled politely, thanked us and went inside to investigate, and we climbed into the van. As we drove off, the facilitator, who was young and Congolese himself, said he wished he had brought more water, that some of the students had walked
for hours to attend the workshop, and that they would now walk for hours to get home.

It is one thing to write something down. It is another to try to tell it out loud.

When I have tried, for example, to tell people about that moment on the sidewalk in Brazzaville, I know I have failed. I can shrug my shoulders and say “bottle,” “water,” “Brazzaville.” I can describe, without ever actually accomplishing it, how easily the moment, and the whole of the trip surrounding it, might be made into an instructive if all-too-familiar parable on the deeply fraught and too often deleterious nature of such well-meaning encounters between members of developed and developing countries. One of those moments that end when one person steps into a waiting van and heads back to an air-conditioned hotel and the other sets off to walk for hours under the hot sun.

What I repeatedly find I cannot express, when I launch my verbal shards of that day into the air is what I really mean to, the core of what I want to say about the moment. Which is something along the lines of, “One hot day in another country, I had some water and someone else was thirsty and I did not give him what I so easily could have.” Which itself is a circumlocution, possibly an unforgivable one, for what I will never be able to say in person: “I’m sorry.”

Vignette – 4
I felt that I was unexpectedly given a gift of clinical material by Eva K when she presented a case to our Mount Sinai Psychotherapy Conference. It involved a young rabbi whose serious procrastination problem prevented him from completing his post graduate studies and getting on with his rabbinical career. She presented process notes from a recent session in which he was complaining about
having to babysit his infant daughter because his wife was busy fulfilling other chores outside the home, while he was trying to work on his paper. His daughter was particularly cranky that morning and cried a lot. He kept trying unsuccessfully to soothe and comfort her but was not getting any of his work done. Although he described all of these events in detail, including his dissatisfaction at not being able to get his own work done, Eva K. had to repeatedly ask him “How did you feel?” because he related this in a distant mechanical manner. At one point he angrily complained that his wife should be taking care of the children, and that he was angry and frustrated that he was not able to calm his crying daughter, and wasn’t able to do any of his own work, ... and sometimes he even wished that ‘she hadn’t been born!’ Eva described the sudden silence that followed this loud and angry expression of his feelings. This was followed by a stunned silence! When he was able to speak again he finally said in a faint voice: “That is the first time that I have said anything like that ... out loud!”

At this point I am suggesting that the long held theoretical goal of psychoanalysis, ... ‘to make the unconscious conscious,’ is NOT sufficient to bring about therapeutic change, ... but that having to say what you already know but find somehow unacceptable, ... to another human being is what can make it psychotherapeutic!

I realize that none of my vignettes are from clinical material. I am offering my suggestion in response to the Symposium question: ‘what works’ ... and invite clinicians in our field to view their clinical work from this perspective ... and share their experience and opinions with the rest of the field.

Informational Note:
The writer and his wife met for the first time some 17 years ago in a Traditional Irish Dance Class, where they became partners while learning ‘Set Dancing.’ Set Dancing is similar to American Square
Dancing ... except that Set Dancing is non-verbal, ... there is NO Caller!