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CREATING SPACE

Yesterday, on the eve of Christmas Eve, I received a card from a patient I've seen several times a week for eight years. The card was beautiful on the outside, embossed and embroidered colorfully with five horses (she owns two). Inside, the card was blank, except for the simple words she had penned:

> you have given me myself.
> thank you for the rest of my life.
> I will live it well.

We do sacred work. It is no less than that. It's because of the potentials of this work that I write, straining to orient, demystify, and make accessible what might seem beyond our reach. The acquired art of psychodynamic psychotherapy involves a whole symphony of skills, and slowly mastered capacities to read and feel and play music of various intensities, with just the right touch at the right moment. The nuance can be daunting. But there will be time for nuance and touch and timing. There will be a lifetime for those things. We are, together, sketching out some of the basics of it that nuance will enhance as time goes on.

Imagine a two-clef arrangement of the music of psychodynamic psychotherapy. Until now, we've been talking about what you need to be able to play with your right hand: the treble clef, so to speak. It carries the melody (most of the time). In our work, this involves the art of listening deeply, listening in an attuned way, listening in a way that is surprisingly different from ordinary listening. The other clef—the bass clef—provides the background music that gives context and meaning and depth to the melody. This plays on your left hand (for most of us, the less dominant hand), and is perhaps mastered more slowly. This clef involves the art of understanding what you're hearing in the therapy *over time*, and what is going on within the music that you and your patient play together.

But for now, I will take us one further step in the art of listening before we turn to the art of understanding. We will touch on what goes into creating the space of resonance, attunement, and potential that I've spoken of so far. How do we find the place from which listening deeply occurs? What does that space look like and feel like within and outside, and how do we optimize the chance that moments of meeting will occur?

In Old Testament symbology, when God directed the building of the temple, he described its construction in detail, including the ark of the covenant, which was to be housed in the holy of holies in the temple; the innermost sanctuary. The ark was to have a platform of solid gold with two gold seraphim (angels) at each end. Between these angels, there was to be a blank space, a place of nothing—nothing but air. That sacred, uncluttered space was to be the place where these most holy meetings between God and man were to occur.

The art of listening deeply requires space, within and outside. Space uncluttered by ordinary social rituals, by the warmth of niceties that are unconsciously but continuously extinguishing anxiety for us before it can find its voice. Space big enough and still enough to hold the aloneness of the one, in the presence of the other. These holiest of meetings, between the unthought, unuttered parts of the one and the listening stillness of the other, these require the disciplined space of potential, or "potential space," as Winnicott would call it. Gaston Bachelard, in *The Poetics of Space*, puts it this way:

> Immensity is within ourselves. It is attached to a sort of expansion of being that life curbs and caution arrests, but which starts again when we are alone. As soon as we become motionless, we are elsewhere; we are dreaming in a world that is immense. Indeed, immensity is the movement of motionless man. It is one of the dynamic characteristics of quiet daydreaming.
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> *(1969: p. 184)*

Psychodynamic psychotherapy takes place in this space of immensity—in the space where the aloneness of the one can meet with itself and come to know itself in the presence of the other. And this space of meeting is delicate, indeed! Years ago, I worked with a senior therapist at an early point in my training who would stride into the waiting room of our clinic, find his (usually male adolescent) client, and, with a sweeping gesture, would slap the client on the back, and say in an upbeat voice, "How ya doin' today, buddy? Come on back!" I couldn't help thinking at the time that in his well-intentioned enthusiasm to set a welcoming and upbeat tone, he had ended the session before it had had a chance to get started.

The internal space of listening deeply requires first and foremost that we collect ourselves inside for the encountering of another person in a kind of raw, unadorned form. Raw and unadorned. Several days ago I visited my friends' newborn baby, Emma, on her second day of life. She was completely without shield or cover—having not yet learned the ways of being human—having to take in the gaze and the energy of any who would come into her space. It was precious and disarming,

but it also struck me as dangerously unprotected. We learn beyond our very first days the art of wrapping ourselves—in social ritual, in bravado, in cleverness, or warmth, or humor, or distance, or authority. It becomes our invisible protection, constantly and unconsciously keeping watch for us against the dangers of the other.

The space of listening deeply, should we want to enter this space, requires an unwrapping of ourselves as therapists—a shedding of the normal cocoon of protection that is our ordinary second skin—a making room for the full force of the other. This means many things—some of them seemingly very small—that mark out this space as big enough and still enough, and steady enough to contain what may want to come forth.

We do many things reflexively (unconsciously) to cover this space ordinarily. The things I write about in this chapter may threaten these coverings. You may be inclined to dismiss them out of hand because they "don't fit" your style, or seem too small to matter. I offer a note of caution in this regard. In 1867, Joseph Lister first proposed the practice of keeping a sterile field in surgery. At that time, the post-surgical death rate was 50%. The aphorism, "the surgery was successful, but the patient died" was the true and common parlance of the day. Lister's methods, although simple and unobtrusive, were met with skepticism and indifference, even hostility. His interventions were perhaps seemingly too small to be of consequence. But some small things really matter. In psychodynamic psychotherapy, they can make the difference between a treatment that lives and one that does not.

Starting Moments

The therapy starts from the moment of our first encounter with our patient-to-be. Our moment of greeting (even our first moments on the phone) must say, "This is a *different* space. In this space, there will be more room for you than you've become accustomed to. In this space, I will wait—we will wait—to encounter you on your terms."

As we prepare ourselves for our first encounter with a particular patient, the clamor of thoughts and concerns that beset us as new therapists (often as old therapists) about our competence, about how this first session will go and what this person will say back to their referral source, about whatever else assails our attention before the moments of meeting, need to be recognized by us and turned aside from, so that we have the space of our own receptivities available. It means that our hearts must be uncluttered with our own need for this person to see us in a particular way or to have a particular response to us. In its place, there should be a simple openness and curiosity of spirit. We don't know what will happen here; what will emerge from this person and in this relational field. We don't know what will be brought forth from them or in us. It is ours only to provide a space where the unknown thing might come forth.

Concomitantly, there should be the recognition that for this person, our new patient, this moment of meeting will be daunting and difficult. They will have thought about this all week, they will perhaps not have slept well the night before.

They will have had to negotiate the (conscious or unconscious) anxiety of choosing the clothes they would wear this day to present themselves to us, finding our office, and getting there at the appointed time. Then there will be the moment of meeting us in person when they have to do the quick internal work of adjusting the image they had formed of us in advance, based on the sound of our voice in the first phone conversation and whatever other information they've gleaned about us in advance. They don't know how it will go in this first session, or what will be asked of them.

Setting the Tone

First moments are pivotal; they set the metric for all that follows. The first few minutes of a therapy are that blank space of meeting that set the tone for the whole of it. As much as our social training has taught us the trade of dispelling anxiety, our job at the outset of a therapy is the opposite: to make a place where anxiety can live in plain sight; to make a place where, over time, a whole range of hidden feelings can live in plain sight.

So, instead of the reflexive launching ritual that includes such para-greetings as "Welcome. Did you have trouble finding this place?" or "I hope this meeting time wasn't too inconvenient for you," there is a blank space, appointed only with the inquiry, "Brett? I'm Dr. Quatman. Please come on back." Instead of a little filler chat about the weather as we make our way down the hall to the therapy room, there is quietude. Instead of the social back and forth as we are seated that might include, "Oh, I really like your office." "Thanks, so do I. I've been here in this building since 1992," there is a blank space. There is an unspoken honoring of the anxiety involved—for the therapist and the patient—in starting a therapy.

This is a practiced and disciplined blank space that is entirely the therapist's responsibility to create. We as therapists can choose to fill up the space of initial anxiety, but in so doing, to paraphrase Ogden (1989), we have committed an act of robbery, having robbed the patient of his or her unique way to find themselves in our presence and their own, and to start the voyage of their own therapy. This is not a *rule* of doing the work, it is a *tool* of doing the work. Setting the tone is a way of communicating from the first moment that we will be with one another in a way the patient hasn't been with another before.

One of my consultees worked in her internship at the local YWCA. The distance between the waiting room and the therapy rooms was an L-shaped hallway that extended half a city block. The discipline of walking all that way each time, well enough ahead of the patient so as to quell that person's attempts at idle chatter was nothing short of valiant in my mind. But necessary to the work, and my fleet-footed consultee could feel that this was true.

The Room

Once we are through the not insignificant first moments of meeting, greeting and seating, there is the all-important first volley. But let me back up. Seating is

important. It's important to be clear about where a patient should sit. It is not OK to indicate that they may sit anywhere. Your seat is a pre-designated space that is set up in a particular way. Your clock is visible to you; what the patient may see in terms of artwork and windows, etc., is something you've set up in advance. Should the patient, by mistake, head for your chair, it's of no small importance to interrupt their movement and reset where they will sit. This is a claiming of your space, which will occur in a temporal sense with the ending of each session. Also, the physical space between the chairs is important. It should be enough to allow their aloneness in your presence; a little more than how you might space normal living room chairs. And here's an extremely practical but utterly critical part of things: I use a digital clock for my sessions, seated on a table to the right of my chair. I routinely have a mug of water that sits on that table. If my mind loses track of the time with my own internal clock, a motion to lift or replace my water mug gets me a good look at the clock.

Office décor is also important. Bion conducted his therapy in an entirely bare room. Pictures of your family or your vacation trip to Hawaii pull the fulcrum of the therapy away from the inner life of your patient, and toward your own personal life. As intimate as a therapy will become, this is not to be the ground on which the therapy is conducted. These are some of the silent background pieces of a practiced therapy.

First Volley

Back to the all-important first volley. As difficult and "antiseptic" as this may sound, it's important to allow the patient to start the session, however they can, with whatever awkwardness or lostness this evokes. This is a signature moment, and it should be signed in the patient's own hand.

In my own practice, I wait. Some starting patients aren't sure what the silence means. They guess their way into the space. "Am I supposed to start?" I nod in response, slowly, with warmth and resoluteness. "I don't know what to say. Why don't you ask me some questions?" "You seem anxious," I might say in response. "Can you tell me what feels anxious about trying to tell us why you've come?"

In such a moment, we've begun together to tell the emotional truth of it. This is exactly what we will try to do the entire way along. There is also the inevitable patient who wants to start with how therapy works, or what your particular therapeutic orientation is. A simple response that says that it will be clearer if we show them rather than tell them is a helpful way to get the onus of starting back where it belongs.

From the beginning, here's what's happening: the patient is beginning a relationship with you that is destined to be the same as *and* different from all other relationships they've ever had. The same as, in the sense that we as humans have a certain pattern that defines and bounds how we are used to "doing" ourselves and being with another person. We try as much as possible to color within these familiar lines with every other we encounter. A relationship that is different, in that

we together will look at and consider these lines and patterns, with all of their various meta-communicative and emotional pushes and pulls, in order to understand their familiarity and function (and constriction). This is what's in play from the first moments. To insert ourselves too patently into this space at first is to usurp from the patient their attempt to enact the familiar with us, so that someday, we can together create the unfamiliar.

Initial Considerations

A note to therapists in agency and training settings. First sessions are desperately important. They set the metronome for the whole of it, as we've said. As new therapists in random training sites with assorted supervisors, there are the inevitable requirements for a structured history-taking, and an elaborated explanation of the exceptions to confidentiality, etc. As much as possible, it's important to start the therapy in a different space from those up-front concerns. Some make their way through this territory by having the legalities and exceptions to confidentiality occur in the initial screening and session set-up process; others, by presenting these things in a written statement before the beginning of the session itself. Some alert their supervisors that they want the history to emerge organically, to be part of the way the patient introduces themself to you. These are realities of training sites that have to be negotiated.

The Space of Quiet

Quietude is the coin of the realm in the beginning. It is the chrysalis from which something of new form will slowly emerge. Sitting quietly with a patient allows us to feel their (somatic) energy, to experience the psychic pulls that they exert on us. It allows us to begin the process of losing ourselves in their presence (and they in ours); of yielding to the thoughts and reveries their presence evokes in our internal (imaginal) theatre.

I'm reminded of an entertaining story told at a local psychoanalytic society gathering by one of the guest speakers. He had decided to begin his own therapy with a well-respected psychoanalytic psychotherapist in the area, finally getting the courage to phone with his inquiry about perhaps starting a therapy at some point. Not thinking that he would be successful in his foray, he was surprised and shocked that the analyst could accommodate him that week at 7:00 a.m. two days from then.

Getting over the jolt of it, the speaker agreed to the meeting, considering privately that it was quite a distance and *quite* an early appointment time. On the appointed day, he rose early in the morning to make his way to the therapist's office. He drove the long distance, arrived at the therapist's office, was greeted and found his way into the therapy room.

He knew in advance that he would probably need to start the session himself, so he did. He made his way anxiously through one topic, then the next, and then

the next, finding himself more and more fitful and uncomfortable as the session continued. At minute 48, he had heard nothing from the therapist—not a word. He considered all the emotional energy that had gone into the decision to see this man, all the hours of nervous anticipation, his fitful night of sleep followed by the inclemently early point of rising. It was all too much for him.

He launched into an end-of-session diatribe. "Fuck you," he said, "and fuck this! I've come all this way to see you, borne all of this anxiety and anticipation and inconvenience. I have talked this entire time, and you have said nothing! This is a fucking waste of time!" To which the therapist at last responded, "Well," he said, "if you could do *that* more often, I suspect you wouldn't need to come here anymore." The speaker knew that he had hit on the truth of it, and felt uncommonly seen by the comment, understanding that in the silence, the whole time, the therapist had been getting to know something quite close to the essence of him. This precipitously tumultuous start was the beginning of a long and successful analysis.

There are huge upsides for the therapy when there is space from the beginning. Often, we are presented with a microcosm of the patient's way of being as they first try to introduce themselves to us. We are, from the beginning, immersed in a field of psychic particles that each person emits. We feel their particular anxiety and their particular way of being with, or positioning the other, around that anxiety. We register their presence in our own bodies—often quite subtly—and feel different energies from the different people we meet in this way. But the art of it lies in creating and allowing the space for this; a space quiet enough for us to detect the barely detectable signals of the patient's inner world.

Creating Space in the First Session

Let me see if I can give us a sense of this creating space from the beginning of things, which facilitates a taking in of the patient's energy, and in turn gives us an experience "in microcosm" of this patient, and why they've come. I'll use moments from the starting session of two patients.

Tedi

The first, I will call Tedi. She was a health ed counselor in the mental health field. She had encountered me in a continuing education workshop I had co-taught, and felt from that venue that she might be able to work with me.

We started the session as I normally do, allowing her to stake out the territory as she wished. She spoke fast, but with a certain emotionality that seemed at first alive to me. As the session went on, I (in my quietude) began to feel a slight sense of agitation. I couldn't describe it to myself. It was no doubt registering itself at the (somatic) level of my body. I remember at first looking into the picture on the wall just adjacent to her, trying to disengage myself enough to locate my experience of what was going on as she talked to me. I eventually took the freedom to close my eyes and attempt to feel what it felt like to be in her presence.

After 30 or so minutes of continuing to listen to her, I saw in my mind's eye (the imaginal register) a stacked set of two large television sets. The upper one—the one at eye-level—had nothing but static on it; the lower one was playing a TV program, but I couldn't quite see what was playing. It struck me that the energy in the room was well described by this split-screen arrangement. I sat with the image for a while, allowing its meaning to suggest itself further to me. I wanted to be able to say something to the patient that was emotionally true to what was happening in that first session.

I stopped her monologue at some point, and with the aid of the picture that had formed in my mind said to her, "You know, there's something I'm noticing as we've been sitting here together. It seems there are two things going on between us today. One is the conversation we're having; the other is in the background but may be more important, because it seems to be carrying more of the story—the anxiety that perhaps you're feeling as you're with me today, but wanting to distract yourself from, and me as well. I wonder whether you feel that in here as we're talking?"

She said that she did, and that she often was aware of a background of anxiety in herself that she didn't know what to do with. She said that at one level or another, it was always with her. She said she was embarrassed that it showed, but relieved at the same time that we could name it and that she wouldn't be required to cover it up as she usually does. Our efforts to slow her down and allow her to feel and understand this anxiety were to become central to the therapy, there in small measure from the first session. Had there been no psychic space for me to consider my internal experience in her presence, this first session might have steered the therapy in a quite different direction.

Barb

The second patient, whom I will call Barb, came to me from a colleague of mine who had led a short-term outpatient group that Barb had attended. She began talking, letting me know that she had had therapy in the past, and that she knew how this went, so to speak. She said this several more times, and I remember being put off by this. To my mind she was suggesting from the outset that nothing new was to be happening in this therapy.

It felt to me as though her description of this initial encounter was roughly akin to the process of having a mammogram—a procedure one has repeatedly over time, where the humans involved are incidental. I also felt strangely uncomfortable, crowded by her presence and the volume of her voice, as I would be on a hot July day, standing in a grocery line with someone's bare arms next to me, occasionally touching into me. I felt a sense of discouragement, not knowing if I would be able to work with this person.

In addition, toward the end of the session, at about the two-more-minutes point, I was suddenly presented in my mind's eye with a picture of Niagara Falls, roaring with power, unstoppable. I braced myself for the moment, sensing that the

patient (undoubtedly unconsciously) was about to launch into an end-of-session fight for an unstoppable extension of the normal time frame. Armed, I was able to say to her that I sensed that what she was attempting to talk to me about was emotionally important, and that I did not want to dishonor it by squeezing it into the thin sliver of time we had left together.

At the fifty-minute point, I stood up from my chair and moved over to my desk area where I typically make out a receipt for the session. As I turned to pivot back toward the patient's chair, I found her standing just a few inches from me. "Can I have a hug?" she asked importunately. "I actually don't do that," I managed to return (relieved to have found words for this moment), "but we can talk about it the next time you're here."

This was a moment when the patient was unconsciously maneuvering to ground the relationship in the familiar for herself. It was a desperately important moment for the therapy, because in addition to being her attempt to drive down the anxiety stirred in her by the session, it communicated in microcosm the impingements inherent in *being* the patient, and my own willingness as therapist to freeze the dance mid-motion in order to *understand* it rather than to (motorically) *enact* it.

The preceding moments of the session had also been part of the microcosm. I was to come to find out, as the therapy moved forward, that she had suffered insufferable impingements of her bodily person and her sense of ownership of her own time and space, from babyhood, at the hands of an off and on psychotic mother. These were the impingements she was putting into motion with me in the therapy from the beginning moments of it. Even my sense of the therapy's feeling *generic* was a foreshadowing of something she had felt on the receiving end of her mother's care. Had I made it my goal to make us both comfortable in that initial interchange, much of what she was communicating to me would have been covered over, perhaps never to be unearthed. In large part, although she did not know it at the time, my experience of her in the first session was at the heart of why she had come to the therapy.

First Session Comments

There are two more pieces I'll mention about creating the space of psychodynamic psychotherapy during the first session. The first is something I've just mentioned. That is, that as much as is possible, I try in the first session to say something of the emotional truth of this encounter between us. This will be my effort the whole way along in the therapy, but if I have the words for it in the first session, I try to say something of it. This communicates to the patient and to myself that this will be the territory of the therapy—that we will be letting the emotional truth between us emerge and be worded as it can (so that it can be transformed). If it has not otherwise surfaced, I often ask a patient at the end of the session if they can tell me what it has been like for them as we've met together today; how they've experienced it, themselves, me. This begins to put their experience of our relationship into play.

The second is something extremely hard to achieve as a new therapist: simply ending the session. This is an unbelievably potent expression of the "space" of the therapy. If the session is allowed to go beyond its appointed time—to spill over "out of bounds," so to speak—we've communicated many things besides our gracious generosity toward and interest in this patient. We've said simultaneously, "I'm afraid of you," "I'm afraid of my own aggression," "I'm afraid you won't like me," "I don't value my time," and "This space won't be steady enough and sturdy enough to hold you and what you bring to it." We've said, in Winnicott's parlance, that there won't be the space for "hate" in this room, so there can't be the space for authentic love either (1947). These are all unconscious communications that take place from the beginning of the therapy, and this piece, though seemingly small, is another pivotal part of creating the space of it.

Necessary Disciplines

We started this chapter with the question, "What does creating the space of psychodynamic psychotherapy look like and feel like within and outside, and how do we optimize the chance that moments of meeting will occur?" The parts and pieces I've shared with you in this chapter have been meant to make sense of the kinds of disciplines necessary to this acquired art. A closing story might put this in better light.

My friend's daughter pursued ballet at a professional level. One afternoon, when I was a guest in their home, she tried to teach me the positioning of one's body that is part of the art of ballet. Amidst my irrepressible laughter and futile attempts to follow her instructions, I could not believe that all that *contortion* was the backweave of such beautiful choreography. But she had acquired it over time, muscle by muscle, bone by bone. And in the end, it equipped her to dance with incredible grace and beauty. It was, for her, truly an acquired art.