I sometimes think I became a therapist not only to make a difference and help people, but because I was starved for conversation growing up. In the world of my childhood, a tight-knit, working-class neighborhood in New York’s Washington Heights in the 1950s and ’60s, none of us kids, and absolutely no one in our families, seemed to genuinely talk to each other, even for a minute. Neighborhood gossip, ritualized chitchat, spirited debates about the relative athletic merits of Willie Mays and Mickey Mantle, expressions
of everyday affection, occasional outbreaks of emotion—sure, those happened all the time. But back-and-forth discussion with questions and responses and then more questions that went in directions you couldn’t predict—not even on the radar! My friends and I played ball, ogled girls, and craved cars, but I don’t remember having a single significant thought in my head, not to mention sharing a thought with anyone else, until I was about 19. We were boys, and as such, nothing more than a bunch of roving reflexes; limbic systems pretending to be human beings. It never occurred to us to inquire about what other people thought or how they experienced life.

This lasted until I met a couple of equally conversation-deprived kids in college who became my best friends. We discussed everything possible, like the annoying vagaries of our parents, the foibles of friends, and, unbelievably, our values and evolving political beliefs. On all fronts, those shared discoveries of “Hey, I’ve felt that same thing, too!” was the most satisfying human exchange I’d yet experienced, until I actually found a girlfriend and discovered that conversation combined with sex was even better. Talking with her about all the same things, but on a deeper emotional level, like “What do you think he meant by that?” or “You’re saying this hurt your feelings?!” or “I’m not sure whether going to this rally might offend my friend who doesn’t believe in this issue—what do you think?” was astonishingly absorbing. When I mustered the courage to move out of my parents’ house after college (albeit a mile away), I did so with two major purposes in mind: to become independent with all the grown-up adventure that entails (while still able to bring laundry home) and in search of more conversation.

When I decided to become a psychologist, I figured conversation would be an essential part of my professional life. What was “talk therapy,” after all, except a specialized form of revealing conversation? But as far as my psychotherapy training in grad school went, I was dead wrong. Of course, in the hallways and between classes we “processed” anything that moved—nothing about what we saw, heard, felt, thought, or imagined seemed too trivial to discuss for hours. But once a therapy session began, that all changed. Free-flowing, spontaneous conversation was verboten. It wasn’t OK to communicate in anything other than the strictly proscribed, impoverished language of therapy-speak.

What was important back then, in the Golden Age of Rogerian psychotherapy and American psychoanalysis, was a mix of unflinching positive regard and in-depth therapeutic interpretation. What was “talk therapy,” after all, except a specialized form of revealing conversation? But as far as my psychotherapy cases. I do remember one of my first supervisors rousing himself from his usual state of inscrutable impassivity to mumble, “Well Ron, that’s another mess you’ve gotten yourself out of.” I learned a lot in the process of countless supervisory hours, but it could be summed up in variations of that one phrase we’ve all used and abused thousands of times, “How does that make you feel?”

So here we were, therapists-in-training at the beginning of the psychotherapy explosion gabbing endlessly together as peers, seeming to understand the centrality of conversation in love, human exchange, and development, but learning absolutely nothing about conversation.

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**We were taught to hold back, to answer every question with moment, to deliver insights the bulwark of resistance.**

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We were taught to hold back, to be blank screens, to answer every question with another question, and, at the right moment, to deliver insights that would cut right through the bulwark of resistance and get to the core of the inner psyche. I’ll never forget a classmate of mine speaking to me before a session as he girded himself with the armor and weaponry of the psychoanalytic warrior. His last words as he went off to battle were, “I’ve been thinking about this great interpretation all week. I’m gonna absolutely nail her!” Forgetting for a moment the sexualized nature of this, my friend’s strategy was clear—he wouldn’t utter a single word until he saw an opening in his unsuspecting client’s psychic defenses through which to launch his therapeutic missile.

Even supervision was an exercise in “conversation-deprivation.” Most of my extremely well-regarded mentors would say almost nothing for hours at a time, as I rambled on incoherently about my own state of inscrutable impassivity to mumble, “Well Ron, that’s another mess you’ve gotten yourself out of.” I learned a lot in the process of countless supervisory hours, but it could be summed up in variations of that one phrase we’ve all used and abused thousands of times, “How does that make you feel?”

Then suddenly in the late ’60s and early ’70s, the world changed in every way imaginable, including the treatment room. Out of nowhere, R. D. Laing began disentangling the psyche in The Divided Self and Knots. Beyond the precints of therapy, the country had quietly entered into a “sharing-caring” mode, spearheaded by 12-step programs of every variety. Werner Erhard began his first iteration of est. Sensitivity groups proliferated; self-actualization and relatedness became our watchwords. The formal therapy universe was profoundly affected by the writings of Heinz Kohut, Alice Miller, and such object-relations...
theorists as D. W. Winnicott, Harry Guntrip, and Ronald Fairbairn, who opened the window onto a new world of “inter-subjectivity.” In what was now acknowledged to be “the therapeutic relationship,” a genuinely mutual connection between therapist and client was beginning to be seen as a critical ingredient in treatment.

But even this new awareness of relationship somehow morphed into therapies that, while different from the old, hard-nosed analytic model, soon became just as rule-bound in their own way. Now, rather than being a neutral presence, we were enjoined to turn every clinical exchange into an achingly authentic, existential moment of truth, fraught with capital-M meaning about fateful choices and agonizing doubts. Sometimes in the therapy something serious. Weren’t the unpredictable vagaries, the ebb and flow, the sheer accidental quality of conversation beside the point of “real” therapy?

Since I wanted to work with kids and teens, I chose to train in family therapy at the Philadelphia Child Guidance Clinic under the watchful eye of the legendary Salvador Minuchin. With this move to Philadelphia, any brief foray of mine into the let-it-all-hang-out school of conversation was over. You might think family therapy would encourage a natural back-and-forth, but, officially, it didn’t. While Minuchin created unforgettable poetry and drama in sessions, the approach he taught was grounded in a highly disciplined technique that offered little room for casual or spontaneous interchange. Mimicking Minuchin, we’d make pro-


circles that defined my postgraduate professional life, it was as if we were actors in a particularly solemn Ingmar Bergman movie. I remember vividly one discussion at a diner during which colleagues and I discussed with great intensity what it “meant” to a waiter or waitress when one left the proper tip—not the correct amount to leave, mind you, but what it meant psychically.

The field had indeed moved into a new “I–Thou” era. But without seeing experienced clinicians modeling a more free-flowing style of interaction, we still didn’t know what such a thing might look or sound like. Besides fleeting pleasurabilities at the beginning and end of a session, having a conversation with a client meant you were probably wasting good clinical time on chitchat. Therapy was supposed to be about something—

nouncements, trying to sound as suave-

ly Argentinean as we could. We’d move people around the room. We learned how to create enactments, which, while they did get conversations going between family members, were mostly intended to build up enough tension to shift the family structure. Sure, these wrestling-kids-to-the-ground sessions were a hoot to watch, but they also left many of us without words.

Similarly, Betty Carter, another clinical superstar with whom I trained, was a genius at demonstrating Bowenian family systems therapy—virtually an entire theoretical worldview that also allowed no idle small talk. As soon as the camera started rolling, Carter was all Bowenian business, albeit with a decidedly feminist perspective, asking questions that shook any taken-for-


ganted family assumptions. But, then again, you wouldn’t watch these videos for conversational pointers either.

Only years after working with Minuchin, when I met several of his old patients, did I learn how much they valued his wonderful gift for connecting, as he warmly discussed the way they felt or dressed or spoke—all of which was left on the cutting-room floor. It was the same with Carter. What I recall as vividly as her clinical brilliance was the silky warmth of her voice as she seamlessly talked with clients before or after sessions. Once when Carter met a family I’d brought in for a consulta-

tion, the mother said how much they’d heard about her. Carter effortlessly replied, “Well, I hope it wasn’t all bad!” and then launched into a spontaneous exchange about how being videotaped was difficult, and made her as uncomfortable as it might make them. This easy chitchat also never made it to the audience of trainees.

Of course, all good therapists do just talk with clients to some degree—it’s really the lifeblood of therapy. But as a field, we’ve been unconsciously aware of the nature of the conversation that energizes our models and techniques. It’s as if the craft of conversation were a secret weapon many of us have, but aren’t allowed to acknowledge, much less consciously work at improving. Yet, without it, treatment can be a textbook exercise lacking the power to make clients feel a truly alive and personal connection with their therapist. After all, we converse to discover a person’s unspoken self beneath the social mask.

I began to pick up this basic truth by noticing that something remarkable happened when therapists went off-script and managed to squeeze in genuine conversation between techniques. I remember one of my fellow interns who started sessions with, “So who’s your favorite baseball team?” or “Where do you like to shop?” Then he’d proceed to get into heated debates about whether the Mets or the Yankees were better, or whether Macy’s
or Loehmann’s had the best bargains. He was, of course, eviscerated for his “unprofessional” behavior by every supervisor who could be rounded up to stamp it out. But here’s what I also noticed: his patients opened up in therapy, while about half of the patients seeing more formalistic therapists remained closed off.

I finally realized how conversation could turn into something unexpected and deeply therapeutic when working with a supervisor on a locked ward. One of the men had become paralyzed from an accident he’d had during a psychotic episode and awoke in the psychiatric hospital still psychotic and now permanently immobile from the waist down. As time moved on and he felt slightly less depressed, a female friend from his neighborhood started visiting him. The two got closer, became “an item,” and within two weeks announced to everyone that they were getting married. Nobody knew how to slow down this romance because most of us were stuck in our diagnostic categories, clinical protocols, and standard therapy-speak.

As a result, the situation was accelerating before our eyes and we were helpless to stop it.

During a session with this man and his intended, with my supervisor present, I ever-so-sensitively asked them “How does this make you feel?” in every permutation I could imagine. I hoped in this way to get to their deeper motivations and create some “observing ego.” My supervisor mercifully broke in and began a casual discussion with the man’s fiancée about cooking, of all things. Finally after going over some of the best ways to throw together a meal, he asked her, “By the way, what do you plan to cook for John when you get married? What are his favorite dishes?”

John mumbled something about a fishing rod.

Mary looked at him baffled, and said, “Are you crazy? I have no interest in fishing whatsoever!”

They looked at each other as if they’d just met. After some hemming and hawing, John said, “You know, I don’t think you understand me very well.”

Mary replied, “Well, likewise about you! Look, maybe we should think about this some more. And besides, my parents aren’t wild about the idea, either!”

All of a sudden the two were immersed in an intense discussion about whether they knew each other well enough to get married at that point—a conversation that then widened into how their respective families were reacting to these developments, and finally a plan to get to know each other a bit better before tying the knot.

I was stunned to see such a powerful outcome from such unscripted dialogue. I understood there was a kind of subliminal point to what my supervisor had been doing. Still, even if his mission had been to stop the marriage, he took his time to create a discussion with these two people and find out who they were. In that process, he elicited each one’s unspoken self, revealing their personal truths.

The Rise of Protocolized Psychotherapy

Such unexpected moments of learning were soon overshadowed by tectonic changes in the field and culture, however. To paraphrase a Terminator movie, the ’90s brought “the rise of the machines,” a revolutionary emergence of protocol-driven interventions for both adults and kids. Guided by symptom checklists and monetized by the insurance industry, all of these protocols underplayed conversation. Each new approach was extremely valuable, though, and allowed us to craft personalized models along the way. My own is a synthesis of psychoanalytic relational, structural, and family systems approaches, with elements of cognitive-behavioral therapy, dialectical behavior therapy, and attachment theory. Yet, there remained a suspicion that something integral to the way people connect—the way we discover each other and ourselves—was still missing in therapy.

In fact, the more I spoke to and consulted with therapists from diverse clinical perspectives, the more I became convinced that the “in-betweens” of official treatment are at the core of therapy. Above and below, within and around the protocols—from psychoanalysis to EMDR—therapists talk with clients in ways that human beings have always talked when they want to establish a real connection. They speak like people, rather than approaches.
Not surprisingly, given our training in all schools of therapy, this form of casual-speak is a cause for some embarrassment among members of our profession. So we widely practice a kind of double-bookkeeping, as one of my early mentors described it to me: “What we tell our teachers and supervisors we do and what we really do in the consulting room are two different things.”

We talk a great deal about the importance of relationship and connection in therapy—the “therapeutic alliance”—but what this really comes down to is the everyday miracle we call conversation: the unscripted exchanges we treasure from our friendships and romances. But does this mean that, as therapists, all we need to do is hang loose and let go? Are there any “rules” for therapeutic conversation? The danger of this question, of course, is in the implication that there might actually be an entire “model” here. But if there were, it wouldn’t be conversation anymore, just another unvarying set of clinical steps to get from point A to point B.

For a trained therapist comfortable in his/her professional skin, however, there is indeed a craft to making good conversation, which does have a purpose beyond simply passing time. It must generate an atmosphere conducive to doing the clinical work at hand—which means there’s an overarching, if not exactly specific, direction to it. The Zenlike paradox of therapeutic conversation is this: an exchange with no purpose other than the interaction itself can guide us exactly to where we need to go in treatment—to the unspoken self of the person sitting across from us. But how do we get started?

I think we make use of what I call “crafted spontaneity,” which means that if we follow whatever infinitesimal signals of life the patient emits and the life happening inside ourselves, we might have an unexpected encounter outside the framework of a specific therapy model. If we accept uncertainty and create conversations that lead to the client’s experiencing his or her unspoken self in the therapy relationship, this can change a client’s behavior, self-concept, and life story.

So, how do we do this? Over the years as both a therapist and supervisor, I’ve nurtured the unpredictable with hundreds of clients and listened to sessions as recounted by hundreds of other therapists. As a result, I’ve begun to see guidelines for the sometimes paradoxical craft of spontaneous therapeutic conversation.

“Rules” for Spontaneous Conversation

Follow the Spark

One true sign that you and your client are having a genuinely therapeutic conversation is that you have absolutely no idea where it’s going. Most of us shy away from life’s unpredictability, and we certainly do so in therapy. It’s easy, then, to think: “What am I doing? Does this really have anything to do with treatment?” So, the most crucial skill to learn, the awareness that guides everything else, is recognizing that if the conversation generates a spark of interest in the client and you’re learning something new—if you both feel more alive in the room—almost without question, you’re onto something.

This “follow the spark” rule is an antidote to that dirty little secret we clinicians live with: how bored we can be much of the time in sessions. I believe we’re often bored because we pay more attention to teaching than to learning, to directing an intervention at a client than actually conversing. We also ignore the clinical relevance of bore-
dom—it’s a signal that it’s time to mix things up—trying instead to narrowly attend to what we think is the “point” of therapy. In doing so, we miss those quicksilver glints of interest flickering across faces or the slightly excited intonation that signals something important is happening, especially when the subject is outside what we consider the “real” work of treatment. Too bad—the taken-for-granted or ignored spark can be the tip of an emerging self.

So, always factoring your client’s fragility and strengths into the equation, when “that look” appears on his or her face or you hear a certain tone of voice and it sparks your interest, go for it. Pursue the conversation without a clue about where it’s heading. Just make sure it continues to feel alive. Follow what’s compelling with concrete questions. Get into enough specific details that you could vividly describe the situation to a fictitious other, and share your own opinions, so your patient knows where you stand. Most of all, don’t be afraid of heated but good-natured arguments, humor, and just plain curiosity, without any specific clinical goal in mind. You may be surprised by the dimensions and characteristics of the client’s unspoken self that begin to emerge.

Vanessa is a gay woman in her mid-thirties with a history of depression. When she came to therapy, she had just one friend, was without a love relationship, and only had part-time employment. She’d barely look at me, reluctantly letting go of whatever I could pull out of her. Then in one session, she and I began to argue about sports, after I mentioned something or other about baseball and saw a glint in her eye. Regardless of how depressed Vanessa was, she’d debate every one of my sports theories with great fierce- ness. You’ll undoubtedly understand how out of touch with reality Vanessa could be when I tell you she disagreed with my unswerving belief that the new home of the New York Mets, Citi Field, was built over the old cement parking lot of Shea Stadium (in order to save money), which clearly accounts for the numerous injuries sustained by Mets players since they moved.

Every debate of this and other sports-related insights not only engaged us both, but temporarily lifted Vanessa’s mood. Then we moved on to films, which she was just as fiercely knowledgeable about as sports—you can watch a lot of Netflix while depressed. I never directly commented on how competent Vanessa was in these areas—I didn’t have to. In fact it would have been patronizing. The shared intensity of our arguments signaled my respect for her views.

One day, without discussing it with me, Vanessa signed up for a community college course in cinema studies. She brought the same passion to her contributions in class that she had to her talks with me, attracting the attention and friendship of teachers and peers. Gradually, her depression lifted just enough to allow her to begin a program in film production, specifically historical documentaries about marginalized peoples. She still has periodic depressive episodes—there are few miracles. Gradually, her depression lifted just enough to allow her to begin a program in film production, specifically historical documentaries about marginalized peoples. She still has periodic depressive episodes—there are few miracles in our work—but when Vanessa comes back for a check-in session, we continue to argue about sports. And for some reason, she still disagrees with me about my Shea Stadium–parking-lot theory.

Develop a Theme

In an Internet era when people’s selves are so fragmented, therapy is a kind of glue for personal coherence. Developing a theme through a series of discussions helps bind the self together. The process begins when the therapist notices a flicker of interest and is open to learning more about it. Because the theme matters to the patient, it surfaces again and again, coalescing into an unspoken aspect of the self he or she can gradually own.

Jozeph, a twenty-something recovering party-animal originally from Eastern Europe, was referred to me because he’d mastered the art of passing school without ever going to a class. Once the community college he was currently toying with caught on to him, he was out on his ass. Jozeph’s relationship with his parents was strained, since they’d labeled him amoral for all the acting out. Our therapy didn’t focus on these concerns, however. Instead, it mostly proceeded as a series of discussions about his reaction to the rudeness he regularly encountered on the streets of New York, how he’d faced down a disruptive kid in one of his classes, or how much outrage he felt about the way his friends were able to “bullshit” their way around parental control.

To develop a theme with him that felt really alive, I asked Jozeph, as I always do, to give as much specific detail as he could for every story about his outrage or exasperation, so we could experience these situations together more fully. I always kept close watch to see whether the stories left me feeling engaged as well. A theme slowly took shape: here was a young man labeled as unprincipled, yet almost every conversation was about principles. Even when Jozeph had been the king of party-life
in Croatia, he’d lived by Godfather-like standards of justice. However, they were so unspoken, he wasn’t aware of them himself. As I called attention to his heretofore unseen moral code, Jozeph began to notice his deeply felt sense of the ethics of everyday life. An unspoken self emerged: a sharp-eyed, 21-st century realist, who could empathize with and stand up for those who were totally different from him.

Jozeph eventually met an absolutely wonderful woman. They fell in love and set up house together. What drew her to him? A lot, but most dramatic was her telling Jozeph, “You’re the most principled person I’ve ever known.”

**Search for Competence**

As a theme develops with our clients, their unspoken self of hidden competencies often begins to surface. One of the best paths to competence for clients who’ve never before been able to experience themselves as successful human beings is to discuss with a truly interested therapist what most engages them in life and brings out their natural urge to get better at something. Not surprisingly, though, those conversations don’t always take the form of what we usually think of as therapy-speak. More often than not, a sense of competence and coherence comes out of conversations that aren’t a linear attempt to buttress a client’s self-esteem. For example, almost nothing can boost a client’s confidence more than cracking up—and I’m not talking about a DSM diagnosis. People appreciate humor and enjoy feeling that they’re funny, tell me something extremely important. Though he called it “crazy,” he believed that people would somehow know if he spoke it out loud, look at him strangely, and laugh derisively.

After trying all the usual techniques for resistance and shame, I decided to start a conversation in a slightly different way. I asked Harold, “Well, how about if you and I both put on a pair of Groucho glasses and you can tell this secret more ‘anonymously’?” Forget for a moment that Groucho glasses don’t make me look a smidgeon different than I already do. However, at the exact same instant we were sitting there in our “disguises” finally discussing Harold’s (quite ordinary) concern, two house painters on a scaffold serendipitously descended and stopped right outside the window. Guess what? They started pointing at us, laughing with great zest and, I do believe, derision. Harold’s paranoid fantasy had become a reality, only now we were both rolling on the floor, hysterical ourselves.

After we two Grouchos vigorously gesticulated at the painters, Harold suddenly began talking about how he’d always had the ability to make people feel cheerful. I could see that myself now—since I don’t normally use stage props in treatment. We then went back and forth about the ironic quirks of family life, as well as stories about fun times that had been interspersed within his family history of chronic loss. Harold had recovered his unspoken and competent lighter self: the ability to bring cheer into people’s lives. His contagious good humor slowly became a central part of the way he thought of himself in the world, influencing his choice of a marriage partner, how he dealt with the multiple sclerosis that later developed, and his career decision—to become a therapist.

**Don’t Fear the Trivial**

Conversations that yield a sense of competence in the consulting room, like those that take place in the rest of our lives, often begin with curiosity about the mundane. But as in any other kind of human exchange, “the truth is in the details,” especially when using conversation to highlight aspects of the self that have previously remained hidden for too long.

Ben was in the depressive phase of a suspected bipolar disorder. Extremely high functioning, he’d had to leave a job in another city, go back to living in the family’s basement, and enter a day-treatment program. One day, he mentioned that in the middle of feeling depressed and unable to remember what kind of cognitive distortion he was dealing with, he’d forced himself to make a sandwich. By this time, I’d also had enough of therapy-talk (a sure sign that you need to mix it up a bit), and seeing a slight glimmer in his eye, I said, “Sandwiches, I love...”
sandwiches! Tell me what you put on this one.”

Ben said “What in the world does this have to do with therapy?”

I replied, “Maybe nothing. But you look like you enjoyed it. I’m gluten and dairy intolerant, and any chance to hear about a good sandwich, I’ll take.”

So Ben described in great detail, every part of the sandwich. We spent almost the entire session on this, with me wondering as one often does in these conversational U-turns, “What in the world am I doing?”

But Ben loved it, and so did I. A theme emerged, not about sandwiches, but about the trivial details his sharp eye took in. Ben’s face lit up as he described the features of anything he was into, and he enjoyed listening to my reactions. This newfound ability to appreciate his capacity for paying attention migrated from the consulting room into relationships. Previously, a self-involved young man, now he actually began listening to his friends, with great success. This love of detail then found its way onto the Web. He started to blog about the subtleties of twenty-something friendships, attaining a small but growing audience. At the end of each session and with all the therapeutic authority I could muster, I’d remind him to keep paying attention: “Ben,” I’d say, “when in doubt, look to the sandwich!”

Barriers to Conversation
Creating an alive conversation in the consulting room has a lot going against it. For one thing, the scripted therapeutic tone we all learn makes us superficially sound very much like one another, at least in our own minds and in the view of pop culture. TV’s top therapists and fictional shrinks, the real life Dr. Drew (Pinsky), as well as the imaginary Dr. Melfi (The Sopranos) and Dr. Paul Weston (In Treatment), all have that canned therapist sound. But I’ll bet if you taped your own sessions (with your clients’ permission, of course), you wouldn’t sound anything like the constrained professional. Your empathy, humor, and impatience—in other words, much of your human repertoire—would show through, despite the model of therapy you practice. That’s the way it should be.

But alive conversations that actually energize the therapeutic process face another obstacle. Not only does training in various models of treatment inculcate certain conversational patterns, even vocal tones, in us, but patients also elicit responses that constrain our own conversational freedom. As psychoanalyst Edgar Levenson described decades ago in his revealing explication of how countertransference works, we’re all “transformed” by the people we see in our practices—for better or worse we become their historical figures. We can’t help it, but this disquieting phenomenon is an uncanny guideline to new, potentially reparative exchanges. So, as you follow a patient, always watch for the ways you’ve become “not you” and reflect on how taking another tack might encourage a more positive interaction. Understanding how we’ve been transformed is a “tell” that will guide us to the client’s unspoken self.

What exactly should you pay attention to in yourself that reveals how you’ve been transformed by your patient? First, look closely at how you may be acting or feeling differently than you usually do. Pay attention to the thoughts, feelings, images, and even the songs that flit across your consciousness, and certainly to any fantasies in session and your dreams at night. Carefully notice your voice tone, by which I mean warmth, decibel level, cadence, and so on. Of course, be aware of the flattened or negative states you may be experiencing with your client. You shouldn’t be ashamed of these—just the opposite. If you follow them, they usually lead to a therapy issue that needs to be addressed; one that can reveal the unspoken self.

With Naomi, a street-smart, impatient young woman, dismissive of me and therapy itself, I found myself uncharacteristically annoyed. Like many clients today, she had a cell phone that occupied her attention all session long. I couldn’t get a word in edgewise, until, largely out of pique, I brought my own cell phone into the consulting room. Every time her device announced a text, I checked my own for messages. This got her attention.

“What are you doing?” Naomi yelled. “You’re supposed to be listening to me!”

I responded, “Well, if you’re not saying anything, I’m not going to waste my time either.”

“But that’s what you’re being paid to do!”

“Not nearly enough for this!!!” I sharply responded. Remembering Levenson, I recognized this “transformation” into becoming her aggressive mother and shifted my focus to say a bit more warmly, “Well, instead of wasting each other’s time, I’d rather talk about who’s calling and texting you so often. Forget about you, I’d love to know more about them.”

Naomi’s face softened a bit, and she began hesitantly detailing one of the texts. In the next session, she described more of her friends’ texts, along with their temperamental and family issues. I responded in many different ways—sharing what I thought about each of them based on her descriptions, telling her about how they reminded me of my old friends, and so forth.

Once I’d gotten past this adversarial transformation, I discovered that Naomi was extremely articulate—rarely have I heard someone speak so lucidly and with such descriptive power. Round and round we went in our weekly discussions; my only Naomi-focused observations were brief references to how articulate she was. She never seemed to fully absorb these positive comments. But, gradually, I began hearing them in her newfound sense of confidence and competence, as if she’d come up with this viewpoint entirely on her own—an experience I’ve become used to when nonlinear conversation is a central part of therapy.

Conversation and Self-Disclosure

Over the years, we’ve seen a growing literature about the power of strategic self-disclosure in therapy. And, whether we admit it or not, most of us engage—consciously or unconsciously—in some sort of self-disclosure during every session. Yet, we once again employ a form of clinical double-bookkeeping, practic-
Then they left.

“What did you do?” I asked, stunned by this revelation.

Telling no one, my mother went down to the Brown House, as Gestapo headquarters was called. She was 26, really not much more than a child. “I stayed at the Gestapo for two days. I wouldn’t go until they changed their mind.”

“What did you do there?” not sure I wanted to hear.

“I don’t really remember,” she said. “I don’t think I want to remember. I just kept talking to everyone I could, until I met a Nazi official I knew growing up. He finally signed some papers and gave us 48 hours to get out of the country. Even with this, I could barely go. Your father had to drag me away because my parents wouldn’t leave with us.”

“Why in the world would they stay?” “They thought,” she told me sighing with a deep resignation, “nothing bad could happen to them—they were always such good citizens. Then in 1942, we received word that my parents had been killed in the camps, along with half of your daddy’s family.” “Why didn’t you ever tell me this?” “I don’t know, Ronnie. I didn’t even think about it until we began to talk.”

I told my mother I couldn’t believe how brave she’d been. She protested that what she’d done was just a part of “normal” life back then. But she also revealed several other harrowing stories about the things she did to survive those times, again new to me and again revealing my mother as a more heroic person than I’d ever known. My mother and I had never spoken quite like this before, but now we were having the conversation of a lifetime, a gift just before she died, before my children were born. Late as it was, it forever changed the way I understood her and my family’s life story, and for the brief time she had remaining, I believe it changed the way my mother saw herself.

After I’d said as much as I could bring myself to, with tears in my eyes—and Irene’s, as well—her whole demeanor changed, becoming noticeably warmer. We began a conversation about “the things we carry,” with Irene exhibiting a deep empathy I’d rarely seen in her.