

Chapter Six
The Listening Process

We have looked at the nature of the psyche from a number of perspectives. We have talked about the unconscious: its infinite extent, the unknowable nature of its contents, the teleological thrust that pushes us into relationship with others and with ourselves. We have studied Bion's ideas about the nature of thinking/dreaming and looked at the way his theory can structure our listening in clinical hours. The eternal human struggle between a related approach to life and to others versus an egocentric, narcissistic one has been explored from two points of view: a structural description of the universal complex that organizes our anti-related or pathological tendencies; and a dynamic description of the conflict between facing into the truth or turning toward soothing lies. Let us consider what impact all of these matters have on our clinical work.

As I have suggested, Bion's work on α function implies that the issue is not so much to help the patient *know* about aspects of experience that he has split off, repressed, or otherwise exiled from awareness; instead, the patient needs to *live* the life experiences he has been unable to bear. Even before Bion's work, some theoreticians suggested that the analyst's task is to reflect back to the patient the particular element of his inner reality that he brings into the consulting room today. Winnicott says:

Psychotherapy is not making clever and apt interpretations; by and large it is a long-term giving the patient back what the patient brings....[I]f I do this well enough the patient will find his or her own self and will be able to exist and to feel real....

(Winnicott, 1971, p 117)

Winnicott believed that the central function of an interpretation was to let the patient know what he had understood of what she was bringing, not to tell the patient something *he* knew that she was ignorant of (*ibid.*). He (1949) suggested that the human animal can deal with only one thing at a time emotionally and that trauma consists of being flooded by more things than can be processed.

There is nothing more important...than that we try to see what the *one* thing is that the patient is bringing for interpretation or for reliving in any one particular hour. A good analyst confines his interpretations and his actions to the detail exactly presented by the patient. It is bad practice to interpret whatever one feels one understands, acting according to one's own needs, thus spoiling the patient's attempt to cope by dealing with one thing at a time.

(Winnicott, 1949, p 192, italics in original)

Winnicott's advice is a simple formula for relatedness. He is asking the therapist to tune in to the patient's unconscious agenda and to join him or her in furthering it. One problem with "correct" interpretations that fail to touch the patient may be that they fail

to speak to the particular aspect of the patient's self that he needs to connect with today. Such interpretations, Winnicott is saying, express the therapist's narcissism rather than his related capacities.

If we begin with the hypothesis that the Self in the patient – the inner spark of aliveness that organizes his emotional being and development – is asking the analyst to perceive and reflect back one previously unknown element of his psyche, the question we must address is how we might know *which* element is crucial in a given hour. It is not possible to say much about what the therapist should *do*. We can talk about the importance of transference interpretations,¹ for example, but the power of any interpretation rests on *when* it is said. To this end, the analyst's personal intuitions of the moment will be her only possible guide. But if we look at how the analyst might listen, we can say much more. How can she receive the unconscious message that telegraphs the not-yet-experienced experience that the patient is trying to have at this moment?

Remember Bion's analysis of the infant whose fear of envy leads him to split his need for milk from his need for love. To one extent or another, all human beings will construct this split in infancy. Love, cherishment and concern will be somewhat feared and avoided by any human creature for these experiences bring up our helpless need for people who are so outside of our control, so unpredictable. Instead of yearning for the mother's love that comes and goes with her mood and her availability, the infant craves milk; as the infant grows the "milk" morphs into toys and trips to Disneyland, and then into designer clothes and snazzy cars, money, fame, power – security – an absolutely illusory goal for a mortal human being in this unpredictable world. The love of another, our species' deepest need, is so obviously out of our control, while the aims of the power drive seem possible to grab. This basic human dilemma has created the analytic attitude that values what the analyst *does* (i.e, interpreting) rather than the environment she creates, what she *says* rather than how she understands and receives what the patient is trying to tell her.

The therapist's narcissism also supports this skewed attitude. She feels as though she is a valuable person when she offers her thought to the patient; she may feel as though she is doing nothing worthwhile when her stance is primarily receptive. Listening is at least 90 percent of the job. When the therapist can hear the patient's communication, she will have the data she needs to think about what to say and when to say it. Hearing the patient also has the effect of making the therapist much quieter as she devotes her attention to understanding instead of telling.

Let us look at the ideas about technique that the founding fathers of analysis, Freud and Jung, put forward. As we shall see, like most analytic thinkers, they offer little advice about what to do, although they give some suggestions on what *not* to do. Freud, Jung,

¹ Transference interpretations are important because they attempt to remove a barrier that exists between the therapist and the patient (Neville Symington, 2005). Thus they facilitate the deepening and intensification of the analytic relationship.

and Bion all maintained that every analyst needs to work out the technical approach best suited to his or her personality. Freud, begins his technical advice with a disclaimer:

I am asserting...that this technique is the only one suited to my individuality; I do not venture to deny that a physician quite differently constituted might find himself driven to adopt a different attitude to his patients and to the task before him.

(Freud, 1912, p 111)

Although he then goes on to write a series of papers filled with suggestions that can sound like rules, I want us to pause and absorb his advice.

Bion says something similar in his seminars when a participant asks him what he thinks of an analyst including among his contacts the patient's family. Bion says that he can talk about what *he* does, but that

[i]t is no good resorting to the method which suits somebody else. The fact that other people do differently is useful – it may give you a hint – but the fundamental point is, can you find out what suits you?

(Bion, 2000, p 265)

Jung wrote only one significant piece on analysis (as opposed to individual psychology), *The Psychology of the Transference* (1946). Because Jung maintains that “every trace of routine ...proves to be a blind alley,” (1946, ¶ 367) in this central work he offers no technical suggestions, instead repeating in many ways that the therapist must be deeply related to his patient by being fully involved with and affected by her, going “to the limits of his subjective possibilities” (*ibid*, ¶ 400). A deep analysis, he said, challenges “not only our understanding or our sympathy, but the whole man” (*ibid* ¶ 367). He speaks to the resistance that therapists must feel to total commitment of ourselves and to the way in which we are tempted to hide behind a professional persona, relying on the “trick of knowing everything beforehand” (*ibid* ¶ 365).

Though he may believe himself to be in possession of all the necessary knowledge...he will in the end come to realize that there are very many things indeed of which his academic knowledge never dreamed. Each new case that requires thorough treatment is pioneer work, and every trace of routine then proves to be a blind alley.

(*ibid*, ¶ 367)

His break with Freud left Jung with a wound that never fully healed. When he writes about psychotherapy, he often seems at pains to emphasize his *differences* with his old mentor. Yet in his major work on analysis, *Psychology of the Transference*, his parsing of the mystery of the analytic venture is not far from Freud's comment that

the most successful cases are those in which one proceeds...without any purpose in view, allows oneself to be taken by surprise by any new turn in them, and always meets them with an open mind, free from any presuppositions.

(Freud, 1912, p 114)

Long before the current focus on the intersubjectivity of the analytic undertaking, Jung noted that the therapist will be impacted emotionally by the patient in painful and disorienting ways.

[T]he psychotherapist... should clearly understand that psychic infections... are ...the predestined concomitants of his work... This realization... gives him the right attitude to his patient. The patient then means something to him personally, and this provides the most favorable basis for treatment.”

(Jung, 1946, ¶365)

From one angle after another, Jung talks about the fact that the truth of the analyst's whole psyche determines her impact on the patient. He notes that the transference relationship consists of six different subrelationships: between the two “I”s in the room, between each “I” and that person's unconscious as well as between the “I” and the other's unconscious, and finally between the two unconsciouses. Attempts to control one's interventions with technical guidelines in mind will impact primarily the “I” to “I” connection of the dyad; the unconscious links will be much less affected by the simple fact of following supposedly desirable procedures than they will by the truth of each person's entire being. Unconscious connections will respond to the factors *behind* the analyst's interventions such as the rigidity versus integrity with which she holds to technical rules, or the way the procedures she uses to guide her are congruent with her true nature. Do her technical guidelines function as a flexible container that holds and nurtures her creativity or do they squash her individuality and talent in an iron suit of armor? The patient will unconsciously know the truth of his analyst's psyche because even if the two “I”s are seriously unrelated, the deeper aspects of the self will be exquisitely tuned in to each other.

Summing up his overarching attitude, Jung says that the analyst, working to pull the disconnected elements of the patient into an integrated whole, seeks to “bind the opposites by love, for ‘love is stronger than death’” (*ibid.*, ¶ 398). Analysis, he says, is “a human encounter where love plays the decisive part” (*ibid.*, ¶ 418). Jung is explicit in underlining the way that the therapist's entire being determines the course of the work. He speaks approvingly of the love that every therapist knows is constellated in an effective clinical situation, a rare and courageous attitude. He does not use the word “related” but his emphasis on love turns us in that direction.

Sometimes, Jung can sound as though he overvalues the analyst's intellectual mastery of her subject, but I think this misleads. As he describes the mutual unconsciousness and disorientation that envelopes the analyst-patient pair when real transformation is occurring, he comments that “the doctor's knowledge, like a flickering lamp, is the one dim light in the darkness” (*ibid.*, ¶ 399). But when he talks about the need for the analyst to hold fast to his “knowledge,” what he means by “knowing” is what Bion means by “K,” an attitude of openness to learning the truth rather than a belief that he possesses

The Truth. Jung says that “faced with the disorientation of the patient, the doctor must hold fast to his own orientation;... he must know what the patient’s condition means, he must understand what is of value in the dreams” (*ibid.*, ¶ 478). But in the same paragraph he goes on to explain his meaning:

In other words, he must approach his task with views and ideas capable of grasping unconscious symbolism. *Intellectual or supposedly scientific theories are not adequate to the nature of the unconscious*, because they make use of a terminology which has not the slightest affinity with its pregnant symbolism....The kind of approach [that is needed] must...be plastic and symbolical, and itself *the outcome of personal experience with unconscious contents*.

(*ibid.*, ¶ 478, emphases added)

He is not talking about the kind of knowledge one might acquire from reading his or Freud’s writing. He is talking about the kind of knowledge one gains from one’s personal analytic work, a kind of knowing that grows out of an interpersonal emotional experience rather than something that emerges from the intellect.

Although Freud did not explicitly credit the unconscious with the creative power we explored in Chapter Two, his primary suggestion depends on that creativity. In Chapter Three, we saw Freud urging the analyst to listen to the patient in a state of evenly suspended attention, trying to focus on the patient’s material more from his unconscious than from his “I.” Although he did not have the extensive theoretical basis for this advice that analytic thinkers constructed by the end of the 20th century, he knew intuitively that the listener will distort what he hears, for the “I” craves security and wants to find only “what he already knows” (Freud, 1912, p 114). Freud reminds us that it is typically only after the fact that we appreciate the import of what we hear and that “thinking something over or concentrating the attention solve none of the riddles of a neurosis; that can only be done by patiently obeying the psycho-analytic rule, which enjoins the exclusion of all criticism of the unconscious...” (*ibid.*, p 119). Just as he asks the patient to associate freely, simply reporting without censorship what comes to his mind, he is advising the therapist to (silently) associate freely. He wants the therapist “not to dispute the guidance of the unconscious in establishing connecting links” (Freud, 1911, p 94). Theoretically, Freud did not recognize the synthetic, prospective, and creative capacities of the unconscious that we have explored, but in his technical advice, he relies heavily on that dimension of the infinite psyche. As we shall see, his advice meshes easily with the attitude Bion recommends.

To conclude this brief survey of the two founding psychoanalysts, I want to point out that neither Freud’s nor Jung’s clinical behavior was completely consistent with his theoretical beliefs. This validates Jung’s idea that it is the whole person of the therapist rather than her theories that matters. What therapists *say* they do and what they actually do may diverge dramatically without the therapist having much conscious awareness of this. And of course there is always the temptation, when describing one’s work, to improve it in one way or another. Many of the case examples in the literature are too good to be true, undoubtedly reflecting how writers decide to omit a few “details” as they

shape the infinitely messy reality of their work into something coherent that demonstrates their point as well as their competence.

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Although he was not explicit in the way that Jung was, we see in Bion's seminars an attitude that clearly considers the truth of the analyst's psyche to be the crucial factor in analytic work. He has advice for the analyst, but it is not about what to do. His advice is about how to listen. His most famous suggestion, to eschew memory, desire and understanding, is presented in what may be the shortest analytic paper ever written, "Notes on Memory and Desire" (1967). The advice is then elaborated at length in *Attention and Interpretation* (1970).

As I have noted, Bion's work is opaque. He consistently asks the reader to do her own thinking about the areas he describes; he does not *want* to explain his meaning clearly. Rather than clarifying the writer's point of view, he suggests (1970) that a psychoanalytic paper should constellate in the reader the experience that the writer is trying to describe; thus the reader has an opportunity to form her own sense of the problem in question. He offers very few case descriptions, asking the reader to provide her own.

In the clinical situation, Bion suggests, the task is to open oneself to the O of the moment. The absolute facts of the analytic hour can never be known. They include the outer interaction, the infinite inner reaches of each participant, and the evolving O of the dyad-as-an-organism, Ogden's "analytic third" (1994). This is the O of the session, encompassing each person's O to create something greater than the sum of the two would suggest. Within that wholeness, the patient speaks, attempting either to express his O or to conceal it. What is the O of the patient? What is his reality? Or, in simpler words, what is he talking about?

By forsaking memory, desire, and understanding, one hopes to *become* O – to be at one with the immediate emotional reality – and therefore to be able to articulate (perhaps only to oneself) some previously unknown truth about the patient-in-this-moment, the patient-in-the-room-with-this-analyst. Bion (1967, 1970) maintained that the analyst must shun memory, desire, and understanding to accomplish the intangible task of becoming O. His prescription is severe:

Do not remember past sessions...*no* [Bion's emphasis] crisis should be allowed to breach this rule...[Avoid] desires for the approaching end of the session...Desires for results, 'cure' or even understanding must not be allowed to proliferate.
(Bion, 1967, p 260)

He speaks to his severity in what we might take as an empathic comment:

For any who have been used to remembering what patients say and to desiring their welfare, it will be hard to entertain the harm to analytic intuition that is inseparable from *any* memories and *any* desires.

(Bion, 1970, p 31, italics in original)

I have not met any analyst who tries to follow this advice literally, something that, in any case, is surely impossible. But turning toward the stance of radical openness to the moment that Bion's advice implies has the effect of enlivening the hour, speeding it up and unleashing a startling flow of new and unexpected insights.

Definitions

But what does Bion mean by “memory,” “desire,” and “understanding?” A misunderstanding of his language has constellated much needless resistance to his ideas. Beginning with memory: two experiences are familiar to any clinician. In the first, the analyst rereads her notes from the previous session before she takes her patient into the consulting room. The patient begins to speak – about his life, a dream, a childhood experience – and the analyst stretches inside her mind, searching for related material. What were the details of the dream the patient is referring to? Who was that uncle he's talking about? Didn't he tell me something different last week?

In his description of “negative capability” – the capacity to sit patiently in unknowing, in Bion's PS or in Fordham's state of deintegration – Keats suggests that the experience I am describing, grasping for a memory *that is not presenting itself spontaneously*, expresses fear of the “uncertainties, mysteries [and] doubts” that arise (quoted in Bion, 1970). This straining to remember is a symptom of anxiety; something is happening that troubles me and I look for something to rescue me from my lost unknowingness.

We do not normally memorize the facts that a friend, a lover, a child, or a patient tells us. We come to know *a person*, something very different from the catalogue of facts that surrounds him. In ordinary life, one's basic relatedness determines the extent to which one can know someone else. There is a *feel* to who an individual is, both over time and at any given moment; intuitively, we know that our ephemeral, inchoate sense is much more central than any data. When Bion says that we should view every hour as a first hour, remembering that the patient is *not* someone we Know but someone we are trying to get to know, he goes too far. Letting go of the Facts that prevent her from sensing the unknown reaches of her patient is a most worthwhile attempt; trying to somehow shed the feeling connection that has been built by the analytic dyad is neither possible nor desirable. Working over time with distorted or problematic aspects of that feeling connection – i.e., of the relationship – typically proves to be the most important source of transformation for both members of the couple.

In the second kind of experience that most of us call “memory,” the patient begins to speak and something floats *unbidden* into the listening analyst's mind: a fragment of a dream the patient told a year ago or an image from a dream of her own, a story from the patient's childhood, a scene from a movie the analyst saw last week. This second experience is the analyst's reverie. This is *not* what Bion means by “memory.” *He reserves the term “memory” for “experience related to conscious attempts at recall”* (1970, p 70, emphasis added). The analyst's reverie is highly valued, and one of the

reasons that Bion asks us to turn away from *attempts* to remember is that working to remember takes away the space for reverie. The listening therapist wants to receive her own free associations, for the *unsought* images, feelings, and ideas that appear of their own accord are messages from her unconscious as it responds to the patient's "transmitting unconscious." Struggling to recall an old fact destroys the inner emptiness that invites the understandings that will develop beyond her conscious mind's limited scope.

"Desire" is a similarly slippery word. The issue cannot be to split off a desire that arises because that would only be an invitation to unconsciousness. The analyst must take her wish as a piece of data, a fact of reality to be interested in; she must try to avoid identifying with the desire and giving herself over to achieving it. In this scenario, a desire for the end of the session can be noted and can lead to curiosity: What is happening here that I want to escape from? Behind the apparent boredom, is something frightening me? In a recent hour that seemed mildly dull on the surface, I found myself vaguely wishing that the patient would terminate. That desire woke me up and enabled me to realize that beneath the patient's rather monotonous tone were hints of suicidal feelings I had not known about. I could not stamp out my desire but I was able to separate myself from the wish so that I could use it to recognize my outside-of-awareness fear of my patient's death wish.

A desire to help the patient is similar: Is the patient inducing in me a subjective sense of helplessness or weakness? Is he bringing up a savior complex or sadistically rubbing my nose in the "helplessness" I feel when faced with his "extraordinary" pain? In wanting to help, am I unconsciously striving to exclude some level of suffering that is trying to enter the room? The desire to help the patient will mean something slightly different every time it comes up even with the same patient, let alone with different people. But whatever its precipitant, the desire blinds the analyst to the ways the patient needs to be seen and accepted in his wounded condition, *as is*, before he can begin to let it go (Sullivan, 1989). This desire to help is a particularly seductive one. Our patients want us to help them and most therapists entered the field out of a conscious wish to help people. But it is important to let go of the wish because, as far as we can tell, it is usually *not* helpful to try to help. Trying to understand the patient as he *is* generally loosens his character structure and begins or reinforces a growth process inside him that leads to positive ("helpful") developments in his inner world.

The understanding that is to be avoided is, again, not universal. The PS ↔ D sequence that we explored in Chapter Three brings understanding with it, one that is unique to the moment. This kind of understanding differs from the theoretical knowledge that we arm ourselves with before entering the consulting room: the archetypal meanings of last week's dream image or the theoretical operation of infantile sexuality or the function and meaning of selfobject transferences. Theoretical knowledge, when clung to, blinds the analyst to the singular meaning of the immediate moment. When theory, based on years of study and experiences on both sides of the couch, is preconsciously present as a background understanding of the psyche, it can be part of the swirling cloud of fragments that constitutes the PS state of unknowing. In that state, the theoretical ideas that arise as

part of the analyst's reverie can facilitate the precipitation of a selected fact that jolts the analyst into a new understanding. But when the "understanding" of this moment takes the shape of a cliché – "you have mixed feelings about your mother," "it is hard for you to tolerate angry feelings for someone you love" – even if the cliché is one that has been developed in the work with the particular patient, the likelihood is that it is sealing out an understanding of *now* that would in some way disrupt previous formulations.

The volatile nature of truth

When the analyst reaches for a memory – of a dream, a story, an interchange – she is treating these past experiences as though they were fixed objects. Jungians are especially vulnerable to imagining that a dream is a *fact*; many therapists fall into this attitude in relation to childhood memories or to the patient's stories of his spouse or parent. What was/is his mother/his wife *really* like? Isn't that the same dream that went on to describe a flood? Did that abuse *really* happen? When the analyst falls into this frame of mind, she is conceiving of inner reality, the world of analytic interest, as though it were outer reality, where a chair is a chair is a chair and if you don't watch your step you will stumble over it. In psychic reality, new "memories" of childhood can emerge in very old age as the individual's inner objects are repaired, damaged or brought down to size by his developmental processes; the dream that originally went on to image a flood can slip into union with another dream and they can together give birth to a "memory" that rearranges the old images and radiates out toward possibilities and implications in this moment that could not have existed when the dreams were first dreamed and reported.

When two people disagree on what happened, we can only let the conflict go. It is extraordinarily difficult to give up one's certainty regarding the story one has constructed about the past and to hold the other's story as equally valid with one's own. But accepting the unknowability of the past puts one in a more congruent relationship to reality than an attempt to discover The Truth. When patient and analyst disagree about what either one of them said or did, establishing the "truth" of the past incident is surely the least meaningful response. The patient's "memory" expresses something that needs to be understood *now*. The therapist's different sense of what happened yesterday or last week may be helpful in understanding what the patient is dealing with at this moment, but clinging to the *rightness* of her memory will only shore up the therapist's narcissistic self-esteem. It has no therapeutic value at all.

Certainly, the analyst needs to be sensitive to the possible ways her patient defensively distorts his images of his loved ones (and of those he hates). But to imagine that the patient's wife is *really* kind when he experiences her as cold, or that his sense of having been intrusively wounded in childhood indicates that he was *really* sexually molested implies a vision of "reality" that is fundamentally defensive. The patient's wife is not *really* anything, any more than any other human being is; she feels and behaves in many ways in different situations, and her husband's image of her, even if defensive, undoubtedly contains at least some truth. Remembering that memories of any era, certainly including childhood, may differ wildly from the memories of the others who were involved, we must reconcile ourselves to the impossibility of knowing what outer

experiences the patient has symbolized with a hunch of sexual molestation. (Though I would certainly not want the reader to conclude from this that sexual molestation does not really happen, or that the question of whether a parent's intrusive behavior is verbal or sexual does not matter. Physical abuse, whether sexual or otherwise, is always more destructive than abuse that respects the growing child's bodily integrity and when the patient feels that he *remembers* sexual molestation [as opposed to *wondering* about it], I would take his memory to be as accurate as any other memory in the absence of other compelling indications.)

The *unbidden* memories that float into the therapist's mind, along with emotions (desires), thoughts (as opposed to directing thinking), bodily sensations, and images constitute the analyst's reverie. Memories that present themselves spontaneously are the voice of the receiving unconscious; memories that are grasped for come from the anxieties of the "I." As I indicated above, conscious attempts at recall are undesirable because they block the clinician's reverie. When the analyst or the patient "remembers" a past event in a state of reverie (as opposed to reaching for facts that were catalogued in the past), whether the event that presents itself was inside or outside the analysis, the "memory" is colored and shaped by the intersubjective reality of the moment. Thus, Ogden, talking about a reverie that immersed him in re-experiencing a painful time with a close friend, says:

The experience in the session was not a repetition of anything, not a remembering of something that had already occurred; it was an experience occurring for the first time, an experience being generated freshly in the unconscious intersubjective context of the analysis. . . . The internal object relationship with . . . any . . . internal object is not a fixed entity: it is a fluid set of thoughts, feelings, and sensations that is continually in movement and always susceptible to being shaped and restructured as it is *newly* experienced in the context of each new unconscious intersubjective relationship.

(Ogden, 1997, pp 187 – 90, italics in original)

Freud urges the analyst to give maximal space to her "unconscious memory," meaning Ogden's reverie rather than Bion's memory. The personal memory that presents itself in the present moment is not irrelevant to the analytic situation as some clinicians defensively imagine; it is a fragment of the dream that the analyst's psyche is constructing to image its emotional experience in the present situation with the patient. The so-called memory is part of the psyche's constant attempt to be fixed and real; the image *masquerades* as a historical fact. When the analyst's reverie centers on the personal interactions of her past, it reflects the emotional situation of the analytic pair at the moment as well as the transformation of the analyst's relationship to her inner figure (spouse, parent, etc.) in the crucible of the analytic dyad's immediate experience. This is what Jung means when he says that analysis is not working until the patient has become a problem to the analyst (1946). *Both* members of the couple must get under each other's skin.

A long term patient walked into my office and there arose in my mind, with marked vividness, a memory of an experience nearly 40 years earlier in which I had felt rejected and treated with contempt by my first husband. I had no idea what to make of the sudden emergence of an incident that had long since lost its sting for me and that had no relevance that I knew to anything going on in my current life. My patient began to talk of things that had no apparent similarity to my inner image. But about ten minutes into the hour, she told me about an incident from the previous evening with her husband. She had looked forward to an intimate evening with him, but he had become caught up on the phone with a colleague for most of the evening. She had wound up surfing the internet instead. The only feeling she was aware of was a faint disappointment. Using the information I had received from my “memory” enabled me to open up her much stronger feelings of abandonment, jealousy, and masochistic submission to what she experienced as her husband’s bad treatment of her.

My memory was not a memory; it was an image found by my unconscious, functioning as a “receptive organ,” to describe what it was picking up from the patient’s “transmitting unconscious.” It is notable that my psyche produced this “memory” as my patient walked into the room, before any words were exchanged. After years of work, my patient and I were deep under each other’s skin. Dieckmann (1976) has described a research group in Berlin that studied process hours of analytic sessions including the analysts’ “highly charged emotional thoughts as they arose [and] also subliminal ones, fantasies, feelings and psychosomatic affects arising from the unconscious” – i.e., the analysts’ reveries. They found that the analyst’s associations were linked *without exception* to the patient’s, even in situations where the analyst came into the hour seriously shaken up by experiences of his own. They also found that the resistances that emerged tended to be carried as much by the analyst as by the patient. Despite our lengthy personal analyses, we remain ordinary human beings, subject to extensive anxieties about the unknown depths of the psyche, anxieties that propel us into behaviors whose meaning we know nothing about. These anxieties drive us toward memory and understanding, away from true *presence* in the obscurity of the moment.

Sometimes a patient will focus on whether or not the analyst remembers some particular detail that he told her. He may feel terribly wounded to learn that the childhood incident or the powerful dream to which he is referring is not coming back to his therapist. Surely this demonstrates her lack of concern! Does it? That would seem to be the first question the clinician might ask herself in this situation. If the answer is yes, her curiosity should be directed to wondering about the nature of the barrier between herself and her patient. How are they failing to construct a functioning relationship? But very possibly, her “inadequate” recall speaks to something very different from a lack of concern. Perhaps this interaction reflects a sado-masochistic dance that the patient/ therapist pair is caught in. Perhaps the patient’s anxiety about being forgotten needs to enter the room and be explored rather than held at bay by his therapist’s perfect memory. Though the analyst’s not-remembering may be painful for the patient, it reflects some element of truth that exists between the two people and analysis is designed to explore painful truths in the belief that that the pain will be worth the resulting development.

Memory is something from the past: Thus-and-such occurred between so-and-so and me at such-and-such a time. Memory and desire operate through the senses. Because the senses orient to pleasure and pain rather than to truth, memory can never be reliable. We shape our memories in directions that give us “pleasure” (i.e., in ways that protect us from pain or disorientation), even if that means twisting them into shapes that are congruent with painful inner fictions that we live by. Letting go of memory and desire will not mean the person feels less pleasure or more pain. When a startling truth suddenly erupts into awareness, both members of the therapeutic dyad may feel great pleasure at the beauty of that truth. But taking a receptive stance strips away all illusions of *controlling* pleasure and pain. It acknowledges that whether life feels good or bad depends on forces outside our power. Bion suggests that the terror of making the transition away from the attempt to control pleasure and toward an undefended openness to life’s experiences is one of the main roots of the universal resistance to seeing the truth. “Unity with O is in prospect fearful,” he says (Bion, 1970, p53).

Being in the now

The practitioner’s goal must be to immerse herself in the intensity of *this* moment’s experience, to be open to the ways her patient is *not* the same person he was yesterday or last week, especially if she takes seriously the possibility and hope of change. A human relationship is never static. Two nonliving things can be related in a fixed pattern, but two people are always growing or deteriorating, their myriad aspects swirling around each other in ever-developing patterns like an always-moving kaleidoscope. Needs shift, preferences change, hopes and fears are always in motion. But therapists cling to the ways the patient is familiar, preventing the emergence of contact with “an unknown, incoherent, formless void” (Bion, 1970, p 52). Rather than developing knowledge about the patient, our goal must be to facilitate the emergence and integration of the denied, repressed, unavailable parts of him. We are not detectives, amassing facts in order to prove something. And truth, in any case, is not a collection of static facts. It is an infinitely shifting and inherently unmapable reality. Like “relationship,” “truth” is a verb. We move toward and away from truth, seeking to know and to not-know, at the same time as the truth-as-we-know-it evolves toward new truths.

Donald Meltzer translates Bion’s advice: “‘Abandon your memory, your desire and your understanding and follow me’ rather than ‘Thou shalt not remember, thou shalt not desire, thou shalt not understand’” (Meltzer, 1998, p 375). It is a positive step, not a forbidding; it does not shut something off; it opens the door to something else. The question is not the memory, desire and understanding that Bion wants to exclude; it is the space for reverie and unknowing that he wants to invite *in*. The concupiscent psyche’s desire for security and its consequent attachment to its inner *knowns* (old facts and theories) fill up the analyst’s mind and crowd out the space to respond creatively to the unfamiliar immediate moment.

Bion wants to divest himself of preconceptions so that the unexpected can catch his attention and ignite his curiosity. He tries to attend to the unknown and unknowable underlying truth, hoping to glimpse “the irreducible minimum that is the patient” (1970, p

59). If we seek an expansion of consciousness, hanging on to what is already known is an irrelevance; it blinds us to the unknown aspects of the unconscious psyche that now present themselves. When the analyst imagines that she “knows” the other, she has petrified a momentary insight as though what has been seen is fixed rather than eternally volatile; she becomes a know-it-all rather than a curious participant in an infinite mystery (Richardson, 2006). Bion’s advice extends Freud’s suggestions regarding listening, especially as to Freud’s comment that when we focus our conscious attention and attempt to logically *think* our way into clarity, we are in danger of seeing only what we already know and of blinding ourselves to unexpected elements that would disrupt the stability of old understandings.

The traditional psychodynamic focus has been to help the patient become aware of unfamiliar elements of his inner emotional reality: to help him develop “insight.” The main thrust of this effort has been through verbal interpretations that articulate some unknown aspect of the patient’s authentic being – of the O of the patient. Until the second half of the last century, the typical therapeutic model saw the patient as a separate person whom the patient and practitioner could join together to study, a model that we now know to be profoundly flawed. We can speak to some previously unknown aspect of the patient *because* therapist and patient are all mixed up together in ways that can never be fully sorted out. This is why the analyst’s reverie so reliably informs her about the patient’s state. O – the O of the patient, the O of the analyst, the O of the couple, the O of the universe – is *one* unified reality, inherently unknowable and inseparably intertwined; it will always be frightening because it surrounds and dominates the supposedly autonomous “I.” Our fear pulls us toward the false security of the material outer world as a model for “reality” – even though the fact that we never actually have direct contact with that world makes our “knowledge” of that reality suspect too. But no matter what the nature of the outer world, the inner world is neither solid nor fixed. What is the “truth?” We believe that the young person who imagines that his mother was “perfect” has come to a “truer” understanding as he recognizes ways she was flawed; but were that same young man to enter a second analysis in his middle age, the understanding of his mother that he developed with his first analyst will again shift, perhaps dramatically.

One axiom underlying analysis is that giving form to some aspect of the unknown self by describing it in words facilitates its integration with the “I” and helps prevent it from propelling the person into mindless action. When an element from that inchoate level of the psyche is articulated in words, especially when the new understanding is verbalized by the patient himself, the mature aspect of the individual can enter into a dialogue with his undeveloped self. But interpretive work on any given element may take place over weeks or months or even years before the adult parts of the patient can engage with that element and begin to integrate it. And, as I noted above, unless that interpretive work is grounded in a field of relatedness and cherishment it will never be integrated. But when a verbal understanding of an emotional complex *is* taken in, it has some constructive impact.

Now it is a truism that analysts often make interpretations that are in some sense “correct,” but that have no real impact even when the patient consciously accepts them.

Although Freud began by focusing on insight as the road to transformation, even in those beginning years of analysis, he knew that the transformation he sought was a change in the patient's *reality* rather than a change in the patient's *knowledge* of his reality. The change in understanding that Freud and many subsequent analysts sought is desirable only because it is imagined that new insights will precipitate changes in the structure of the patient's self. But analysts can become confused and act as though increasing what the patient *knows* is the issue. This confusion translates into interpretations that describe unconscious drives, archetypal meanings, the genetic roots of complex-driven behavior, or some other theoretically-informed perspective on the unconscious psyche. Interpreting the general dynamics of the patient's psyche is very different from speaking to the unique way these dynamics manifest at a specific moment in a particular dyad. When an immediately present emotional experience is interpreted, the interpretation has a reasonable hope of actually impacting the patient; when general dynamics are spoken to, they may be taken up by the patient's mind but they are unlikely to impact his being.

Returning to our central focus, listening, we must remember that the unconscious is not "inside" the person. Dreams image the *dreamer* as inside, surrounded by the universe we call "his unconscious." An individual's unconscious extends far beyond his puny "I." As Jung's description of the five unconscious links that operate at all times in the analytic container emphasizes, the psyches of the two people interpenetrate each other. I have imaged this situation by picturing the body as the "I" with the intangible force field of each person's psyche extending out around his body and mingling with the other's psyche like a liquid or a gas. This is the field from which projective identification, introjection, and intuition emerge, making viable Freud's suggestion that the analyst turn her unconscious toward the patient's "transmitting unconscious" like a "receptive organ." In the therapeutic session, as in life, both members of the dyad are surrounded by and immersed in the unconscious – in O – at every moment. The unconscious psyche is not a *place* that can be explored; it is a living process that sustains and directs our conscious selves in the moments of the analytic hour as at all other moments. The analyst's hope is to glimpse the unconscious-of-*this*-moment, not to analyze the patient's unconscious as a stable constellation that can be dissected and parsed.

Recall Bion's suggestion to *become* O in order to find this moment's relevant interpretation. The analyst "becomes" O by sinking into her own experience. This turning in and down supports the action of the Self that is being constellated in the intersubjective reality of the moment. If the analyst can let go of memory, desire, and understanding, she can sink into a state of mind where O evolves toward consciousness because she is not trying to pin anything down; she is trying to be open to whatever wants to come in. In this fluid atmosphere, the reality of the patient in the moment will be invited in; a hunch about today's unique twist on his complex may emerge for the analyst, enabling her to reflect it back to the patient.

Interpreting – a strange word for this tentative, always-open attempt to suggest who seems to be here today – thus flows from becoming one with O. The patient's response to his therapist's comment will revise or at least personalize the analyst's idea. Subsequent associations will image the continuing unfolding of the O of the hour, and it is hoped that

they will surprise the listening clinician rather than confirm what she already knew. An interpretation should consist of something that could be said only to this patient, only at this unique moment. Memory is problematic partly because memory is all about time, while the growth process, like the unconscious, is outside of time. When the patient talks about a way he “used to be,” that supposedly no-longer-existent tendency is present *now* in some form (perhaps in the *analyst’s* behavior, for example). The image of long ago can be understood as describing something metaphorically far distant from the conscious self.

We can never know exactly what the patient said or did in any given hour, even though we feel strongly that there *are* absolute, objective facts transpiring in our consulting rooms. We can, however, understand the patient through our own psyche. Bion calls this act “intuition.” Kohut called it “empathy.” Jung might have also called it intuition (though I believe he meant something narrower by the term than Bion did) but this would have been Jung’s way because he was (in his terms) an intuitive type. We each “get” the patient in our own way. Jung says:

The patient, by bringing an activated unconscious content to bear upon the doctor, constellates the corresponding unconscious material in him, owing to the inductive effect which always emanates from projections in greater or lesser degree. Doctor and patient thus find themselves in a relationship founded on mutual unconsciousness.

(Jung, 1946, ¶ 364)

A living being is in constant flux. One is developing or deteriorating at every moment. Meltzer (1973, p 156) notices that life inevitably uncovers more problems than it solves; I would add that just as opening oneself to the unconscious seems to expand it, “solving” a problem opens the door to more puzzles and confusions. As one very unhappy patient put it, each time we turn over one rock to find what’s underneath, three more rocks that need to be investigated come into view. The analytic task is to attend to these proliferating, unsolved mysteries. This attitude forms the optimal link from analyst to patient; it precludes a state of “understanding.” In this mode, although we are always *coming* to understand the other, we never arrive there. Jung expresses this idea when he says, “The goal is important only as an idea; the essential thing is the *opus* which leads to the goal: *that* is the goal of a lifetime” (1946 ¶ 400).

Making the volatile fixed

From a state of at-oneness with the patient, the therapist can say something about what she sees, giving him a glimpse of his true self. The psyche seeks always to be seen. This is how the nonmaterial psyche becomes real. Freud commented that self-exposure oozes from every pore. The psyche produces symptoms and slips that communicate its conflicts, its needs, its unacknowledged aspects. Our ability to grow depends on this fact – our unknown selves *want* to be found. When the patient or analyst verbalizes something that was previously unconscious, the alchemists’ injunction to “make the volatile fixed” is approached. The “volatile,” a formless unconscious content of O, is “fixed” by describing it in words. Because the “I” is terrified of the suffering emotional self, it calls

that nonmaterial entity “imaginary.” Our narcissistic society emphasizes that suffering is something to snap out of, especially since it’s all in our heads and we all know that *that’s* not real. Against the “I”’s frightened attempt to stamp out the inner world, the soul struggles to be as real and solid as the floor beneath our feet. Winnicott’s advice to find the aspect of the patient’s self that is pressing to be seen is important because it supports the psyche’s attempt to be recognized as real.

O “cannot be known by any human being; it can be known *about*, its presence can be recognized and felt, but it cannot be known. It is possible to be at one with it” (Bion, 1970, p 30). Putting this in more accessible language, he says that “the more ‘real’ the psychoanalyst is the more he can be at one with the reality of the patient” (1970, p 28). Winnicott (1971) suggests that mirroring himself back to the patient enables him to feel real. “Feeling real is more than existing,” Winnicott goes on to say. “[I]t is finding a way to exist as oneself, and to relate to objects as oneself, and to have a self into which to retreat for relaxation” (1971, p 117). By being “at one” with the patient’s unknown inner reality, the analyst intuits the element that the patient needs to make fixed (real) in order to go on to the next bit of his evolving self. Ogden’s attempt to interpret the “leading transference anxiety” is his way of speaking to the aspect of the self seeking existence at this moment in the conscious world. It emphasizes the way an intrapsychic factor in the patient becomes interpersonal in the analytic situation. All these perspectives seek the *real*, an aspect of the truth that I explored in the previous chapter.

Not-knowing

The patient brings something singular that has never before existed in the world to be seen and held today. Even when the patient seems to be droning on about the same old thing out of fear of the unknown, the unknown is pressing to be seen. The tension between truth and lies is always present. In a dead, boring hour when the lying tendency is creating a bulwark against the truth, the unknown truth is also asking for recognition. Perhaps the therapist can pick it up through her reverie. Or perhaps the patient is asking the therapist to experience his deadness until she can find a way to comment on it constructively. The moment’s truth will never be an element that fits neatly into any depth psychological theory because no matter how universal Freud’s oedipal complex or Jung’s animus may be, a given individual’s relationship to these universal factors will develop in a unique manner. It is his *particular* volatile inner self that the patient seeks. And the analyst can see that only by emptying her mind of expectations, of the preconceived notions that distort perceptions in order to make “reality” less frightening than it threatens to be. When the analyst turns away from the known, toward the mysterious, she opens the door to painful experiences

that are usually excluded or screened by the conventional apparatus of ‘memory’ of the session, [or by] analytical theories [that are] often disguised desires or denials of ignorance, and [by] ‘understanding’ (which consists more often than not of [lies]).

(Bion, 1970, p 48)

So the first requirement is that the analyst begin in a state of not-knowing.

“Doubt is the crown of life because truth and error come together. Doubt is living, truth is sometimes death and stagnation,” says Jung (1984, p 89).

[W]e must be very careful not to assume that we know all about the patient or that we know the way out of his difficulties....It is important that the doctor admits he does not know....Personal opinions are more or less arbitrary judgments and may be all wrong.

(Jung, 1984, p 3)

Where do we get this belief...that we know what is good and what is bad?...We are all only limited human beings and we do not know in any fundamental sense what is good and bad in a given case....To see through a concrete situation to the bottom is God's affair alone....Therefore I say to the young psychotherapist: Learn the best, know the best – and then forget everything when you face the patient.

(Jung, 1959, ¶ 862, 882)

The path to wholeness, he says, is filled with “fateful detours and wrong turnings” (Jung, 1952, ¶ 6). Space must be preserved for the *unreasonable*, the *inappropriate*, the *unfitting* in life. At the simplest level, the therapist cannot know that the patient is making “a mistake” when he chooses to betray his wife or to break off his analysis. If the goal of life is becoming oneself, one may need to meet oneself in the most painful and humiliating ways, after making foolish or shameful choices that bring one face to face with the most disturbing aspects of oneself. We hope, of course, that a gentler path can be found, but we cannot know what any person needs to endure to find himself.

This attempt to approach the work with an attitude of not knowing has been spoken to by many analysts besides Jung who predate Bion. Clare Winnicott describes her deceased husband, for example, as someone who

made it his aim to enter into every situation undefended by his knowledge, so that he could be as exposed as possible to the impact of the situation itself. From his point of view this was the only way in which discovery and growth were possible, both for himself and for his patients. This approach was more than a stance; it was an essential discipline, and it added a dimension to his life as vital to him as fresh air.

(from the introduction to Winnicott, 1986, p 2)

Bion explored and elaborated the attitude of openness advocated by Freud, Jung, Winnicott, and others. As the emotional experience of a session unfolds, both members of the dyad are transformed and to the extent that one can accept being carried along by the living process – to the extent that one can let go of trying to dominate and control it – one's ability to remember what happened is diminished. Winnicott (1949) speaks to the obverse of this when he talks about the way the individual unconsciously catalogues (memorizes) the facts of a trauma as it is happening. It is because he cannot have his

experience that his psyche memorizes it, hoping that at some future time a situation will develop in which someone will contain him well enough to enable him to live his experience instead of holding it in the frozen deadness of memory. Taking off the armor of memory causes the tempo of the session to speed up. The 50 minutes are eternal and very quick, both at once. An attempt to reconstruct what happened in what order is undermined by the aliveness of the experience, an aliveness supported by the analyst's relinquishing the attempt to dominate the session through mentally recording it.

It is frightening to face the unknown and unknowable reality of our world, our selves, our intimates. Jung tells a story about Schopenhauer, lost in thought, walking through a flower bed. The distressed gardener called out,

'Hey! What are you doing...? Who are you?' 'Ah, exactly, if I only knew!' said Schopenhauer. That is why people prefer a safe persona: 'this is myself'; otherwise they don't know who they really are. The main fear of the unconscious is that we forget who we are.

(Jung, 1984, p 248)

Grotstein suggests that the universal terror of unknowable reality refers both to who one is and to the mystery of others, of our relationships, of the world at large (Culbert-Koehn, 1997, p 26). He suggests, in fact, that "what handicaps psychoanalytic training is really our own unconscious addiction to clarity" (*ibid*, p 30). Without the comforting fictions that we wrap around ourselves and call "reality," we fear that we are nothing, with no solid ground to stand on. It is rare and most distressing to truly glimpse how distorted, unreliable, and shifting our perceptions and memories are.

Jung called rationalism

an egocentric point of view – because *I* believe, *I* think, things have to behave according to this law. If a stone should defy the laws of gravity and suddenly begin to rise...everybody seeing it would be sent to the lunatic asylum...Human experience is only three months old, and when it is six months old it may be that the stone will rise instead of fall. The recognition of the essential irrationality of the universe hasn't yet filtered through into our Western *Weltanschauung*.

(Jung, 1984, p 448)

Bion comments:

For all the laws of science there isn't any evidence that anybody or anything obeys those laws. It would be convenient if the world of reality kept within the bounds of our comprehension – but it doesn't and there is no reason why it should.

(Bion, 2000, p 237)

I found both of these statements rather extreme, but then I came upon an article in *The New York Times Science Times* about the unknown dark energy and matter that make up 96 per cent of the universe (Oct 24, 2006, p D3). Dark energy (76 per cent of the

universe) is the anti-gravity force that fuels the cosmic expansion by pushing stars and galaxies apart. “Dark energy,” the journalist (Dennis Overbye) wrote, “was a complete surprise. How often do you toss a handful of gravel into the air and the rocks speed up as they leave your hand and disappear into the sky?” Truly, there are more things in heaven and earth than are dreamed of in our philosophies.

Christopher Bollas (2006), in a public lecture in San Francisco, referred to Freud’s advice to turn one’s unconscious toward the patient’s unconscious. Bollas said that the field has largely moved away from this stance to one that expects the analyst to *know* what is going on. By definition, we often cannot know what is going on if our *unconscious* is the organ receiving and making sense of it. Bollas described the way that demands for clarity destroy the space for unknowing, leading the analyst to bring into the hour her pet organizing ideas and to cling to them like a fetish that protects her from the castration anxiety of not knowing. The analyst imagines she is having intercourse with the patient, he said, where the actual situation is more perverse than loving. Bollas’s language – fetish, castration anxiety, perversion – of course embodies something of what he is protesting. These are evocative metaphors that suggest the emotional experience being described, but they have been reified by the analytic community as though the anxiety of unknowing is “really” anxiety about bodily integrity. Many metaphors speak to the fear of the unknown, and the most “accurate” is not the one that spoke to historically admired figures like Freud or Klein; it is the one that resonates most deeply for the anxious person.

The analyst’s task is to settle into the state that Keats called negative capability, a state of not-knowing, devoid of persecutory anxieties, an experience of comfort with profound vulnerability. I do not think this is possible. Perhaps one can approximate it. To be with one’s not-knowing reverberates into the inconceivable fact of mortality, where Death sits always on everyone’s shoulder, giving no warning of when He will take His turn, snatching away someone without whom the individual “cannot survive,” suddenly destroying some unthinkably important aspect of the person’s physical being, like sight or mobility. In the clinical hour the stakes seem less severe, even if opening the door to unknowing leaves one vulnerable to this ultimate level. In the hour, not-knowing exposes one “only” to experiences of terrible foolishness and helplessness. It is difficult to settle into presenting oneself to the world as a highly trained expert who is entitled to a substantial fee for the ability to tolerate being lost and clueless in the face of a suffering human being.

Bion’s idea is that when we can approach an empty state, we can be penetrated by the emotional flash that he called a “selected fact.” This “fact” – most people would call it a “feeling” rather than a “fact,” but Bion’s problematic language has the advantage of reminding us that feelings *are* facts – organizes the disparate bits and pieces of material that have been swirling around the analytic couple in an apparently disconnected cloud. It precipitates a wholeness or gestalt that has been missing and leads the analyst to understand something integrative about the hour. The emergence of the selected fact is one aspect of the experience of “becoming O.” But as soon as an understanding is

achieved, it can become a shield that both analyst and patient cling to for protection from the infinite unknown universe that lurks just beyond this newly understood element.

In fact, the couple needs to rest in the illusion of Knowing for a bit. This provides stability and continuity for the couple and for each individual, a sense of self and pair that is defensive and illusory at the same time as it is partially true and wholly necessary. This Knowing distorts the patient's ability to let his associations flow freely and it distorts the analyst's ability to open herself to the new stretches of mystery expressing themselves in the thoughts and feelings that are emerging both from the patient and from inside the clinician. In optimal situations, the two individuals can gradually relinquish the newly won and already obsolete Knowing and return to a state of emptiness, waiting for a new selected fact to bring about a fresh view of reality that will first enlarge both people's selves and then block their further unfolding.

This is the oscillating PS ↔ D sequence that we explored in Chapter Three. Bion emphasizes that before a meaningful interpretation can be arrived at, the analyst must pass through a period of "patience" (the PS stage of fragments) and into a phase of "security" (D, where the split opposites are brought together). The experience of sitting patiently in unknowing will include some feeling of persecution; the coming into D where a gestalt pulls together the pieces of the hour or the week or the month and makes an interpretation possible will bring with it some depression over the possibilities that have been sacrificed to make room for the new wholeness. He suggests that the movement between 'patience' and 'security' is the hallmark of meaningful work (1970, pp 123-4). The interpretation that emerges from this oscillation is framed in what he called the Language of Achievement (*ibid*, p 2), emphasizing the accomplishment that emerges from the severe demand to sit with unknowing.

The transcendent function

Jung (1916) called the psychological capacity to traverse an arrhythmic sequence of disorientation-insight "the transcendent function." Writing so long ago, Jung's formulations sometimes seem primitive now. His rather unified images of "the conscious" and "the unconscious" have been displaced by the contemporary emphasis on the multiple selves that make up consciousness and the infinite unconscious aspects and possibilities that are present. Thirty years before his intersubjective masterpiece (1946) on the transference relationship, Jung still thought of the analyst and patient as separate people, each with his individual psychology. He did not appreciate the way each person in the dyad is neither fully separable from the other nor fully continuous with who he or she is in other situations. Jung speaks of *opposites* that he imagines belong to *the patient* rather than of a chaotic mass of unsorted bits emerging from neither analyst nor patient but from the couple. Despite this overly simplified perspective, his theory of a transcendent function that works to bring together elements from conflicting aspects of the self, and that helps the person come to a new attitude toward life, is similar to the process Bion describes as PS ↔ D.

Jung speaks of the generic patient as someone who cannot fit comfortably into the prefabricated shapes society has laid out for “normalcy.” The person who seeks a therapist is someone who needs an individual solution for his unique problem. The problem, Jung emphasizes, cannot be solved logically. He describes the familiar experience of being caught up in an emotional conflict:

The shuttling to and fro of arguments and affects represents the transcendent function of opposites. The confrontation of the two positions generates a tension charged with energy and creates a live, third thing – not a logical stillbirth...but a movement out of the suspension between opposites, a living birth that leads to a new level of being, a new situation.

(Jung, 1916, ¶ 189)

Jung’s attitude “presupposes insights which are at least potentially present in the patient and can therefore be made conscious” (Jung, 1916, ¶ 145). These insights cannot be found in theories or even in the wisdom accumulated by the analyst over decades of experience. Each insight is unique to one patient and must be unearthed at one particular time. Viewing the session in its singularity, with eyes uncontaminated by previous images, constellates Winnicott’s area of transitional phenomena where paradoxes are accepted without question, allowing symbolic activity to develop in the psyche. The transitional area, where play holds sway, does not sound painful, while the state of being pulled or torn between the opposites certainly does, but emotional play is actually serious in nature. It is the way the child works through painful inner realities. The “play” aspect of emotional play lies in its volatility: at this moment we declare such-and-such to be the basis of our play, but at the next moment we can turn that upside down and thus-and-such will be the case. Today the plastic dinosaur is the dangerous monster who lives in the closet, but tomorrow it may be an ally who attacks Aunt Margaret for laughing at Mommy and making her cry.

Even in 1916, Jung noted that intrapsychic conflict could manifest as a struggle between analyst and patient and that the action of the transcendent function could be seen in a rapprochement between the two people, but his personal bias led him to focus on its action within the individual. Some years later, in the early 1930’s, he pointed to the way that symbol formation depends on the transcendent function (1930-1932/1976), reinforcing the parallel that I noted above with Winnicott’s (later) formulation of transitional phenomena. Jung also noted at that time that the Self both guides the transcendent function in its operation and emerges from its operation. In this context, Ulanov (1997) points to the way the transcendent function brings toward consciousness an awareness of “the mysterious presence of what lies beyond and undergirds the whole analytical enterprise” – the infinite reality of Bion’s “O” or Jung’s collective unconscious and the Self.

Where Jung believes that the “answer” to the impasse of the present – the insight, the wholeness, the meaning of any given situation – will lie in implicate form in the *patient’s* being, Bion looks to *the analyst* as for enlightenment. Where Bion focused on the need for the analyst to sit with the unknown until an emotional flash brings to his mind the

missing gestalt of the moment, Jung looks more to the patient who will find his meaning by turning inward and sitting with the personal unknown that pulls him now this way and now that. In his theory of a transcendent function, Jung proposes a model describing the therapist's central job as providing and holding the space in which the patient's inner struggle can emerge in its full intensity. The transcendent function, a natural process controlled by the unconscious rather than by the "I," does the essential work. Contemporary thinking implies that we should turn to *the couple* as the source of meaning, but what seems most important to notice here is the way that both Jung and Bion emphasized the uniqueness of the sought-for "solution," its irrational nature, and the need for patience while waiting for its arrival.

An understanding of an analytic experience or of the unfathomable inner workings of a human soul will never be deduced via logical thinking. For Bion it arrives in an emotionally charged intuition, for Jung it is "a living birth." Either formulation points to the dead end of consciousness's sterile ideas and toward the new perspective that emerges in its own good time, making something whole of previously disconnected fragments.

The frightful fiend

Remember that what is unknown is always infinitely greater than what is known and that we are seeking contact with the *unknown* in an analytic session. But many parts of the analyst's self fear, even dread, contact with the unpredictable, potentially dangerous and certainly destabilizing unknown. The parts of ourselves that crave control and safety rather than a search for the infinitely ungraspable truth of our emotional psychic reality are gestured toward by Coleridge:

Like one that on a lonesome road
Doth walk in fear and dread;
And having once turned round walks on,
And turns no more his head;
Because he knows a frightful fiend
Doth close behind him tread.

(quoted in Bion, 1970, p 46)

This "frightful fiend" is duplex. It is the terrifying unknown truth from the depths that we flee from; and it is that very impulse *not* to know the truth, to wrap ourselves in lies and evasions that will not upset our equilibrium and throw us into vulnerable, out-of-control states. The fiend is the truth one fears (fiendish when seen from the perspective of fear), and it is the driven flight from that truth into lies (fiendish because lies are inherently the work of the devil). In so far as one relies on memory – on what was true *yesterday* – one blocks the possibility of learning something unknown, *today's* truth that disturbs the tidy arrangement of "facts" that we lean on to remain safe in the swirling mystery of the obscure, unfathomable universe.

The more anxious the analyst is, the more inner pressure she will feel to reach for “facts.” When the patient is in crisis, the frightened analyst may search inside her memory for the “cause” of the threatening disaster, closing her mind to the current moment. But the psyche does not operate by cause and effect. If the analyst can focus on the nature of her immediate experience and open herself to her unconscious reverie instead of looking for what triggered the crisis, startling meanings emerge. For example, a patient pressured his therapist with increasingly disastrous behavior in his work life. Any sensible person would know that the way he was acting would cause him to lose his job. The therapist became more and more anxious, offering one idea after another about the genetic roots of his behavior, his fear of success, his inability to tolerate a positive self-image. She was *filled* with the desire to prevent him from losing his job and making a mess of his life. The therapist’s theories were protecting her from a direct experience of the terror that permeated her patient’s inner world. His self-destructive behavior had constellated his panic inside her. Her interpretations were actually attempts to discharge his tormented inner state instead of holding it. The patient’s fear was Winnicott’s *one* thing he was bringing to be seen, and the therapist’s driven attempt to get rid of it rather than suffering it forced the patient to ratchet it up and bring it in over and over.

Faith

Bion suggests that if the analyst can shun memory, desire, and understanding – all of which reflect attempts at mastery – she leaves a space into which faith can flow. By turning away from the world of sensuous reality – the outer world – the analyst can find a state of mind imbued with “faith that there is an ultimate reality and truth – the unknown, unknowable, ‘formless infinite’” (Bion, 1970, p 31). In Klein’s language this would be faith in the existence of good inner objects; in Jung’s poetry it is faith in the Self, in the reality of the psyche and in the transcendent function; Winnicott might call this faith in transitional space and in the psychic paradoxes that must be held and accepted rather than resolved; Ogden might point to faith in the analytic third and the psychoanalytic process. What is called for is faith in the intangible inner world that supports us in our harsh and rocky journey through the world of matter. It is faith in the meaning of suffering and the possibility of joy. Earlier ages might have called it faith in the goodness of God, or simply in God.

The basic psychoanalytic attitude is one of faith. Where memory, desire, and understanding seek to control events and to dominate them, individuation – the process of becoming increasingly whole – depends on allowing experience to overtake one. In this way one encounters one’s true self. But so often a person wants to create a self he can admire rather than to become the self he is. Bion suggests that the central point of any interpretation is “to help the patient to be less frightened of his own horrible self” (2000, p 248).

Eigen (1981), describing the area of faith in Winnicott’s work, contrasts the areas imbued with faith – those of transitional relating and object usage – with the area of object relating. Object relating involves splitting oneself, projecting parts of the self into the other and then introjecting parts of the other into the self. Splitting is the basis of lies. It

enables the individual to not know about aspects of himself that would disturb the idealized or degraded self-image that is familiar to him. It is also a fundamentally solipsistic activity: the individual imagines that his omnipotent fantasies control other people. The other is important, but not quite real, not a subject in her own right. The splitting/projecting/introjecting activity of object relating reflects an attempt to master a situation. This projecting/introjecting activity is an aspect of memory (introjecting) and desire (the projecting that seeks to control the other) (Eisold, 2005). It seeks to eliminate the traumas of separation through the continual enactment of a fantasy of control, an (unconsciously) untruthful activity that shuts out the individual's real creativity. When the individual reaches Winnicott's version of the depressive position, the capacity for concern, the other is seen more fully, as someone who is both good and bad, and toward whom the person has both good and bad intentions. But rather than bringing the individual anything like faith, this realization creates a permanent anxiety about the way his own badness requires constant monitoring. It is as though the individual is left always worrying: are my hateful feelings polluting my behavior, is my envy leading me to devalue her, am I centered in my love or am I falling into my wish to triumph? When the individual has developed the capacity for concern, his *goal* is to be related, but as Winnicott parses the dynamics of object relating we see how it works *against* relatedness, for true relatedness demands an undefended openness to the other that must include the possibility of hurting the other as well as nurturing him.

Object usage, on the other hand, involves the destruction of the other in fantasy, followed by the startling and wonderful discovery that fantasies can *not* destroy the other. The other becomes a *real* person; the subject can believe in her; she is not an extension of himself who can be controlled by his internal mental activities. The distortions inherent in object relating are transcended. The possibility of being one's whole self without compromise is reinforced and a true relationship becomes possible: the other can be valued for her own self. A world of love begins to be created since the need for guilt is obviated. One does not need to be good to make up for one's badness, for the person has learned that the other can survive his badness; loving for its own sake becomes possible.

Object usage leads to the discovery of an outer reality that exists apart from one's self. One can have faith in the world: it is real – other people *exist* – and this truth gives the subject a more immediate sense of himself and of the realness of his inner world. The recognition of a real outer reality goes hand in hand with the discovery of a real inner reality that is safe enough to generate faith. Both worlds are essentially unknowable. As Grotstein notes, our ideas about “reality” are actually myths protecting us from the vast ignorance in which we live (Culbert-Koehn, 1997). Fully *using* another person who *survives*,² allays the individual's terror of his own destructiveness. The attempt to dominate life can be renounced for the possibility of relationship has come into being. Our mutual realness takes center stage, enabling us to participate together in the development of our mutual aliveness.

² It is important to remember that survival means continuing to function adequately in one's role (analyst, parent, etc), not simply continuing to breathe.

The faith of the transitional area has a different quality from the faith of object usage. It depends less on the subject's activity in the interpersonal world and more on his experience of a kind and loving environment. The mothering person's good-enough adaptation to the baby's needs allows the baby to imagine that there is neither one person involved (as in object relating) nor are there two (as in object usage); instead there is an interpenetrating field³ that fits well-enough. The baby's creative gesture is met with a responsive creative movement; faith in the goodness and safety of the world lays the groundwork for later attempts at object usage.

Bion has faith in the intangible universe of O. His faith does not seem markedly different from other kinds of spiritual faiths. He considers faith crucial for any scientific attempt to understand reality, including the attempts of the hard sciences. In analysis, faith involves opening oneself to the perceptions of the moment regardless of the way those perceptions may support or contradict the analyst's preconceived theories. Through faith the therapist "sees" or "feels" the nonsensuous activity of the patient's mind in interaction with her own. To center oneself in faith means to come forth without reservation, opening one's heart and soul fully to the unknown reality of this person and this hour. According to Bion this is the core method of psychoanalysis, far more crucial than any kind of knowledge.

Jung looks at this same area of faith in different terminology.

If the work succeeds, [he says], it often works like a miracle, and one can understand what it was that prompted the alchemists to insert a heartfelt *Deo concedente* [God willing] in their recipes, or to allow that only if God wrought a miracle could their procedure be brought to a successful conclusion.

(Jung, 1946, ¶ 385)

Rather than faith in O, Jung is expressing faith in the purposeful energy of the Self that works both within and beyond the individual. If the person can let go of control and turn himself over to it, that energy may bring about the wholeness – the realness – he seeks by facilitating the development of his capacity for relatedness. The concept of the Self speaks to the inherent aliveness of the unconscious – of O – and to its active attempt to integrate the whole living person both inside himself and interpersonally, in the human world.

Reliance on faith maintains that resting in the unknowability of reality will lead, in time, to the emergence of coherence and integration. All human beings have parts of themselves that refuse this faith, insisting that *I* am the universe; there is no inner or outer, there is only *Me* and I am *in charge*. This is Bion's frightful fiend.

³ In fact, this experience rather than the more adult sense of the absolute separateness of individuals seems to be closer to the truth.

The analytic perspective

In letting go of the life preservers of memory, desire, and understanding, the analyst opens herself to the ineffable reality of the psychoanalytic relationship. In terms of the faith-mastery set of opposites that we have been exploring, the analyst, centered in faith, turns to listening and receiving rather than to knowing or formulating; she is looking for direct and undefended contact with *now* in its unique constellation. She enters into the present emotional truth of the couple that is composed of two individuals who will be different people this evening or tomorrow. When Freud tells analysts to artificially blind themselves in order to “focus all the light on one dark spot” so as to see the dark unconscious (letter to Lou Andreas-Salome, quoted in Bion, 1970, p 43), he is describing an act of faith through which one “sees”, “hears” and “feels” the nonsensual psychological truth that is present.

Therapists and even analysts often express the fear that taking this stance will result in the loss of patients. They imagine that patients must be gradually inducted into an analytic experience, that they must be educated about “how analysis works” rather than simply met with an analytic approach. It will be too disorienting and frightening for the naïve patient, they suggest. When the therapist listens deeply, trying to hear the specific element that the patient brings in today, the therapist becomes quieter and leaves more space for the patient. Deeper and more surprising material emerges. *Therapists* tend to be frightened of so much space; the fantasy that the *patient* will not be able to tolerate this generous container is a rationalization that protects the practitioner from acknowledging her own distress at experiencing her smallness and vulnerability. Partly, the analyst’s driven need to *give* the patient something (an interpretation) is a function of the greed for material stuff that we have explored, for an interpretation is a kind of thing while a relational link is inherently ephemeral; her greed leads the practitioner to focus on something concrete to give the patient and to devalue the nonmaterial attention and concern that is more fundamental to healing (Sullivan, 1989).

(The patient, of course, has his own version of this greed, and it can lead him to want things – interpretations, homework – because the greed overwhelms his ability to recognize the value of the cherishment on offer. When this is the case, an “educational” response may well be called for: “I can hear how much you want me to give you something concrete to hang onto, but right now we both need to attend to listening to what comes up inside you. If you can let yourself continue to associate, we will arrive at an understanding that will make sense of your confusion.” This is very different from the more impersonal sort of comment that is imagined to be educational: “Analysis works best if you will just associate; I will speak when I have something valuable to say, and that is not the case right now.”)

Analysts turn toward interpretations for many unconscious reasons. Beyond the feeling that an interpretation offers something *real* lies the practitioner’s narcissism. It is hard for many of us to be quiet and unobtrusive; it can feel as though we are not contributing anything when we are not receiving direct attention. And, of course, leaving the space for unexpected primitive energies to emerge is inherently dangerous. We do not know what

infantile needs or demands may arise, constellating unknown aspects of our own infantile desires.

It is important to remember that being quiet is not the same as being avoidant. An *impulse* to speak (as opposed to the choice to speak) will often reflect one anxiety or another on the therapist's part. A pressured impulse should usually be resisted. A *fear* of bringing something up is a completely different animal from a choice to provide the patient with maximal space for self expression. If the practitioner can notice that she is avoiding taking something up – if she can manage not to get caught up in rationalizations that turn her avoidance into a thoughtful choice – she can use that avoidance as an orienting principle. When a subject feels too hot to talk about, it certainly means that that subject needs to be approached in some way or other. This is different from a subject that seems premature to open up, although the two experiences can easily be confused.

Writing about the distinction between avoiding something and comfortably listening in silence demonstrates the difficulty of discussing technique in the abstract. The differentiation I would like to make is real and important, but because our perceptive and judging apparatus is so deeply distorted by unconscious currents, it is extremely hard for any individual (certainly including myself) to make these differentiations without input from an independent third. Perhaps the therapist whose fear frequently leads her to avoid bringing things up can work with her fear by pushing herself simply to be more active, even if this means cutting into the space that she can offer her patients.

But most of the objections to the stance of radical openness that Bion's advice creates are projections of the therapist's fears of not knowing. The profound intimacy constellated by receptivity to the immediate moment leaves one vulnerable to the other in a way that "educating" the patient never will. While there will certainly be patients who flee the space that an unknowing approach offers, there will be others who relish it and expand to fill it up. It is both frightening and relieving suddenly to find enough room to become one's true self.

And in any case, renouncing dependence on memory, desire, and understanding does not mean that the analyst cannot respond to the patient's terror of the greatly expanded container on offer. Some of the classical deprivations that psychoanalysts believe to be necessary are unconscious attempts on the analyst's part to project her own fear of the immediately present unknown into the patient. There is no reason to refuse to answer a question, even if the answer is an empathic statement about one's inability to answer. The parent of a frightened child does not need to *answer* the child's unanswerable question to comfort him with soothing words that convey the constancy of her strength and her love, even in an objectively dangerous situation. One need not comply with a patient's demand that a symptom be addressed or an answer given to respond with empathy and concern that soothes his terror:

"I can hear how frightening it is for you not to know what to talk about, but I think that if you can just continue to say out loud whatever comes to mind, even if it seems irrelevant or foolish, what we need to focus on will emerge."

“I hear how desperate you are to know what it means that you forgot that important meeting, and I wish I could just *tell* you why this happened, but my hunches are still too unformed. I feel sure that if you can bear to keep saying out loud whatever comes to mind, your psyche will take us where you need to go.”

“I hear that you want me to be the expert and to tell you why you felt sexually aroused when reading to your little boy, but we will be able to find that out only by listening to what your psyche has to say. Try to keep saying what comes to mind, and we’ll both try to hear what might have been expressing itself in you last night.”

Everyone loses patients. No matter how “flexible” (or strict) a practitioner tries to be, there will always be people who need something she does not have. But if the therapist believes that people grow as a result of finding and connecting with the missing parts of themselves – if she believes that what matters is the *unknown* – and if she has faith in the Self – faith in the psyche’s knowledge of where it needs to go and how it needs to heal, there is no reason to “educate” the patient before taking an analytic stance. When some element of the clinician’s behavior (or apparent non-behavior) disturbs the patient, it is helpful to explain why the analyst acts this way. I see no value in leaving the vulnerable patient terrified if the terror can be truthfully soothed. But the explanation should be personal and immediate. What is needed is not an explanation of how *analysis* (or therapy) works; what is called for is an explanation of why this particular practitioner is working this way at this precise moment. There is no reason to teach patients how the work works – especially since no one actually knows how it works. But there can easily be moments when it is important to make the therapist’s apparently bizarre behavior understandable rather than disorienting and frightening. The process is the same as when a parent explains a painful medical procedure to a child as the little one endures it. Explaining the pain makes it meaningful and tolerable rather than persecutory.

We know, in fact, that the most powerful interventions are rarely planned. Just as the patient comes to know what he thinks as he speaks his associations aloud, the therapist may realize the meaning of the moment *in the act of speaking to it*. It is not her conscious memory or understanding that is operating; it is the Self, the energetic force of O, bringing out a truth that may surprise both people in the room. The explosive interpretation that ultimately transformed my work with Gertrude expressed a truth *I did not know* until I spoke it. Coltart’s sudden eruption similarly resolved a very difficult situation (perhaps more rapidly than mine did). These were acts of freedom that informed the speaker of the situation’s meaning at the same time as it informed the patient⁴.

⁴ As all sensible thinkers have indicated, it is impossible to offer any positive guidelines for technique. It is true that one should avoid acting on a pressured impulse to speak; it is also true that an unthinking outburst can be transformative.

When one turns away from sensual reality and toward faith, the accompanying emotion is dread. By letting go of our armor we open the door to experiences that are painful and difficult for the patient and/or the therapist. To the extent that one needs a sense of power and control, it is too dangerous to go naked into the clinical encounter. We want to be experts who can survey a vast landscape and make sense of its essence. Jung calls this narcissistic urge the analyst's attempt to hide behind a "*persona medici*" (1946, ¶ 365). Winnicott, looking back as an older man, said that he derived far greater pleasure from watching a patient come to his own understandings than he did as a younger analyst from giving the patient interpretations (1971).

Fear of change

Almost all human beings imagine that they want to change. Certainly, all analysts and patients consciously hope to develop, usually thinking of this as wanting to "get better," to "improve," perhaps to "be cured." But people cling to old patterns and resist change. Change is slow, "bad habits" have us in their grip. Fairbairn (1952), in a foreshadowing of attachment theory, talks about how we cling to our bad objects. Bion suggests that change is experienced as catastrophic for the personality. The word "catastrophic" turns on its head the perspective from which we view the situation. Instead of focusing on how desirable change is and hacking away at those wicked resistances that block it, we are suddenly looking at how terrifying it is and empathizing with the poor person's attempt to cling to the known and to hold off transformation. Especially since the poor person in question may well be oneself.

There is much evidence that fear of change begins at the latest with birth, the largest transformation a living creature experiences short of death. Being born is typically lengthy and fraught with strong sensations, at least some of which are probably unpleasant. And the wordless infant can have no concept of how long the process will last. From his point of view, this may as well be the new state of affairs as the beginning of a transition to a new state. Winnicott (1949) hypothesizes normal as well as traumatic birth experiences, but I am unable to imagine a birth, even a Cesarean delivery, that is not traumatic.

And while birth will bring many wonderful things, at first it can be only terrifying and incomprehensible to find oneself expelled from the safety of the watery existence one has known into the gaseous outer world. Suddenly all the bodily systems that have been developing must kick into action, regulating the infant's temperature, digesting his food, and eliminating his wastes. He must breathe, suck, cry. No one who has spent any time with a newborn can fail to notice how difficult this transition is and how much suffering the baby experiences as he traverses his first few months and settles into life, opening up to the many pleasures available in an ordinary good-enough family situation. All later change reverberates back toward his first amazing shift, bringing back the helpless infant's terror at being propelled through the narrow birth canal into the world of light.

One way that Bion explored this fear of change is in his work on the mystic and the group (1970). Drawing on his own experience in the British Psycho-Analytical Association, he

wrote about the tension between an innovator, whose ideas shift familiar notions of reality in disorienting ways, and the group he belongs to that must try to preserve its integrity by maintaining the world view that holds it together. Translating this tension into the inner world illuminates the universal intrapsychic conflict between the wish to face the truth and grow toward wholeness versus the wish to maintain the status quo that is known and secure, even if the security in question is similar to that of the prison or the grave. The inner “genius” has a new thought, a new perception that disturbs previous understandings; the inner group – the character structure, the noisy parliament of inner figures all of whom want to hold onto their power – resists the disorientation and confusion that taking in the new would entail.

Using Bion’s insight in the context of the clinical relationship, we can see the anti-relational pressures inherent in the situation. A creative idea emerges from one or the other minds present, an idea that challenges old certainties and stabilities. The “group” – those parts of both people that fear the pain of disruption, unknowing and confusion – fights to maintain its established way of perceiving, thinking and being.

Bion’s advice on listening presents us with a recipe for the establishment of a living relationship. Put aside all the protections against the other that we carry around, he is saying when he tells us to forsake memory, desire and understanding. The facts of our lives on which we have anchored our identities will change if our relationship is deeply meaningful; remembering these facts by casting them in stone will hardly facilitate this process. Our desires will surely clash to some extent with the desires of the other, and if our relationship develops, positive and negative possibilities that we could never have imagined before will emerge. Our understandings of the psyche’s nature and operation will surely be reworked, perhaps radically, in the next decade or two, and what we know about people in general will always be revised in some way by any particular person’s singularity. We can *never* Know a human being, neither ourselves and nor another. Bion’s formula for analysis is actually a formula for relatedness.

In the clinical hour we arm ourselves with psychological theories, with capacious memories containing extensive lists of things we know about the patient, with the therapeutic desires to guide or shape the patient or the hour in ways that we are certain are felicitous. We cannot help but work to defend ourselves against the helplessness of not knowing. Analysts almost always tell themselves that they are without an agenda for the patient, but I am skeptical of the possibility of attaining that perfectly pure state. At every moment the practitioner must turn away from the siren songs of memory, desire, and understanding. The struggle can never be won.

And despite all I have said, it would be undesirable not to *care* about a patient and caring must bring with it a desire for his well-being. Here we have a paradox that must simply be accepted. The analyst must let go of desire, even the desire to help at the same time as she remains involved and concerned, desiring the best for her patient.