

SOME THOUGHTS ON A THERAPEUTIC STATE OF MIND

Moran Shoham

The following is an attempt to delineate a state of mind deemed “therapeutic.” Bion’s (1967) paper on “Memory and Desire” has been a prevailing influence. Eigen serves as another source of inspiration (e.g., Eigen, 2005). Yet, and this seems to be the whole point stated succinctly, nothing could have been expressed here that is meaningful unless it was completely owned by self.

First, I would like to address what it is I find I do or do not do as a therapist. It might be noted that all I “do or do not do” is in itself a wrong way of addressing things, for, more accurately, I would say that something happens in the therapeutic encounter and that this “happening” determines my actions and moves as much as it is determined by them. When the process begins, I am taken, so to speak. But—and this I think is essential—comfortably taken.

Mostly, when a patient enters a session I find I do nothing. It is not true to say I listen. Listening is too active, too heavy. When I listen I usually hear, and so the end was prescribed. When I listen, that is, I seek to impose my being (taste, associations, needs of . . .) on the created field. So I try not to listen. If I do hear the patient I hear him or her *despite* my not listening, and here a pressure begins to accumulate that is relevant. There is a presence, an intonation, a rhythm of speech that is made apparent, that emerges from, the patient’s speech and forces itself, so to speak, on me. I change. This is, admittedly, uncomfortable. I become, for a moment, not myself. I find myself elsewhere. Something is happening to me, some string pulling me somewhere out of myself. I am, each time, and over and over

again, minutely, shocked.¹ I stay with it. Sooner or later, however (and this could be a minute or a session long), I am *compelled* to say something, and this too is unsettling. For I have almost always found that I speak in order to find relief, first and foremost, from something, an accumulation foreign to myself. I could rationalize that I speak for the patient's sake, and my words might, indeed, carry this effect. But, I insist, basically and invariably—I speak to find relief. As I speak a wonder happens: that which was so foreign to me, the patient's intonations, rhythm of speech and the like, becomes, in a moment, my most intimate possession. I become *part of* something the patient said, as I have transformed it according to my own tone of voice, rhythm of breathing, capacity to find words. . . . I find myself in motion, moving ahead of myself, being myself and something more. I feel warmth, compassion, and now, I find I mostly see. I see how my words affect the patient (other). I see something changing. I see my words finding their way to him or her, making something alter. I see alternation.

A female patient in her forties, in early sessions of therapy, says that *in addition* she is afraid she will run out of something to say. She says more. And more. And she repeats. And gives examples—previous therapy. I have to resist thinking of greed, of “more and enough,” of the anxiety incorporated in this. I keep not listening. Slowly, her voice accumulates to something. Eventually something happens. I don't know where it came from. It surprises me. I feel (I don't see it, although it is easy to report it as seeing) a baby looking up from the crib, wondering, fearful, uncertain, *who will come up next* (and what the arrival of a different person calls for?). In a moment this realization pervades the entire therapeutic space. Nothing is left untouched. Now I find I am anxious. I get irritated. Angry. Despairing. Oh. There's my patient speaking. Her voice contains me. Calms me down. She complains. I smile at her. She calms down. I know I know her. She knows that too. Eventually I might say, “It would be just the same, whether you have something to say or not. Things won't change much.” Or I might just think it. It matters little. Later during the day, I remember that this patient was raised in a kibbutz, with common housing for newborns. But I did not remember it as I listened to her complain, and as I am remembering it now I know more about it than as a simple fact.

I have been there, to some extent at least. The following week, when she comes in, I forget it all, all over again.

The reader can see for himself or herself what the mention of an external fact, one that lay outside the immediate area of interplay between patient and therapist, the kibbutz sleeping arrangement, does. It raises doubt. It stirs what is perhaps at the root of such doubt, namely, criticism (or self-criticism). "Did you not know about her past something that should have informed your so called free-floating attention and enabled you to arrive at the 'clinical fact'?" The answer is that I knew but it still did not inform my thinking, and here the whole territory of faith opens up (Eigen, 1981). One has to be in that moment, to have undergone the process to know that what one has arrived at was not preconceived. Nevertheless, the doubt is typical and goes with almost any move we make in therapy relying on external facts. Each and every time we grasp our patients' experience by relying on pre-existing theory, which is itself external to *this* treatment, or on facts supplied but not yet meaningfully related to the therapeutic field, such doubt, a form of self-criticism arises. It is this self-doubt, so toxic in its own turn that can give therapy a heavy, unhappy, unfree atmosphere. At best it should be an indication that facts from outside the immediate field are being used, and that the patient is thus being coerced into believing something, as well as that the therapist is equally coercing himself or herself into believing something, and that the whole dance is danced for the sake of avoiding something deeper. What? Well, that an encounter is taking place. There is, as noted, a shock involved in it all.

On this issue, Mitrani (2007) recently has written the following: "I propose that the act of introjecting the patient may be the most difficult aspect of our work, as it is not a matter of good will or good training, but an unconscious act governed by unconscious factors" (p. 834). She adds: "The soothing nature of this theoretical pacifier is seductive and requires a concerted effort on part of the analyst to remain in the unknown and unfamiliar long enough to hear something new and unexpected in the patient's material when the *pressure to interpret prematurely is stimulated by our own as well as the patient's need to survive*" (p. 840). Similarly, Searles (1979) writes:

It is currently one of our great human tragedies that hundreds of thousands of personas are living out their lives in gigantic mental hospitals, existing largely in chemical cocoons, because behind our scornful shunning of them is our unformulated sensing that any one of them, if we were to permit him or her to do so, would become personally more a part of us than we dare to allow. (p. 177)

Next is the question of what we wish for our patients. That they do better is a reasonable, conscious answer. But as we listen to a patient, what does wishing mean or do? More often than not I find that wishing is itself incapacitating. Wishing is the projection of the self beyond the moment and thus entails impoverishment. Wishing within a session is most often aggressive and symbolizes the need to possess. It is the taking of the other into my own field of reference, and this is already an act to be avoided. It is not that views cannot be shared, not that good moments, progress, relief cannot be welcomed with joy. Striving toward that end, however, wishing it were so, deprives one of the very means of getting there. When a patient speaks, there is the moment of speech, a moment that repeats, over and over again, until the patient himself or herself breaks away from that moment and moves beyond it. My presence enabled something, to be sure, but I wished it not. I followed a thread. What a patient hinted he or she wished. What he or she guessed he or she would want. And I stayed with that. Not knowing whether it is to be had. Not wanting it so.

A young schizophrenic patient speaks. Whenever she speaks I cry internally. Her mind was broken some years ago and she is still overwhelmed, trying to come to grasps with what happened. She is young and hopeful, but I cry. I realize I am crying so that I won't sense what I cannot tolerate, that I produce emotions as a defense against things happening I might never be able to allow myself to feel. All this is wishing and serves as a defense: "I might never be able to," and "she might never be able to," and "if only it were otherwise." By doing so I impede her progress, and we might spend a long time wishing in the form of crying. And after that, what? I guess it will all really begin. If I can bear it.

It is not easy to stay completely without. To let the moment fill one anew like a vessel. Mostly, as noted, I think the fear is of

the potential alienation involved in allowing oneself to be taken by the other. To let things completely in can make one wonder on levels where it is not easy to wonder or be confused. Contemplation itself, like this paragraph, is a way of avoiding opening, of staying related *to* things. Language, in its potential for rhetoric, serves us well as a mean of avoiding ourselves. See how coy that remark is: as if *we* are not the language that we make. The giving up, the surrender, the submission: “I felt it was done to me”; “It was put into me.” More accurately: it took place, it happened. And it happened in me *as well*. And I surpassed it and stood beyond it and made something of it. Not painful. Not hard. Beyond the fear, and free from the pressure. I welcomed it all into myself as part of myself. *As* part of myself—but not as myself. For I was no longer there or anywhere else to be had. I was happening: a therapeutic state of mind.

There’s a beautiful line of Bion’s (2005) in his Italian seminars where he says: “Once the patient begins to understand what the analytic experience is, then he changes so fast that what he thought or felt at the beginning of a sentence is out of date by the time he has reached the end of it” (p. 29). It took me a while to feel comfortable with the use of the word “understand” and how it might be related to the poetic observation to follow. Slowly, however, I came to realize that it is most accurate as it denotes true *differentiation* between analyst and patient, as the patient becomes his own therapeutic state of mind. Here the therapist becomes superfluous and “out of date.” He becomes, and herein lies the gain, beyond memory and desire.

NOTE

1. On this see also Eigen’s (1985) discussion of Bion’s sense of catastrophe. “Being shocked,” thus perceived, is the result of the taking in of raw materials to be digested and transformed by the therapist’s alpha-function to produce workable alpha-elements.

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*18 Sport Street
Haifa, Israel
E-mail: moran9898@hotmail.com*

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