The clinical psychologist is an architect responsible for the creation of an environment in which a therapeutic conversation can take place. There are a number of ways of describing the basic psychoanalytic attitude and the parameters of the analytic dialogue but the goal remains, to make the unconscious conscious, to talk about what is difficult to talk about, to create the conditions for the patient to speak and for the therapist to listen psychoanalytically, interpret and bear witness. To listen psychoanalytically is to listen with free-floating attention, with neutrality and without judgment. But beyond that there are other varieties of psychoanalytic listening and those are what I’d like to talk with you about today.

I would like to mention that after I finished writing this paper I discovered a recently published book by Salman Akhtar, *Psychoanalytic Listening: Methods, Limits and Innovations* (2013). In his first chapter Akhtar noted that after Freud’s recommendations on psychoanalytic listening, in 1912, few analytic texts referred to the subject and in a computer search for the term “analytic listening” in the PEP website, the twenty-eight articles that appeared were all published since 1980. So it seems to be an area of interest whose time has come. Not surprisingly there is some overlap between my paper today and Akhtar’s book. I highly recommend Akhtar’s *Psychoanalytic Listening*, not only for the overlap with my work but for the outstanding clinical vignettes and the other areas he treated that I did not address. That said, let us begin.

The basic psychoanalytic idea is that psychological symptoms serve as caps that cover untold stories. And when the stories can be told in detail and with emotion, be examined and retold, sorted out and have their affects liberated, it often has a curative effect.

Imagine for a moment an anxious person having trouble breathing. The psychologist invites the patient to speak in a free and uncensored fashion, in the confidence of the clinical situation. To this invitation the patient tells his story, unburdens himself, cries, and laughs. In the course of the conversation the patient’s story is punctuated with, “You know I’ve never told this to anyone.” “I don’t know what you’re gonna think of me, but I’ll say it anyway.” “I don’t know why I am saying this.” “I had no idea I was going to be talking about this.” And at the end of the session the patient breathes deeply, exhales fully and says in a relieved tone of voice, “Oh, I’m so glad I finally got that off my chest!” This is a museum specimen of the analytic dialogue in which the symptom, difficulty breathing, in this case, serves as a cap covering a story that must be told and when it is told the symptom is no longer needed. Of course, with most symptoms it is a lot more complicated and requires more than one session but the principle remains the same – create the conditions for disclosure.

LISTENING LIKE BERNFELD

Siegfried Bernfeld was among Freud’s closest associates in Vienna. After his emigration to San Francisco in 1937, he wrote *The Facts of Observation in Psychoanalysis* (1941, 1985). In it he described psychoanalysis as a method of personal investigation based on the model of an “ordinary conversation”. Bernfeld noted that conversation is characterized by questions, revelations, overt communications, and subtexts and that analysts can “…transform the give and take of the conversation into an inquiry” (Bernfeld, 1985, p. 344). The inquiry is to discover what gets in the way of the story that needs to be told. Thus “the facts of observation in psychoanalysis” do not pertain to the content of the dreams, fantasies, or anamnesis, but rather to the shifts and changes in the analytic dialogue - specifically the resistances and transferences. Attending to the shifts and changes in the analytic dialogue, Bernfeld gave the example of how a listener, closing a door, can create the conditions of privacy that allow a person to say that which was previously difficult to disclose. Transposing this model onto the analytic relationship, Bernfeld suggested that just as the lack of privacy had been an external obstacle to self-disclosure, shame and distrust are internal obstacles, which similarly require the therapist’s skill to remove. Bernfeld emphasized that it is not the
content of the patient's secret, or confession, to which the analyst should be attending, but rather the nature of the obstacle to disclosure – the nature of the resistance. If the analyst fails to note the resistance, he/she misses completely the opportunity of getting what Bernfeld called a "confession" (Bernfeld, 1985, p. 345). “By saying the right things at the right time he (the analyst) creates the condition under which the patient is likely to confess secrets. These communications are the facts to be observed…” (Bernfeld, 1985, p. 346). To avoid confusion, it is useful to regard Bernfeld's use of the term "secret" as referring to consciously and unconsciously held secrets and to regard "confession" as referring to both revelation but also elaboration.

Using the “ordinary conversation” as the model for the analytic dialogue, Bernfeld schematized the psychoanalytic dialogue in five phases, abbreviated as U-S-I-C-U. The patient engages in his usual (U) behavior or discourse. Under the analytic conditions of free-association and the analyst’s neutrality and confidentiality, the resistance naturally gets established and the patient begins to keep a secret (S). The secret can be something the patient is fully aware of and yet consciously suppressing or it can be a secret he keeps from himself under an arsenal of defensive strategies mobilized as resistances in the analytic hour. The analyst, seeing the patient’s method of secreting or resisting, intervenes in the patient’s discourse by interpreting (I) the resistance or demonstrating the resistance. If the interpretation is correct and is presented with good timing and tact the patient confesses (C) the secret or elaborates it and then returns to the usual (U) discourse whereupon the cycle begins again.

Bernfeld’s model U-S-I-C-U enables us to follow the psychoanalytic dialogue, evaluate the accuracy of the interpretation, keep our eye on the resistance, and avoid making the stimulus error – that is, getting caught in the content. Another advantage to this model is that in facilitating the analyst’s focus on the analytic dialogue, the analyst is less likely to impose preformed theoretical assumptions on the patient and more likely to listen to the material as it emerges – allowing the patient to say what needs to be said and possibly even overhear himself saying it.

Bernfeld said, “Psychoanalysis is a Spurenwissenschaft – a science of traces” (Nathan Adler personal communication 1990). One finds the traces of the unconscious imposed upon the free-associations. Detecting the traces in language, we locate ourselves in the process by hearing the manifest content as derivative of the transference, the genetic, and the intercurrent (between sessions) material. Decoding the “traces” enables the analyst to identify the resistance and offer a well-placed interpretation in the flow of the analytic dialogue.

Bernfeld helps us in those difficult moments in our work by inviting us to wonder: What is my patient saying and how is he/she saying it? and more than that, How is my patient not saying something that needs to be said? When we ask, How is the patient not saying something? we are asking, What resistances are being deployed? and What is the nature of the transference?

Theodore Reik wrote, “The psychoanalyst has to learn how one mind speaks to another beyond words and in silence. He must learn to listen “with the third ear.” (Reik, 1948, p. 144)

LISTENING TO THE RESISTANCES, TRANSFERENCES AND THE REPETITION COMPULSION

Psychoanalytic work begins with the notion that the psyche, like an iceberg, is comprised of a small conscious portion above "water", a ribbon of pre-consciousness at the "waterline" and a vast unconscious portion "underwater" so to speak. Consciousness refers to that which is in our awareness, directed attention, etc. The preconscious is not fully in consciousness but can be summoned at will or noticed suddenly while never having been completely unconscious. The unconscious portion is inferred from various conscious experiences that give us the sense that something outside our awareness is operating - driving our moods and behavior, shaping our dreams and fantasies, our slips of tongue, our passions and our psychological symptoms. With the notion that behavior is motivated by impulses and ideas of which we are unaware – that is, lying hidden in the unconscious - we say that psychotherapy is about making the unconscious conscious or learning to keep as few “secrets” from one’s self as possible.

Between the conscious and preconscious are some rather flexible defensive strategies, which permit the passage of
information from preconsciousness into the consciousness and vice versa. Between preconsciousness and the
unconsciousness are some much stronger defensive strategies, which block the passage of information from
unconsciousness into awareness.

The clinical approach of Freud’s early Id psychology focused on examining the manifest content of the dream, slip,
free-associations, etc. and interpreting its latent or unconscious meaning. The clinical approach of his later Ego
psychology focused on first interpreting the resistances to becoming conscious of what was unconscious and only
then shifting to the interpretation of the latent meaning.

Some will ask, "Why are you being defensive?" as if one were somehow supposed to get rid of one’s defenses. But a
person without defenses is either unconscious or dead. We all need our defenses if nothing else, simply to be
conscious. And while everyone has defenses, no two people have the same defensive constellation. Defenses are
tools and while everyone has a toolkit of defenses, every toolkit is unique. Typical defenses include projection,
intellectualization, denial in fantasy, humor, negation, splitting, reaction formation, suppression, projective
identification and so on. Each person has a preferred set of defenses and deploys those defenses in different ways
and with varying levels of flexibility. Under stress the defensive constellation (defensive toolkit) enlists different
tools to meet the challenges presented. A person that is described as “defensive” is not just deploying defenses but
deploying more defenses than appear necessary. In such circumstances we become curious about the story beneath
the hyper-defense or symptom and seek to interpret the defense in a way that allows the patient to let the defense
down and speak freely about that which is difficult to put into words.

As a point of clarification, there is a difference between defense and resistance. Defenses are constantly being
deployed by the psyche but when the defenses are deployed in therapy before the invitation to speak in a free and
uncensored fashion, we call them resistances. In short, resistances are resistances to speak in a free and uncensored
fashion. Everyone resists but we all resist in different ways and the way we resist conceals our unique untold
stories.

Yes, we sometimes speak of the “interpretation of defense” but all interpretations of defense in psychotherapy are
“interpretations of resistance”. That said, resistances include more than just defenses. Defenses do not stand by
themselves. They form part of the structure of the psyche along with object relations. Object relations are the
internal representations of parents, siblings and other important figures of early childhood with whom one engages
in early love relations and in the vicissitudes of libido development. When, for example, a patient's paternal object
relation (internal image, imago, engram, etc.) is projected onto the person of the therapist under the conditions of
confidentiality, neutrality, and the invitation to free-associate, we call that projection a transference, as the patient
has transferred the early childhood object relation, the internal representation, onto the person of the therapist.

When a patient has the same sorts of authority problems year after year, gets involved in romantic relations that
always fail in the same fashion, keeps engaging in self-sabotage, has curiously similar problems with most of his/her
friends, runs into the same sorts of recurring problems with money or with time, we are witnessing not simply
defenses or transferences but defenses and object relations in a dynamic constellation we call the repetition
compulsion. The repetition compulsion is the compulsion to repeat early childhood traumas in the form of scenarios
relying on contemporary circumstances, on present day stages and with actors in the patient's everyday life. A wife
becomes a familiar mother in a resuscitated early childhood drama; a boss becomes a familiar father in a revived
adolescent rebellion and as long as the trauma remains sufficiently buried, the drama continues. The repetition
compulsion is a contemporary version of the drama that is analogically related to a childhood trauma. The
contemporary drama, which the person feels compelled to repeat, has the function of concealing the original trauma.

To listen to the transference is to listen to whom it is the patient directs his discourse: a punishing other, a critical
other, a betraying other, an abandoning other, an absent other, a loving other. To listen to the repetition compulsion
is to listen to the scenario of the drama that the patient is seducing us to enter, recruiting us to live out, auditioning
us to act out. The patient does not simply want to have a particular kind of relationship with us but actually IS
the relationship looking for an other with whom to play out the scenario. And if we do not fulfill our assigned role,
the patient will often try to reverse roles with us. If we don't criticize the patient, for example, the patient may
criticize us. The patient is, in a sense, an experience looking for an event - an angry person looking for something to be angry about; a failure looking for something to fail at; a saboteur looking for someone to sabotage; an abandonment looking for someone to leave, a betrayal waiting to happen; and so on. As therapists we want to listen to whom the patient directs his/her discourse and listen to the scenario of the drama within and the drama without. If we don’t act out and can interpret what is going on, we have the opportunity to make the unconscious a bit more conscious.

LISTENING TO YOURSELF
As our patients speak to us we listen to what they are saying, how they are saying it and how they are not saying something. But we also listen to ourselves in therapy. We listen to the thoughts that appear and pass through, across the stage of our mental theater. We become aware of thoughts that are engaging, stimulating, judgmental, hostile, confused, excited, amused, and so on. We feel ourselves falling into positions and stances in relation to what is being said. Our body feels comfortable, uncomfortable, energized, heavy. We feel sad, proud, envious, hurt, sleepy, frightened, absentminded, jealous, competitive, hurt, overlooked, ignored or angry. Our mind sometimes becomes foggy; we think about something in our personal life; we get lost in a memory or lapse into a fantasy. Within the analytic context, these are experiences we describe as countertransference.

When listening to the countertransference the therapist wants to distinguish when the countertransference tells him/her mostly about the therapist and when it seems to say more about the patient. If the patient touches one of the therapist’s personal conflicts, the countertransference is going to tell the therapist about the therapist. But when the patient has managed to export an object relation into the therapist, transfer an important figure from early childhood onto the therapist, has managed to engage the therapist in the patient’s repetition compulsion, the therapist’s countertransference ends up being information useful in understanding the patient.

The countertransference always tells us either a bit about the patient and a lot about the therapist or a lot of the patient and only a bit about the therapist. When we listen to the countertransference we are listening to our thoughts and feelings, fantasies and associations as information telling us something about what is going on between the patient and therapist. Hostile or erotic fantasies can, for example, tell us something about the nature of the psychotherapeutic relation when interpreted analogically. Countertransference fatigue is a common problem and is sometimes associated with a patient that is trying hard not to say something or a therapist that is resisting hearing some aspect of what the patient is trying to say. Resistance is sometimes diminished and the narrative opened up by the therapist saying, "I wonder how you are feeling talking about this with me today." Such an intervention brings the patient into the moment and frequently revives the narrative. And, of course, there are other interventions as well.

Every countertransference fantasy contains a ratio of narcissistic and object related components. The more narcissistic the ratio, the more it has to do with the psychotherapist and his/her personal psychology. The more object related the ratio, the more the therapist's fantasy has to do with the patient and his/her psychology. As an example, I once had persistent countertransference fantasies of conducting cosmetic surgery on a young man’s face. No other patient before or since has ever evoked such fantasies. I didn't know what to make of them but observed their persistence and listened session after session. The patient was a somewhat plain looking young man who always left his hair just a little bit uncombed. On anyone else I might have seen it as an artsy style and not given it much more thought but with him I found myself often desperately wanting to reach forward to comb his hair back. Then one day he explained that his father was well known for being very good looking, well groomed and impeccably dressed and he was also always invasively trying to fix-up the patient and make him look more like the father. Suddenly my countertransference fantasies made more sense to me.

With a somewhat obsessive woman patient I found myself often sleepy as she recounted details of stories about which there never seemed to be feelings or even much of a point. One day I suddenly dropped into a fantasy, which was the reliving of an adolescent memory. The memory was of being at summer camp playing water polo in the pool with a watermelon (which will float in water) covered in Crisco. When I came out of the memory I wondered, why I had fallen so deeply into that particular adolescent memory and concluded it had to have something to do with what I was hearing from my patient. The feature most prominent, for me, was the slippery watermelon. I said to my patient, "You know I am having trouble getting a grasp on what you are saying today. Your story seems somehow
slippery." Her eyes popped open and she began to speak with great feeling about how important the word slippery was to her and how being slippery has been a survival strategy most of her life. My countertransference fatigue, of course, disappeared immediately and the previously blocked associations began flowing once again.

**LISTENING TO THE NARRATIVE AND READING THE SUBTITLES**

Another mode of listening is to hear three narratives in whatever is being said. The three narratives are the intercurrent, the transference, and the early childhood narratives.

The intercurrent narrative is about what has been happening between sessions: events, dreams, thoughts, relationships, etc.

The transference narrative is about the patient's relation to the therapist.

And the early childhood narrative is about emotionally charged experiences from early childhood.

The idea is that as the patient speaks about intercurrent, transference, or early childhood experience we are in a position to put two sets of imaginary subtitles under everything that is said in order to listen to the manifest story analogically and obtain two latent subtexts. The subtexts we read will always be suppositional, intuitive, and subject to countertransference so we need to regard them as hunches, mindful that they will also arrive with a mix of narcissistic and object related components.

The patient may enter the office and say "Hey! How about those Seahawks?" (intercurrent)

The transference subtitle might read: "I am afraid of you so I will try to join with you in the pleasure of our football team winning a competition and in that way stay out of the competition with you."

The early childhood subtitle might read: "I managed my Oedipal rivalry by identifying with my father and watching the game with him but he always scared me and I always wanted to beat him. So I'm going to try to beat you at your game and distract you from our analytic relationship with comments about the football game. I will, in that way, win and lose by defeating you at your own game."

The patient may say: "No, I just don't feel you are understanding me." (Transference)

The intercurrent subtitle might read: "I am not feeling understood these days by my wife or my boss."

The early childhood subtitle read: "My mother and father never understood me because I didn't talk and I found safety in not being understood by them."

The patient may say: "My grandfather always touched me in such a prideful and respectful way" (early childhood)

The intercurrent subtitle might read: "Things are going well with my new boyfriend."

The transference subtitle might read: "You are listening to me the way my grandfather touched me, sensitively, not the way my father touched me."

We use the subtitles, or subtexts, to hear what the patient is trying to tell us, to elaborate in metaphor the patient's response to an interpretation or to create additional space to help the patient hear himself/herself. To listen to the subtexts is to listen analogically in relation to these three narratives.

**LISTENING TO METAPHOR**

To speak with a patient in concrete terms is to see him/her as monadic and univocal. The monadic person is a unitary being, a discreet individual, an encapsulated identity. It is a useful way to see oneself and to see others but it is an illusion - a sometimes-useful illusion. The monadic person is a rational willful agent of his/her destiny: a patient, a consumer, a voter, an effective person in the world. But if truth be told, we are not unitary but interactional. We are not discreet but intersubjective. And our identities are comprised of identifications. We may have only one mouth and strive for personal consistency but we are not inherently univocal. We are polyvocal. We speak in many voices. We each speak in the name of our mother, our father, our siblings. We speak in the name of our teachers, our fears, our hopes, our critical voices, our impulsive demands and even in the name of our child-selves. The monadic and univocal discourse is concrete. The composite and polyvocal discourse is fluid, changing and metaphorical. The mouth is an anatomical structure but through the symbolic function it gets metaphorized into a world of oral symbols through which we convey orality. The same holds for anality, oedipality, genitality and so on. We listen for
the metaphors of infantile sexuality in derivative material: dreams, fantasies, art, and relationship dynamics. We hear psychological dynamics in the metaphors of religious, political, and philosophical concerns; hobbies; favorite films and books; special interests and so on. We construct ourselves with metaphors, are imprisoned by the metaphors we use and in therapy, interpretations in the form of metaphors loosen resistances and afford us new possibilities of being.

LISTENING TO WHAT THE PATIENT IS HEARING
When we listen to the metaphors and subtexts of the patient's narrative we hear an on-going commentary on how the patient is hearing what is going on in the session. This allows us to evaluate if we are being effective in helping the patient to say what is difficult to say or if our treatment is fortifying defenses and blockading the process.

An elderly woman said, "Now that my husband has died I don't feel like going out much and am spending a lot of time at home alone."
I listened and replied, "Yes, it must be very painful to have lost your husband but I think it will be important to also find a way to get out from time to time."
She replied, "Yes, and I'm so irritated with my children because they don't understand me at all when I want to stay at home and they are always trying to get me to do things and right now I just don't want to. I just want to stay at home for now."
"Yes, and you get irritated with me as well when I encourage you to get out."
She smiled, giggled and said, "Yes, thank you."

LISTENING TO THE PATIENT'S THEORY OF PERSONALITY
Related to hearing what the patient is hearing, is hearing the patient's theory of personality. It is sometimes useful to ask the patient quite directly about how the symptoms came to be and if the patient has any ideas of how therapy can be useful. Beyond that, it may also be useful to explain how we think about therapy and how it works. If we can't hear the patient's implicit or explicit theory of personality and therapeutic change and we don't explain or clearly demonstrate how we work, the patient is likely to fall back on a standard concrete expectation associated with a wide variety of other services in the health professions in which the patient shows up and the professional does something to them or gives something to relieve suffering. In psychotherapy many patients await medication, advice, a stern lecture, punishment, absolution, or whatever else might be in their imagination. Without being inducted into the analytic dialogue, some patients will hear an interpretation as a criticism or think that when the therapist speaks of an unconscious desire, it is a conscious desire and they will simply deny it.

When we listen to what the patient is hearing and how the patient is hearing, we are better able to hear the echoes of our interpretations, track the process and thereby stay empathically closer to the patient. But some psychotherapists are more interested in their own theory than in the patient's theory. In these circumstances an otherwise good theory can be used as a filter or cookie cutter to impose upon the patient, obscure the therapist's view of the patient and limit what the therapist would otherwise be capable of hearing. A good theory, like a good lens helps us to see things that are not so readily apparent but we make an error when we think our theory is the "true reality". This is why it is useful to be able to see the patient through the patient's lens to understand and empathize with the patient and then see the patient through multiple theoretical lenses employing critical thinking to determine the theory or theories that offer the greatest explanatory power and treatment implications.

One of the biggest errors a therapist can make is to over-identify with a particular theoretical orientation to such an extent that the therapist is simply scanning the patient's narrative for data related to the preferred theory. When the therapist can only think of the patient in relation to a single theory, the patient may be in danger of being clinically abandoned. This is a religious attitude and it does not do justice to a good theory.

LISTENING TO THE WORDS
Sometimes it is useful to listen to what the patient intends to say and sometimes it is useful to listen to what the patient actually says, the words the patient actually uses and the ways the sentences are constructed. In the words the patient uses we can hear slips of the tongue and see the way language constructs narrative, subjectivity and otherness. In the use of words we can hear the way a patient speaks as if we are stupid, critical, dangerous, all knowing,
benevolent, friendly, and so on. The use of words constructs subjectivity and otherness and it is in this way that we recognize the transference and the resistances. The depressive, for example, speaks of things "happening" and of "waiting" and being "powerless" to effect change. The hysteric also feels powerless but provokes other to action and moves only when the spirit moves them. The person lacking psychological insight speaks concretely, logically, abstractly, and intellectually; and has trouble thinking metaphorically, figuratively, analogically, and integrating emotion.

A good copy-editor reads the text and helps a writer to say what he/she is trying to say. A good therapist listens to the narrative and helps the patient to speak about that, which is difficult to say. The repressed or suppressed may be difficult to speak about because it is painful, conflictual, embarrassing, sublime or some secret pleasure. But the therapist listens to the words and offers the patient the opportunity to open up the narrative and elaborate the story.

THE WAY LISTENING SHAPES THE NARRATIVE

Errors in listening are made when we are too concrete in our understanding or interpretation of the narrative; when we are too metaphorical and miss the affect in the concrete telling of the story; when we are stuck in our preferred theory and can't hear anything outside of it; when we reduce every narrative to the infantile sexual metaphor, or the religious metaphor, or the interpersonal metaphor, or the transference metaphor, or the sexual and aggressive metaphors; or when we miss the multiple interpretations of the narrative. The error comes when we only have one way of listening. We need multiple modes of psychoanalytic listening and critical thinking to evaluate and deploy them. Clinical thinking is critical thinking in the clinical context.

Many psychologists have a tendency to overlook substance abuse and the physical basis of psychological problems. Other psychologists listen only to themes that interest them and leave patients with other issues unheard. The way that we listen and respond to the narrative gives the patient information that tells him/her how we are listening and what we like hearing and don't like hearing. These cues shape the story that is being told and in this way limit or canalize the narrative. A judgmental scowl will limit what the patient has to say. A competitive rebuttal may shut one down. An understanding nod might encourage one to keep going. A silent reply might rupture rapport and derail the therapeutic alliance or conversely initiate the analytic dialogue into greater depth. It is in this sense that the way we listen shapes the narrative. We sometimes hear it said that patients of Jungian analysts have Jungian dreams and patients of Freudian analysts have Freudian dreams. Patients often tell us only what we can hear.

LISTENING FOR SOMETHING YOU’VE NEVER HEARD BEFORE

I once had the rare opportunity to enter the original cave at Lascaux, in Southern France, to see the 17,000-year-old Paleolithic cave paintings. As a small group of us shuffled slowly along a path, through the dark, we were asked to stop at various points when lights would be turned on briefly to reveal the cave paintings. The tour was presented in French and one of the archeology grad students who had been in the cave before translated for me. As we neared her favorite image, she leaned close in the dark and whispered, "Now get ready to be surprised." Other than the suggestion to listen, I cannot imagine better advice for the psychotherapist. "Get ready to be surprised."

I once heard a musicologist describe the height of music appreciation as listening to a piece of music you have heard many times before without anticipating the next note. Sometimes while preparing to see my next patient, I'll have a thought refreshing my memory about the current issues being dealt with in therapy. I then scold myself gently for anticipating the next session and invite myself to listen more openly so as to hear something I've never heard before. In short, I think it’s a good idea to listen to the familiar narrative, hear something you've never heard before and get ready to be surprised.

REFERENCES