PSYCHOANALYTIC LISTENING

METHODS, LIMITS, AND INNOVATIONS

Salman Akhtar
CHAPTER ONE

Four kinds of analytic listening

"[The analyst] must turn his own unconscious like a receptive organ towards the transmitting unconscious of the patient"

—Sigmund Freud (1912e, p. 115)

In his papers on psychoanalytic technique, Freud (1911e, 1912b, 1912e, 1913c, 1914g, 1915a) dealt with almost all important aspects of our clinical enterprise, including the need for a certain frequency and regularity of sessions, payment, use of the couch, free association, the limits of memory and recall, resistance, transference, anonymity and neutrality, working with dreams, and interpretive interventions of the analyst. He also made a number of remarks about the analyst’s manner of listening and what exactly it is that he ought to be attuned towards in his attention. Note the following recommendations made by Freud in this context.

- “The technique ... is a very simple one ... It consists simply in not directing one’s notice to anything in particular and in maintaining the same ‘evenly suspended attention’ in the face of all that one hears” (1912e, pp. 111–112).

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• "The rule for the doctor may be expressed: 'He should withhold all conscious influences from his capacity to attend, and give himself over completely to his "unconscious memory"'. Or, to put it in terms of technique: 'He should simply listen and not bother about whether he is keeping anything in mind'" (ibid., p. 112).

• "He must turn over his own unconscious like a receptive organ towards the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone ... the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious which has determined the patient's free associations" (ibid., pp. 115–116).

It is clear that Freud put immense trust in the direct communication between the patient's and the analyst's unconscious and held the analyst's free-floating attention to be the outer half of the patient's free association. This is not to say that Freud was not cognizant of the hindrance to the treatment caused by unresolved problems in the analyst's personality. He exhorted the prospective analyst to "not tolerate any resistances in himself" (ibid., p. 116), undergo an analysis himself, and "continue the analytic examination of his personality in the form of a self-analysis" (ibid., p. 117). Otherwise, there was a risk of not listening to the patient properly, omitting cues offered by the patient and, worse, projecting one's own personal issues on the matters under consideration.

Analytic listening, for Freud, was not restricted to the patient's spoken words. It also included paying attention to his silences, and to the non-verbal cues he offered (Freud, 1909d, 1914g, 1917). Attention of such breadth required a relaxed submission to all the input that was coming one's way. There was no scope for focussing, choosing, or censoring here. In a later paper, Freud reiterated that

We gather the material for our work from a variety of sources—from what is conveyed to us by the information given us by the patient and by his free associations, from what he shows us in his transferences, from what we arrive at by interpreting his dreams, and from what he betrays by his slips or parapraxes. All this material helps us to make constructions about what happened to him and has been forgotten as well as what is happening in him now without his understanding it. (1940a, pp. 177–178)

For such a transaction to take place, the analyst had to make sure that he was not putting up resistances in the pathway to listening; the best way to assure this was to undergo a "psychoanalytic purification" (Freud, 1912e, p. 116) himself. This was especially important for handling transference love with equanimity since an analyst who has worked through his narcissism would understand that "the patient's falling in love is induced by the analytic situation and is not to be attributed to the charms of his own person" (Freud, 1915a, p. 161). However, arriving at such a mental posture, especially on the novice's part, required some effort. The tension between the passive surrender to an "evenly hovering" state of mind and the active measures undertaken to enter that state of mind is something that later contributors have had to struggle with. They also had to face the paradox that the analyst's not listening to anything in particular is precisely what leads one to find things that are particularly significant. Psychoanalytic contributors who came after Freud thus found their own solutions to these dilemmas and added further nuances to the manner in which an analyst listens to the patient's communication.

Given the broad spectrum of these listening styles and the great diversity of what their respective proponents focus upon, any attempt at categorising them is bound to falter or remain incomplete. Moreover, the various ways of listening that have evolved are not surgically apart; they show significant overlaps. With such caveats in mind, I propose that in the literature subsequent to Freud's (1912e) original ideas about the topic, psychoanalytic listening has been described in four major ways. These include (i) objective listening, (ii) subjective listening, (iii) empathic listening, and (iv) intersubjective listening. Each perspective deserves separate consideration though without overlooking its complementarity and confluence with its counterparts.

**Objective listening**

This manner of listening has its foundations in the "classic" vision of human nature, its maladies and their amelioration. Such a perspective, found most clearly in Kant's thought, holds striving towards autonomy and reign of reason to be the essence of being human. Extrapolated to psychoanalysis,

The classic view sees man as governed by the pleasure principle and the development towards maturity is that towards the
predominance of the reality principle. The analyst’s attitude towards the patient is a combination of respect and suspicion and the analyst takes the side of the reality principle. The ethic is stoic: maturity and mental health depend on the extent to which a person can acknowledge reality as it is and be rational and wise. (Strenger, 1989, p. 601)

The “classic” attitude places the analyst in the position of detached observer and an arbiter of “reality” and, when it comes to analytic listening, prompts a certain amount of scepticism regarding the patient’s verbal productions. The analyst’s listening does not get seduced by the patient’s avowed difficulties. It is propelled towards deciphering “the ways in which the patient’s wishes and fantasies colour his perception of reality, past and present” (ibid., p. 603). Attention is paid to what the patient is talking about but greater interest remains in how the patient is talking; the process is accorded more value than the content. Consequently, pauses, hesitations, emphases, peculiarities of intonation, and slips of the tongue evoke the analyst’s interest to a greater extent than the “story” on the patient’s mind.

This perspective on analytic listening ardently upholds the value of the patient’s “free association”. Its proponents (Brenner, 1976; Busch, 1997, 2004; Fenichel, 1941; Gray, 1994; Hoffer, 2006; Kris, 1982, 1992) assert that it is only by following the patient’s chain of thoughts—and impediments to it—that one can gain access to the unconscious meanings of the patient’s conflicts. To be sure, over the course of time, the purview of what falls under the rubric of “free association” has enlarged (see Peter Fonagy’s remarks in McDermott, 2003) to include visual images (Kanzer, 1958; Warren, 1961), bodily movements and postural changes on the couch (McLaughlin, 1987, 1992), and even an occasional invitation for the patient to draw something that he or she is finding difficult to put into words (Brakel, 1993; Slap, 1976). Also pertinent in this context is Makari and Shapiro’s (1993) clarification that analytic listening attends to non-linguistic communications as well as the subtle linguistic categories pertaining to narrativity, symbolic reference, form, idiom, and interaction convention. An unmistakable feature of an analyst listening “objectively” is that he relies less on his intuition and more on his intellectual capacity, however “silently” the latter might operate during his clinical work. Brenner’s (1976) painstakingly methodical way to arrive at a “conjecture” or “an analyst’s formulation in his own mind of what he has learned about the patient’s conflicts” (p. 36) exemplifies such a stance. Without ruling out the element of sudden subjective grasp of meanings inherent in the patient’s communication, Brenner puts a premium upon the step-by-step, logical, and intellectual process of conjecture formation. In no uncertain terms, he states that it is “important to keep in mind one’s analytic knowledge of symptom formation and to apply it when one is analyzing patients” (p. 21), and that “whatever the patient reports or does should be viewed in the same way, i.e., in the light of the analyst’s understanding of the nature, the origin, and the consequences of conflict in psychic life” (p. 29).

To this end, Brenner (2000)—later in his analytic career—went so far as to suggest that a selective and strategical shifting of focus of attention is more useful than “evenly suspended attention” (Freud, 1912e, p. 111) in listening to analytic material.

More sustained respect for the data obtained from listening to the patient’s free association was demonstrated by Gray (1982, 1994). His suggested method of listening hones in on the moment-to-moment shifts of direction, emphasis, and nuance in the stream of the patient’s associations. It pays sharp attention to a pause, an abrupt change of topic, the emergence of an incongruent affect, and an unexplained avoidance of the logically expectable. Such “close process monitoring” (Gray, 1982) places the ego in the centre of psychodynamic technique, helps unmask transference proclivities, and facilitates resistance analysis. Busch (1997, 2004) has further elaborated upon this manner of working with patients.

The Kleinians, though opposed to such “ego psychology” in important theoretical ways, demonstrate equal interest in the moment-to-moment changes in the flow and direction of the patient’s thought. However, they tend to regard all free associations as referring to transference (Hinshelwood, 1989; Klein, 1952; Riviere, 1952). Moreover, unlike the ego psychologists who focus upon what causes the turn in the flow of the patient’s associations, the Kleinians are interested in what is caused by the turn in the flow of the patient’s associations. This is because the Kleinians regard free associations themselves as actions.

**Subjective listening**

Standing apart from the analysts who listen “objectively” are those who rely a great deal upon their subjectivity in their attempts to
understand what the patient is trying to communicate. To such analysts, understanding often comes in the form of inspiration with no (or very little) conscious effort to put the “two plus two” of the situation together. They subscribe to Freud’s (1912e) declaration that the analyst’s unconscious, if properly attuned, is directly able to pick up what the patient’s conscious is transmitting. Reik’s (1937) warning that conscious logical unconscious is transmitting advances this line of thinking. Isaacs’s (1939) statement that a conjecture about the patient’s unconscious is detrimental to analytic perception advances this line of thinking. Isaacs’s (1939) statement that a conjecture about the patient’s thinking, and the spirit of an intuitive way of functioning during the clinical hour. Yet another illustration is formed by Bion’s (1967) grim declaration that since “memory is always misleading ... [and] desires distort judgment” (p. 271), it is best that the analyst should listen to the patient without memory or desire. It is only then that the ultimate truth of the moment—“O” in sharp clarity would then lead to the “act of faith” (Bion, 1970), that is, an analytic intervention that is based upon intuition and has left experience and knowledge behind.

Less dramatic and far more systematically presented are the views of Jacobs (1973, 1986, 1991, 2007). He holds firmly to the analyst’s counterpart for the “fundamental rule” (Freud, 1913c, p. 134) for the patient: the injunction that the analyst should privately consider all that occurs within him for its potentially informative value in terms of the patient and in terms of what is taking place between the two of them. More than any other analyst—perhaps with the exception of Searles (1979), who largely dealt with severely ill and often psychotic patients—Jacob relies upon his inner emotional state, his passing associations, his reverie, and even his attire and postural changes to discern the events that are taking place between him and his patient but are just so slightly out of the conscious awareness of both. He notes that:

The manner in which the analyst begins and ends a session; his posture, facial expressions and tone as he greets or says goodbye to his patient, convey kinetic messages of which he may or may not be himself cognizant .... There is, however, another aspect of the analyst’s non-verbal behavior that has received relatively little emphasis in the literature: the bodily movements that accompany the act of listening. Certain of these movements, such as tapping a foot or motor restlessness may, through sound, be conveyed to the patient, and, in fact, act as conscious and unconscious communications. At other times, the patient may detect from the slightest acoustical clues an otherwise unexpressed attitude or feeling on the part of the analyst. (1991, p. 104)

Jacobs goes on to speak of “body empathy”, or the increased cathexis of the bodily ego that accompanies well-attuned listening. The analyst’s bodily responses reverberate with the patient’s unconscious communication. By paying attention to his own posture, gestures, and movement, the analyst gains deeper knowledge of the patient (see Chapter Four for more details). Jacobs wonders if work with physically traumatized patients is more often associated with somatic resonances in the analyst. He also allows for individual variations within analysts themselves.

While it seems self-evident that an analyst, while listening, utilizes his entire self in the process and that bodily movements are an integral and essential part of the “analyzing instrument”, the degree to which bodily reactions are both available and useful to the analyst unquestionably differs from individual to individual. In some analysts who have had significant experiences of bodily illness or trauma, or who perhaps for other reasons of an innate or experiential kind have a highly cathexed body ego, there may be an increased capacity to utilize bodily responses in their analytic work. In others, whose development along different lines may have led to an increased investment in the visual or auditory spheres or in fantasy formation, or in individuals in whom defensive operations may be directed against awareness of bodily sensations, such experiences may play a lesser role in the analyst’s use of himself. (Ibid., p. 116)

Lest this gives the impression that in “listening subjectively”, Jacobs relies solely upon his bodily experiences, I hasten to add that he cites numerous clinical vignettes where a passing thought, a childhood memory, the discovery of his wearing mismatched clothes, and a strong but unexplained surge of emotion within himself became a clue to the deeper messages emanating from the patient. He asserts that contact with such elements of one’s subjectivity “helps illuminate preconscious material in the patient that is rising towards consciousness” (2007, p. 104). Jacobs
(1992, 2007) credits the origins of his thinking to Otto Isakower’s (1963a, 1963b) concept of “analytic instrument”. This refers to a joint creation of patient and analyst. Assembled in, and existing only during the analytic hour, it might conceivably be imagined as a brain containing two halves. One half belongs to the patient, the other half to the analyst. In the analytic session as both analyst and patient loosen their ties to the external world and enter into a slightly altered state of consciousness—essentially a condition of daydreaming—these two halves come together in a temporary union, a bridge is built, and unconscious messages can flow between them. In this state of mind, which the analyst must consciously employ—and, arguably due in large measure to this state of mind—it is highly likely that the analyst’s subjective experiences will be meaningfully and importantly related to communications from the patient. (2007, p. 100)

One issue that also needs inclusion in this section on listening subjectively pertains to the concept of “projective identification” (Klein, 1946). This is a process that begins in early infancy and consists of parts of the rudimentary self being split off and projected into an external object. The latter then becomes identified with the repudiated part as well as internally controlled by it. While starting out as a developmental process parallel to introjection, projective identification can come to serve many defensive purposes. These include attempted fusion with external objects to avoid the existential burden of separateness, extrusion of bad internal objects that cause persecutory anxieties, and preservation of endangered good aspects of the self by depositing them into others. Bion (1967) extended the notion of projective identification to include the depositing of unthinkable thoughts (“beta elements”, in his terminology) into a receptive other who can metabolise them and return them to the subject in a piecemeal manner.

Within the clinical situation, the use of “projective identification” on the patient’s part leads the analyst to experience what the patient cannot bear to feel or think. The frequent development of violently negative countertransference while working with borderline patients has been elucidated by Kernberg (1975, 1984, 1992) in great detail; he has also described the technical strategies consequent upon such feelings. However, the deployment of projective identification is not limited to borderline patients. Individuals with other severe personality disorders also tend to use this defence mechanism. And its impact shows up in the turbulent subjectivity of the treating clinician. The analyst working with a narcissistic patient, for instance, experiences feelings of inferiority and even shame (about his clothes, office, language skills, knowledge of world affairs, etc.); such feelings constitute not only the “natural” responses to someone’s grandiosity but, on a deeper level, reflect an identification with the projected shame-laden parts of the patient. Similarly, schizoid patients who have been coldly hated and wished “gone” by the parents often deposit their “alive” aspects into the analyst who begins to feel an increase in his vitality and goodness (Kramer & Akhtar, 1988). The analyst who “listens” to himself and pays close attention to his subjective goings-on can learn a lot about his patients.

**Empathic listening**

The exact opposite of “projective identification” is empathy. The former involves the patient’s actively putting something into the analyst’s mind. The latter involves the analyst’s actively seeking to resonate with the patient’s experience. To understand this well, we need to return to Fliess’s (1942) remarkable paper, “The Metapsychology of the Analyst”. Introducing the term “trial identification”, Fliess explains the process by which one comes to understand what someone else is actually saying. In order to empathise with someone, one “introjects this object transiently, and projects the introject again on to the object. This alone enables him in the end to square a perception from without and one from within” (p. 212, italics in the original). Applying this scheme to the patient’s transference-based strivings in the clinical situation, Fliess describes:

the following four phases in this “metabolic process”: (1) the analyst is the object of the striving; (2) he identifies with the subject, the patient; (3) he becomes this subject himself; (4) he projects the striving after he has “tasted” it himself, back on the patient and so finds himself in the possession of the inside knowledge of its nature, having thereby acquired the emotional basis for his interpretation. (Ibid, p. 215)

Fliess allows the space for the analyst’s own reverie but declares that it should not extend beyond “conditioned daydreaming”, that is,
the analyst’s daydreaming should be triggered only by the patient’s material, not by his own personal preoccupations. Resolute in his attention to the patient’s spoken words (and their associated affects), he states that the analyst “restricts his vigilance almost exclusively to one sphere, that of hearing. The eye serves as but an accessory to the ear; smell is almost, the sense of touch completely, excluded, for he reciprocates his patient’s motor restrictions” (ibid., p. 216).

Greenson (1960), another major contributor to the empathic perspective on analytic listening, added further nuances to the topic. Listening alone is not enough, he says. The analyst must possess the ability for controlled and reversible regressions in his ego functions (see also Nichols, 2009). A temporary decathexis of one’s own self-image is also necessary. Only then is it possible to shift “from listening and observing from the outside to listening and feeling from the inside” (p. 420). Greenson traces the origins of empathy in the early mother-child relationship and holds that male analysts must come to terms with their “motherly component” (p. 422) in order to be truly empathic.

Whether empathic listening—as opposed to, say, objective listening—can more rapidly yield meaningful information about the patient is also addressed by Greenson.

Empathy and intuition are related. Both are special methods of gaining quick and deep understanding. One empathizes to reach feelings; one uses intuition to get ideas. Empathy is to affects and impulses what intuition is to thinking. Empathy often leads to intuition. The “Aha” reaction in intuited. You arrive at the feelings and pictures via empathy, but intuition sets off the signal in the analytic ego that you have hit it. Intuition picks up the clues that empathy gathers. Empathy is essentially a function of the experiencing ego, whereas intuition comes from the analyzing ego. (p. 422)

While showing great interest in the empathic perspective, Greenson largely maintained an eclectic approach towards analytic listening, moving deftly between various forms of listening though without explicitly registering such latitude. In contrast, Heinz Kohut and Evelyne Schwaber made the empathic form of listening the centrepiece of their approach. This reflects what Strenger (1989) has termed the “romantic vision” of psychoanalysis. Founded largely on Goethe’s and Rousseau’s humanistic thoughts, such a perspective sees man as striving towards becoming a cohesive self. Development aims at a self which consists of a continuous flow from ambitions to ideas, from a sense of vitality towards goals which are experienced as intrinsically valuable. Mental suffering is the result of the failure of the environment to fulfill the self-object function and the patient’s symptoms are the desperate attempt to fill the vacuum in his depleted self. The analyst’s attitude towards the patient is one of trust in his humanity and the analyst takes the side of joy and vitality. The ethic is romantic: maturity and mental health consist in the ability to sustain enthusiasm and a sense of meaning. (p. 601)

That noted, let us return now to Kohut’s and Schwaber’s contributions. Kohut, a classical Freudian and most likely an “objective listener” for most of his early analytic career, took a dramatic turn in the late 1970s. In his The Restoration of the Self (1977), he placed the self as a superordinate constellation and downgraded drives and defences from being the self’s originators to its constituents. His language also changed. The grandiose self, idealised parent imago, narcissistic transferences, and transmuting internalisation (Kohut, 1971) gave way to nuclear goals, nuclear ambitions, selective inclusion, and self-object phenomena (Kohut, 1977). To put a final stamp on this radical shift, Kohut (1982) declared that his “self-psychology has freed itself from the distorted view of psychological man espoused by traditional analysis” (p. 402).

All this had a clear impact on the listening perspective he came to embrace. The analyst’s empathic immersion in his patient’s subjective experience now became the cornerstone of his technique. In a series of papers and a posthumously published monograph, Kohut (1979, 1980, 1982, 1984) elaborated upon the reparative function of the analyst’s empathy and the need to listen—solely—from the patient’s point of view. His widely read (and gossiped about)5 paper “Two Analyses of Mr Z” (Kohut, 1979) laid these ideas out in eloquent details.

The proposal of listening from the patient’s perspective then found a fervent advocate in Schwaber. In contributions spanning three decades (Schwaber, 1981, 1983, 1995, 1998, 2005, 2007), she has championed the cause of empathic listening. Taking the monumental shift, in early psychoanalysis from seduction theory to fantasy-based neurogenesis as her starting point, Schwaber laments that the listening perspective of many analysts has not undergone a corresponding change. They do not
seem to heed Freud’s (1917) declaration that “in the world of neuroses, it is psychological reality which is the decisive kind” (p. 368, italics in the original) and continue to talk the patient’s “misperceptions” and “distortions”—which they, presumably, as superior arbiters of reality, seek to correct. In contrast, Schwaber proposes a:

mode of attunement which attempts to maximize a singular focus on the patient’s subjective reality, seeking all possible cues to ascertain it. Vigilantly guarding against the imposition of the analyst’s point of view, the role of the analyst and of the surround, as perceived and experienced by the patient, is recognized as intrinsic to that reality; the observer is a part of the field observed. As a scientific modality, empathy employs our cognitive, perceptual, as well as affective capacities ... The analyst’s empathy draws upon modalities which are significant components of the essentials of parental empathy—attunement and recognition of the perceptive and experiential states of another. (1981, p. 378)

The shift in perspective from listening from the outside to listening from the patient’s perspective has profound implications for the analyst’s view of the patient and of the clinical process itself.

Transference, the inner representation of the past amalgamated to the present, is then not viewed as a distortion, for this would imply that there is a reality more “correct” than the patient’s psychic view of us, which we as “outside” observers could ascertain. Understood as the property of the system, psychic experience is not separate from its context; the “transference” is inseparable from the “real” ... Thus the reality, for each of us, represents only our psychic view—even of ourselves—the notion of an attainable certainty of an ultimate knowable reality must be regarded as illusory, a perspective often most difficult to sustain, perhaps because it is disquieting. (Schwaber, 1983, p. 522)

Schwaber emphasises that the analyst’s task is to seek the inner world of the patient and there is no better way to do so than to listen from the patient’s perspective. The analyst must avoid foreclosure, the temptation to guide, and to help the patient see “hidden meanings”. His recognising the inner state of the patient—his “getting it”—is in itself good enough. Feeling understood renders the patient capable of increasing the exposure of his inner world and this, in turn, enhances psychic coherence and self-regulating organisation. “The search to ‘get it’ is the route, and the goal, enabling the therapeutic action” (Schwaber, 2007, p. 38).

Nosek (2009) advances this discourse to a higher level. In his remarkable plenary address to the 45th IPA Congress held in Chicago, IL, he proposed that interpretation is, in the end, a form of psychic violence and psychoanalysis is essentially about helping the patient reveal himself to himself and to the analyst. Nosek details such radical reformulation of the fundamentals of our technique in the following passage.

If we are prepared to forego the violence of knowledge, if we are not incited by the urgency of ontology and the power of positivism, we encounter the territory of hospitality: this means receiving the foreigner as such, allowing him his own existence. This gesture, configured as goodness, does not ennoble or exalt me; its character comes from the infinite to be received, unraveling my possibilities ... For us psychoanalysts, this is a radical hierarchical reflection: psychoanalysis is no longer a talking cure but a listening cure. (p. 145)

**Intersubjective listening**

This perspective is derived from Harry Stack Sullivan’s (1947, 1953) interpersonal view of psychoanalysis which declares that self is nothing but a collection of reflective appraisals and anxiety can only occur in an interpersonal context. As a result, the intersubjective listening has a threefold theoretical foundation: (i) clinical work as embedded in the dynamic interplay between two selves, (ii) all the analytic material (including transference and countertransference) is co-constructed, and (iii) analytic listening is a shared process. A challenge to the positivist scientific orientation of “classical” analysis, the intersubjective paradigm proposes that no mental phenomena can be properly understood if approached as entities existing solipsistically within the patient’s mind. The analyst’s perception of the patient’s thoughts, feelings, and fantasies, etc., is always shaped by the analyst’s subjectivity. Therefore, the patient’s psychology—the “material” for analysis—is itself co-constructed.
Intersubjective clinicians (Benjamin, 1995, 2004, 2007; Hoffman, 1991; Ogden, 1992, 1994; Spezzano, 1993; Stolorow, Brandchaft & Atwood, 1987, 1992) regard their method to more truly reflect the nature of human psychology; it is less mechanistic and less likely to reify mental life. They view the clinical process as a dialectical interplay between the patient’s subjective reality and the analyst’s subjective reality as well as the interaction of these two psychic realities with the intersubjective reality they create together. These analysts put emphasis upon reciprocal listening, that is, how the analyst is listening to the patient and how the patient is registering (and interpreting) what the analyst is saying and how that alters what the analyst would say next, and so on. This is where Ogden’s (1994) concept of the “analytic third” comes in. This term refers to the intersubjective experience which is a product of a unique dialectic generated between the individual subjectivities of the analyst and the analysand within the analytic setting. The “analytic third” is not a “structure” insofar as it is forever fresh, being created, destroyed, and re-created in every passing moment of the clinical hour. There is more here to consider. “The analytic third is a creation of the analyst and the analysand, and at the same time, the analyst and the analysand (qua analyst and analysand) are created by the analytic third” (ibid., p. 93). This affects how one views the analytic process itself. According to Ogden:

Analysis is not simply a method of uncovering the hidden; it is more importantly a process of creating the analytic subject who had not previously existed. For example, the analysand’s history is not uncovered, it is created in the transference-countertransference and is perpetually in a state of flux as the intersubjectivity of the analytic process evolves and is interpreted by analyst and analysand (see Schafer, 1976, 1978). In this way the analytic subject is created by, and exists in an ever-evolving state in the dynamic intersubjectivity of the analytic process: the subject of psychoanalysis takes shape in the interpretive space between analyst and analysand. (ibid., p. 47, italics in the original)

The intersubjective perspective regards the analyst’s affective state as an active constructing force of the transference and countertransference. It is not merely a response to the patient’s material but a co-creation of the two members of the clinical dyad. Viewing all communications of each partner as designed to elicit responses from the other, the intersubjective approach harks back to the child’s early curiosity about (and the desire to connect with) the mother’s feelings; this is seen to repeat in the form of the analysand’s curiosity about the analyst. Aron (1991) and Mitchell (1991) argue against considering such curiosities drive-based. Such interpretations, according to them, thwart the developmental stirrings of the patient.

Benjamin (2004, 2007) takes the notion of the “analytic third” further, delineating three subcategories of it: (i) “primordial third”, emanating from the musical or rhythmic exchange of sounds and gestures in the mother-child relationship and showing up in the analytic situation as accommodation, attunement, and regularity of the dyad’s relatedness, (ii) “symbolic third”, which involves more nuanced procedures and expectations of narrative recognition of separateness, and negotiation, and (iii) “moral third”, the agreed-upon principles of “the valuing of truth, striving for accommodation, responsibility and respect for the other, and faith in the process of rupture and repair” (2007, p. 99). This last-mentioned principle demands that the analyst listen most carefully to himself and try to ascertain how he might be contributing to the disruption of the clinical dialogue at any given moment. Analytic listening is ideally directed equally to the patient’s subjectivity, the analyst’s subjectivity, and the intersubjectivity they create together. In fact, the first two designations are inherently suspect, since the “third” creates them while being created by them as well. In essence, nothing can be listened to without taking the impact of the relationship between the analyst and the patient into account.

Putting the four models together

It seems desirable—indeed, tempting—to seamlessly blend the four models of analytic listening described here. Synthesis of such elegance would reduce theoretical ambiguity and diminish the technical necessity of making choices and exercising judgment. However, this conceptual pastiche—assuming that it can be assembled—carries the risk of oversimplification on both theoretical and clinical planes. It is therefore best to not force a union and instead let the models stand as they are without overlooking their potential harmony and confluence. In starting this way, one might even end up with the discovery of some deeper
The four models need not only a proper space in the external sense of the word but also “the internal analytic setting” (Parsons, 2007) for their optimal unfolding. The latter concept refers to “a psychic arena in which reality is defined by such concepts as symbolism, fantasy, transference, and unconscious meaning. … The internal setting defines and protects an area of the analyst’s mind where whatever happens, including whatever happens to the external setting, can be considered by a psychoanalytic viewpoint” (p. 1443).

- The four models have areas of overlap. “Objective listening”, for instance, might lead to a great sense of empathy with the patient and, conversely, “empathic listening” might benefit by objectively registering each and every facet of the patient’s narrative. “Subjective listening” seems an essential component of “intersubjective listening”. Moreover, the latter might actually require a certain objectivity in order to be truly comprehensive. Smith (1999) notes that “Subjectivity and objectivity are both necessary pathways to knowledge and are dependent upon each other. Any form of looking or listening does to some extent preclude another, but to speak solely from a subjective or an objective perspective represents a regression in thinking to a form of naive objectivism or naive subjectivism” (p. 465).

- The four models described here might not be exhaustive of the ways of listening employed by analysts. There might be hybrid forms that use an admixture of these approaches. The manner of listening recommended by Arlow (1995) is a prime example of this. On the one hand, its governing principle is that the analyst must demonstrate to the patient “how present-day experience may be misinterpreted in terms of derivatives of persistent unconscious fantasies from the past” (p. 221). This is reflective of “objective listening”. On the other hand, Arlow recommends that the analyst must “try to understand the message behind the manifest productions … [and] be alert to the connecting thread that runs through the patient’s productions” (p. 222). This is closer to “empathic listening”. Going one step further, Arlow notes that the analyst must observe the impact of his statements upon the patient and “the interchange itself is subject to examination and interpretation” (p. 229), thus coming closer to the intersubjective perspective described above. Arlow is not alone in employing such hybrid forms of listening. Gill (1979, 1994), with his dual emphasis upon transference interpretation and the need to acknowledge the plausibility of patients’ perceptions, also seems to blend the “objective” and the “intersubjective” approaches to listening. In his technical recommendations regarding enactments, Boesky (1990), too, straddles the “objective” and “intersubjective” approaches.

- The four models of listening give rise to different questions in the analyst’s mind. “Objective listening” directs one’s attention towards syntax, shifts in the direction of association, parapraxes, and so on. “Subjective listening” intensifies vigilance towards the countertransference experience. “Empathic listening” facilitates a deeper grasp of the patient’s narrative, especially in its conscious and preconscious aspects. “Intersubjective listening” spurs curiosity about the two partners’ influence upon each other and upon their mutuality itself.

- The four models of listening are implicit in Schlesinger’s (2003) wise recommendation that the analyst must learn to listen from several modes at once. These include: (i) listening contextually, or taking into account the patient’s history, the course of treatment so far, and the realities of the patient’s current life, (ii) listening naively and without preconception, (iii) listening to intent rather than to content alone, (iv) listening empathically, and (v) listening in the light of transference and countertransference.

- The four models of listening yield different sorts of data which, working in unison, can enhance the understanding of the patient. In the same vein, Spencer and Balter (1990) underscore the complementarity of the “introspective” and the “behavioural” modes of observation in psychoanalysis. In the former, the analyst puts himself in the position of the analysand and derives clinical understanding from the latter’s perspective. In the latter, the analyst adopts the “view of a spectator, without regard to the subject’s own thoughts or feelings” (p. 402). The two methods, often yielding different sets of information, modify each other in the service of deepening the grasp of the analysand’s mental functioning.

This last-mentioned point can become the springboard for a synthesis, after all. Perhaps the “objective” (more so) and “intersubjective” (less so) models of listening constitute what Killingmo (1989) has called “sceptical listening” and the “empathic” and “subjective” forms of listening might constitute what he has termed “credulous” listening. “Credulous
listening” focuses upon what the patient is saying, “sceptical listening” on how the patient is saying what he is saying. The analyst who is listening credulously pays great attention to the patient’s preoccupation and complaints; he finds them meaningful in their own right and is not in a rush to unmask their meanings. The analyst who is listening sceptically is attuned to what is hidden behind the patient’s manifest content; he eschews what is on the surface and wishes both the parties in the clinical situation to delve deeper. Klauber has captured the implications of this difference in the following succinct passage.

The degree to which analysis of conscious and preconscious attitudes should be allowed to shade off into discussion of the patient’s problems depends upon the theoretical orientation of the psychoanalyst. For those analysts for whom interpretation is oriented to the ego, it seems inevitable for the accurate clarification of the unconscious conflict that the conscious and preconscious derivatives of the unconscious should be fully explored. Other psychoanalysts might dispute the appropriateness of the discussion of the patient’s problems—of which some analysts approve—and consider it a degradation of psychoanalytic technique. (1968, p. 137)

Contrast this last statement with what Schlesinger says regarding the tension between listening to the surface and depth of the patient’s material.

What is importantly unconscious and determinative at the moment, though it may derive ultimately from sources far from consciousness, will generally be represented in more superficial manifestations that are accessible to the knowledgeable observer. (2003, p. 118)

This underscores the importance of listening credulously. The fact is that such listening helps establish a sense of mutuality and of being “on the same page”. It provides a glimpse of the patient’s ego functioning in the external world and of the issues that preoccupy him, even though they might be chosen because of their significance in terms of unconscious conflict. Such attention to “surface material” also gives a hint of transferences that are about to unfold or are already going on. Sceptical listening, in contrast, is essentially deconstructive in nature. It consists of the following aspects.

- Listening to the ommissions in the narrative (e.g., an individual talking in detail about a house he is purchasing but never mentioning its price, a woman talking about her boyfriend but omitting his name) helps discern pockets of anxiety and transference-based resistances.
- Listening to slips of the tongue, and mispronunciations that are not based on unfamiliarity with the language being spoken, and other verbal gaffes of the patient also provides access to his unconscious functioning at that moment.
- Listening to the intonations and points of emphasis (e.g., “All I want from my husband is a little attention”, “I really do love my mother”) yields useful information regarding characterological styles and self-deceptions that individuals are often compelled to deploy.
- Listening to pauses can also be informative (see Chapter Two for more details). Often the clause of the sentence added after a pause turns out to be defensive against the anxiety the first part of the sentence has stirred up (e.g., “Sometimes I think of committing suicide” followed by a pause, and then the phrase, “Well, not really”).
- Listening to negations and unsolicited disavowals reveals the distressing deeper content (e.g., “The last person who comes to my mind in this connection is my father”, “Look, I’m not competing with you”).
- Listening to the patient’s sighs and grunts permits access to areas of pain, anxiety, and resistance. Attention to such sonic cues yields even richer data when an eye is also kept on the patient’s bodily movements during the session (McLaughlin, 1992).

The developmentally derived prototypes of the “credulous” and “sceptical” listening styles are divergent (see below). And the same might apply to the four models outlined here. “Objective listening” seems more paternal and “empathic listening” more maternal in nature. “Subjective listening” and “intersubjective listening” fall somewhere between these two poles, with the former being closer to the paternal and the latter to the maternal end of the relational spectrum. Indeed, the proponents of “empathic”, “subjective”, and “intersubjective” models link the style of their attunement to the mother’s early attention to her child. Schwaber (1981, 1983), Jacobs (1991), and Ogden (1994) invoke the observations of Sander (1975), Burlingham (1967), and Winnicott
(1953), respectively, for this purpose. Interestingly, no one mentions the father-child dialogue as a prototype for listening in psychoanalysis, even though the echoes of this relationship are discernable in the “objective listening” model. This lopsided approach is rectified in the developmental model described below.

A developmental postscript

The technical polarities of listening with credulousness versus listening with scepticism seem to have their respective developmental prototypes in the maternal and paternal styles of relating to young children. Herzog’s (1984) elucidation of the “homeostatic” and “disruptive” attunements of parents to their growing child is especially illuminating in this context. Through video-monitored child-observational studies, Herzog has demonstrated that mothers usually join in with a toddler in his or her ongoing play, thus giving the child a “continuity of being” (Winnicott, 1965, p. 54), validity, and harmony with the environment (“homeostatic attunement”). Fathers, on the contrary, characteristically disrupt the playing toddler’s equilibrium by cajoling him or her into joining them in a new activity (“disruptive attunement”). Homeostatic attunement has affirming qualities necessary for the sustenance and consolidation of self-experience. Disruptive attunement has enhancing qualities necessary for broadening and deepening of self-experience. The influence of the two types of attunements is additive and contributes to the fluid solidity of a healthy self-experience. Herzog further observed that fathers distract the child from the game he is playing only when the mother is with the child. In her absence, and especially with younger children, fathers, too, start playing the child’s own game (i.e., resort to homeostatic attunement). This suggests that homeostatic attunement is an experiential prerequisite for disruptive attunement.

Extrapolating these developmental observations to the clinical situation suggests the following. The analyst’s credulous listening and his “holding” (Winnicott, 1960a) and “affirmative” (Killingmo, 1989) interventions are akin to the maternal “homeostatic attunement” insofar as they, too, aim to validate, strengthen, and stabilise the self-experience. The analyst’s scepticism regarding the patient’s conscious material and his unmasking interpretive interventions seem akin to the paternal “disruptive attunement” insofar as these cause cognitive expansion by introducing new material into the patient’s awareness.

Herzog’s conclusion that homeostatic attunement is a prerequisite for disruptive attunement also finds a parallel in the clinical situation wherein the analyst’s holding and affirmative (i.e., homeostatic) functions must be securely in place in order for his interpretive (i.e., disruptive) efforts to be fruitful. The patient’s inner sense of the analytic relationship must be stable (or should be stabilised) for him or her to utilise the destabilising impact of interpretation which, by definition, brings something new to the patient’s attention. The patient must possess or be helped to possess a “safety feeling” (Sandler, 1960, p. 4) before the risk of encountering the repudiated aspects of his self-experience. Couched in the developmental metaphor, the analyst’s exercise of maternal functions seems to be a prerequisite for his or her exercise of paternal functions. Restated in clinical terms, credulous listening must prepare the ground for listening with scepticism.

Designating such maternal and paternal interventions as “two poles of therapeutic technique”, Wright traces their respective origins to Freud and Winnicott.

Freud, it seems to me, stands for the father with his forbidding and prohibitions. Winnicott stands for the mother and her caring, nurturing, and loving. Freud is the mediator of the reality principle to which the child must adapt; Winnicott is the protector of a kinder, more lenient space, which keeps reality, to some extent, at bay. (1991, p. 280)

In Wright’s view, analysis involves a renewal of the process of psychic formation. It provides the space within which new forms or symbols of the self may be created. However, for fully separated and representational symbols, as well as less separated and iconic symbols in the human discourse to emerge, be understood, and coalesce, the analytic technique requires both maternal and internal elements. The maternal element (holding, facilitating, enabling, and surviving) “posits faith in the background process. Things will happen if you wait” (p. 283). The paternal element (searching, confronting, deciphering, and interpreting) underlies the analyst’s scepticism, his struggles with the patient’s resistances, his confrontations with the turbulent world of intrapsychic conflict. Wright goes on to suggest that the two modes of intervention might be appropriate at different times and foster different modes of symbolising. Analytic listening is not static and shifts according
to the patient’s structural level at a given moment (Killingmo, 1989),
degree of psychic organisation in general (Wright, 1991), and the ever-
changing tone and direction of the patient’s free association (Miller &
Aisentstein, 2004).

In general, maternal holding of the physically banished elements has
to precede a meaningful looking at them with the aim of further self-
understanding. “Containing holding” is a prior condition for “trans-
formative looking” (Wright, 1991, p. 300). Moreover, the maternal and
paternal elements of technique “provide a point and countercpoint in
analysis between two styles and two visions and neither wins the day
completely” (ibid., p. 280). It should also be remembered that such
maternal and paternal attributes are not gender-based in a literal sense.
There are male analysts who seem more maternal and female analysts
who seem more paternal in technique. At the same time, it is true that
most analysts, regardless of their actual gender, possess both these
attributes and strive to incorporate them in their technical approaches.

Wright’s bringing together of the Freud-Winnicott technical schism
seems to have seamless underpinnings in Herzog’s (1984) developmental
observations. In the end, it all boils down to placing agreement
before disagreement, consolidation before deconstruction, empathy
before insight, affirmation before interpretation, and “father” before
“mother”, while recognizing that both experiences are as necessary in
psychoanalytic treatment as they are in the course of development.

Concluding remarks

After Freud’s (1912e) seminal recommendations on analytic listening,
there developed a protracted silence on the matter. The textbooks of
psychoanalysis (Moore & Fine, 1995; Nersessian & Kopf, 1996; Person,
Cooper, & Gabbard, 2005) and monographs devoted to psychoanalytic
technique (Etchegoyen, 2005; Fenichel, 1941; Greenson, 1967; Volkan,
2010) published over subsequent years said little about the nature of
analytic listening. The PEP (Psychoanalytic Electronic Publishing) web*
reveals that all twenty-eight papers with the words “analytic listening”
in their title were published after 1980, or nearly seven decades after
Freud enunciated his views. The reasons for both the long silence and
the sudden spurt of interest are unclear. The difficulty in coming out of
the master’s shadow and the increasing theoretical pluralism in psy-
choanalysis might account for these, respectively.

By bringing together the pertinent literature that has emerged,
I have delineated four models of analytic listening, namely, (i) objec-
tive listening, (ii) subjective listening, (iii) empathic listening, and (iv)
tersubjective listening. Each has its theoretical anchors and its technical
yields. After elucidating these, I have attempted to discern the areas
of overlap in these models and also noted some hybrid forms that can
easily fall between partisan cracks. I have also traced the developmental
prototypes of various forms of listening and linked the “credulous
listening/affirmative intervention” and “sceptical listening/interpre-
tive intervention” dichotomy of analytic technique with the maternal
and paternal forms of relating to children, respectively. Putting extra
premium on neither of these and underscoring the utility of both, I have
opted for a technique that oscillates, in an informed manner, between
the two ends of this developmental-clinical spectrum (for further details,
see Akhtar, 2000). An optimal blend of the two is what makes analytic
listening properly attuned and ultimately useful to the patient. Such
listening is directed to the patient’s words as well as to his non-verbal
communications and silences.

Notes

1. Greater effort to listen deeply is, at times, necessitated by the nature
of the patient’s psychopathology. Feneczi’s (1929) recommendations
for dealing with people who, as children, have been unwelcomed
and hated, are pertinent in this context. Gammill (1980) also notes
that in dealing with schizoid patients, “very considerable attentiveness
was necessary to pick up even the faintest indications of affect
and of material linked with the remains of [an] authentic and personal
self” (p. 376).

2. Analysts also vary in their choice of “listening aids”, the things or
activities that anchor their mind in one place and thus permit free-
floating attention to the patient’s material. Some analysts take notes.
Others doodle or draw. Some (mostly outside the United States) smoke
cigarettes or cigars. Others knit or crochet. Some place their chairs in
a way that permits them to see the patient’s face. Others close their
eyes. A few have their dogs and cats present during the clinical hour.
And so on.

3. Meissner (2000) also notes that analytic listening is not naive, but rather
prepared and focused. He says that “Listening to theoretical models
rather than to the patient is obvious mishearing … or better, ‘mis-
listening’: but at the same time, listening takes place partly by means