UNITY IN DIVERSITY:
ITS RELEVANCE TO OUR CLINICAL WORK

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SYNOPSIS
In this paper the conference theme initiates a clinical consideration of a diversity in our clinical goals arising from the concluding clinical understandings of Lacan and Bion. Lacan came to see that the goal of analysis was to assist the analysand to embrace the Real of their existence, free from the Other. For Bion, in contrast, it was to experience the unknowable truth of one's existence as it arose in the interaction of two minds in the analytic situation. Both of these are seen to direct towards the existential challenges of the I – the subjective sense of self -, how it becomes part of either, the us, from where it can be retrieved, or the them, where it becomes lost. These concepts are explored through the consideration of a number of theories.
It is proposed that this clinical/theoretical difference between Lacan and Bion arises according to the I's fate (us or them) leading to two different pathologies – neurotic and borderline – and two different clinical approaches. A brief clinical vignette exemplifying working with the former is outlined.

Ladies and gentlemen. I would like to discuss with you some ideas pertinent to our clinical work which arise from our conference theme which, following the Whitman quote, I have changed to the more relevant to our work "Unity in Diversity". In particular I will focus what seems to me to be a crucial but seemingly unrecognised diversity in our therapeutic goals which arises from the contrast between Lacan and Bion. With Lacan, in parallel with Jung and his ideas about individuation, towards the end of his career he eventually saw that the goals of analysis were what he called "subjectification", the individual reaching a point in their analysis at which they were able to embrace the Real of their existence free from and separate from the Other[1]. With Bion the eventual goal of his work was to embrace the unknowable truth of one's existence – "O" – as it arises in the interaction between two minds in the analytic situation[2]. One is embracing of the fundamental truth of the I's existence as it lies at the basis of the I, the other that of the

[1] This is discussed at length Fink, B. (1997) *A Clinical Introduction to Lacanian Psychoanalysis*, Harvard pp215- 216
[2] This is discussed Vermote, Rudi. (2019) *Reading Bion*, London: Routledge. Pp122-127

fundamental truth of the I as it arises interactionally with the other. There is a fundamental difference between the two theories and each of us, I suggest, must decide which we believe to be correct for the patient we are seeing at that point of time, an idea which I will attempt to clarify.

In this paper, accordingly, I will work towards this important diversity and its relevance to our clinical work by beginning with a more basic consideration of unity in diversity.

However this concept obviously directs to a social perspective and in this time of growing uncertainty in our lives because of the shameless political exploitation nationally and internationally of divisions and polarisations using the usual culprits of race, religion, sex, and before the next election the climate and power, such a social focus would seem particularly apposite. However as our work is focused on the intrapsychic and intrapsychic interpersonal interface an initial question is how do we draw the theme back to this level? I propose that dividing the psyche into constituent parts is a necessary first step. These parts begin with the most fascinating and challenging conceptualisation that of the I, the essential sense of self as subject. We know that this I exists because we each live with and within it but how do we know this, from what position is this knowing of our I's existence possible? And further once the I begins it is as if it has always been there and always will be. And how does it begin, what was there before it? I don't think the parallel with the big bang theory in physics is too idle. And I would like to add that the existential struggles of the I and understanding these to me seems the starting point for Freud and hence is the birthplace of our work.

The I moves to the I am when there is a distinction between inner and outer worlds. And this leads on to the concept of the you. Although this may masquerade as singular I don't think that it is a coincidence in English and French at least that the word "you", "vous", is both singular and plural. Then there is the us, the I merged with you but still retrievable, unlike with the them in which it has become lost: the borderline dilemma and what the narcissist so desperately fears and defends against.

Having defined my starting point what I wish to do is to consider some theoretical points which may assist in understanding the interaction between these parts and their pertinence to our discussion, then discuss a brief clinical vignette to draw these parts together before putting forward some ideas about our clinical work in light of the Lacan and Bion theoretical division described.

As always the best place to start is with Freud. Certainly his ideas about condensation and displacement direct towards unity in diversity but mindful of time I will only focus on one of his ideas. This relates to his observation that we cannot, or our egos cannot, let go of an object to which it is related[3]. Instead a process of introjection, incorporation, and identification takes place leading onto the further process of grieving the lost object. What this means is that as soon as we emerge from the psychosomatic blur of earliest life we begin to relate to objects the first of which is our mother or equivalent. However our mothers are complex creatures laden with attachments, associations, conscious and

[3] Freud, S. (1923) *The Ego and the Id*, SE XIX, pp29-31

unconscious emotions of their own all of which inevitably play a part in how they interact with us. And at weaning we have to grieve the loss of that initial mother and adjust to the new one who in Lacan's terms is under the yoke of the Other. Accordingly weaning is a time of grieving and following through Freud's ideas about identification that means our earliest and basic sense of self will be affected by our incorporation of and identification with the complex creature called our mother. Our basic I will not only be I but also I, us, perhaps them as I will attempt to explain later. This idea of Freud would seem to have been developed further, or perhaps rebadged, by Bollas in 1987[4] in his concept of the shadow of the object. Bollas explains the way our mothers handle our earliest interactions with them will be determined by their inner workings and these experiences of the other will be woven into our earliest sense of I and re-emerge in our dreams.

Continuing this briefest of overviews another analyst I believe has contributed to the concept of unity in diversity, the I, the you etc., is Winnicott. As people know, Winnicott wrote of the crucial role of the mother in our earliest development, what he called primary maternal preoccupation[5]. And even though he wrote of the innate development of the ego protected from reaction to impingement from inside and outside by the mother he also wrote paradoxically of how the mother must fail her infant in attuned doses and with the timing that is based upon her intuitive feeling of what her infant can experience and grow from the experience without a defensive reaction against it. Of course mothers being fallible they will get it right and get it wrong according to who they are and their essential feelings about their infant at each point of time. That is, the most important sense of impingement with which the infant has to contend and either weave it into their personality or defend against is their mother's attunement or otherwise with her infant's inner workings. This again will be determined by their mother's emotional state determined in turn essentially by her relations with others e.g. the child's father, her mother, her relationship with her female identity etc.

In a more focused way Winnicott also rather poetically writes that when a child looks into its mother's eyes it should only see it self[6]. If the child looks into his mother's eyes and sees only the mother, or worse sees nothing, these will become woven into the sense of I as already suggested with Freud and Bollas from different perspectives. It will also become the basis of Winnicott's concept of the false self-structure.

The other analyst to whom I wish to refer is Bion. Again I trust that you are familiar with his work. Accordingly you will know that for most of his analytic work he believed that the work of analysis was to assist the patient developing an increasingly abstract understanding of the emotional truth of their existence as it arose through and by the interaction with the analyst and their interpretations.

To achieve this growth in emotional understanding Bion outlined facilitating factors and functions. Of relevance to our discussion is one of these: container/contained[7]. Bion proposed that this function was crucial to our beginning capacity to think about our

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[4] Bollas, C. (1987) *The Shadow of the Object,* Columbia, pp13-18
[5] Winnicott, D.W. (1975[1956]), *Through Paediatrics to Psycho-Analysis*, Hogarth Press pp300-305
[6] Winnicott, D.W. (1971) *Playing and Reality*, Penguin. pp131-132
[7] Bion, W.R. (1967), *Second Thoughts*, Aroson, pp116-117

emotional experiences. His idea was that the earliest experiences arising within the body and accordingly having a life and death quality about them were overwhelming for the nascent mind. However, following Klein he hypothesised that these earliest experiences, which he called beta elements because we can never know them, could be projected into. They could be projected into the body and then discharged for example by vomiting, defecating, fist shaking, screaming as one observes in the distressed infant. But importantly they could also be projected into the mind of the mother if she was receptive. These emotional experiences are the contained, the mother‘s mind becomes the prototype container. Once contained then the mother processes these experiences by what he called alpha function because it too remains unknown and unknowable, and these processed emotional experiences could then be projected back into the infant’s mind in a form that made them now potentially thinkable – alpha elements. These accordingly become the basis of our thinking about our emotional experiences of ourselves.

But, if our experiences are to be processed by our mother’s minds presumedly at an unconscious level, then they will be subject to the mother’s associations at that level and these of course relate to the mother’s experience of her relationship with the child, the child’s father, her own mother etc. and in a more extended sense to her lifetime of experience of herself and her place in the world. So when the mother projects the processed experiences back into her infant’s mind they will be laden with the multitude of associated experiences of the mother. Again therefore our basic sense of I will be linked to the you, the us and the them.

As I am beginning to repeat the same ideas let me focus them.

The idea is that our beginning sense of I within each of these theories will be affected by the presence of, experience of, the other. And further this other won’t be emotionally neutral. And importantly what is going on inside of them in relation to the interaction with the nascent I of the infant will be variable across a broad spectrum and this will have profound effects upon the infant’s sense of I. If the mother‘s immediate thoughts and concerns are about her infant and this is guided by love for it and the child’s father then her intuitive attunement will be very different and will have a very different effect upon the child’s nascent I from the mother who is acting through disinterest and distracted emotions or worse whose central position is one of hate. And in the terms I am using the infant’s sense of I can be reinforced by the loving attunement of the other, but more likely it will be drawn into an us, but if the mother is distracted, disinterested or hating then the I is drawn into the them where it can or will be lost and the rest of their lives can be an Odyssey of attempting to find it or accepting that this is impossible and struggling with consequent despair. As indicated earlier this is the predicament of the borderline or if it is totally destructive of the I that of the psychotic. The difference here being that the borderline believes that the I still potentially exists and seeks in vain for it, the psychotic is looking for the corpse and the reason for its destruction with a magical hope of resurrection.
So coming back to our work and my beginning with Lacan and Bion: classical analytic work as begun by Freud is focused on the I, the you and the us i.e., the I is still in there somewhere and our work is to help the patient to find it. This is where the transference became so important because in the transference the therapist becomes inevitably drawn

into the us i.e., they will in their phantasy experience the us of the patient in the crucial interactions of the patient's development. However as the therapist restores their I by extracting themselves from the fog of the transference they are able to help the patient to understand the key factors of the other that have intruded upon the I and drawn it into the us. This becomes the basis of the transference interpretation. From this perspective the therapist is inevitably, unavoidably and importantly drawn into the transference enactment and then is able to retrieve themselves and this is not only important because the therapist in their interpretations has a sense of an essential reality because they have looked at the patient's difficulties from inside but also their ability to extract themselves from the us lays the foundations for the patient to be able to do the same.

However the question arises how do we help the patient if the I is lost in the them? Here the work will be very different. If the therapist becomes drawn into and becomes lost in the transference enactment the patient will become terribly anxious because the therapist paradoxically becomes too alive, too real, as part of their inner world, an inner world in which their sense of I, and I am, has become totally lost to the them, an inner world which the patient will now feel the therapist belongs and is central i.e., their sense of reality will be that of the therapist.

Let me explain this to attempt to make sense of the apparent conundrum. At an unconscious level the therapist can become lost in an identification with what the patient projects into them, which is essentially the them of the patient in which the patient's sense of self, I, has become lost. By this identification the them, i.e. the object who has no place in their inner world for their infant/child except as an object of hate, disparagement, belittlement and dismissal, comes alive in the room and can accordingly become the therapist's feeling towards their patient and guide their actions.

If the hope of re-finding the I in the borderline or the magical hope of resurrection in the psychotic is what keeps them going if such is felt to be totally lost to the other, as can be their feeling in the transference, then all hope will be felt to be gone. To counter this, the therapist's task is to be acutely aware of what is being projected into them, and why, and this will assist in not being drawn into the transference enactment and becoming lost. In Klein's terms the projection into the therapist can be because by doing so the hated object can be controlled at arms-length or the idealised object can be preserved against hate in the patient's inner world or between the patient and the object. In Bion's terms the patient so desperately needs the therapist to contain and process the projections and return to them the contained, processed and understood experiences so they can make sense of the disaster that has befallen the I. The therapist's personal sense of I in this has to be preserved so they can consider their own experience and understand what has been projected into them and why. Again, in Bion's terms if the therapist can maintain their personal sense of I in the interaction they can understand the essence of the emotional interaction that is being projected into them and if they can contain it and live with it as part of their experience then they can help the patient to find the beginning of a sense of I within the truth about the essence of the interaction.

I am happy to discuss these ideas further within any questions you may have but mindful of the time let me begin to finish with a brief clinical vignette[8].

This vignette is directed towards clarifying the interaction of the constituent parts of the psyche as outlined. It outlines analytic work with a patient who, at least at this stage of the analysis, is struggling with retrieval of the I from the us and possibly the them.

The patient is a professional woman in her mid to late 30s, married to a professional man. They are both successful in their careers and belong to a group of such young professional people who are well off and focused on their careers and their growing wealth. However the patient presented for analysis because of her insightfulness that the distractions of career and wealth were defensive against the realisation she could not, as she put it, grow into herself as a woman, find herself accordingly as a woman sexually and as an extension, have children. She believed if she could not at this stage of life find herself as a woman she would become more empty and depressed and perhaps kill herself following the pathway of her mother's professional father who had killed himself while the mother was an adolescent.
The patient had been attending four times a week for two years and this is a brief vignette from the Friday session.

The patient says: We will be going away with X and Y over the weekend. We have booked a place in the Clare Valley so we, although I'm determined not to, will probably get shitfaced.

I say: Shitfaced. An interesting idea but one because of its pushy quality helps distract away from what you actually mean.

Patient: What do you mean?

Pause

Yes you're right. What I mean is they'll get drunk, amorous, disinhibited, suggestive, as they always do and Bill [her husband] will join in and then I'm supposed be all turned on whereas it really turns me off.

Therapist: Just off or off and separate?

Patient: I just don't want to be with him when he's all excited by Y's suggestiveness and disinhibition. If he wants to have sex with her then he should, but he doesn't have the balls to take her up on it because he's afraid of what X might do. So I'm supposed to take X away, get all turned on by the idea. Be drawn into it all.

Therapist: Drawn into this as some form of alternative, to fill a space in somebody else's fantasy.

The patient starts crying:

I don't know why I'm crying.

Therapist: Perhaps it's because somewhere in there - there is a you trying to find yourself but it is difficult to do if you're always being pushed from inside and outside to be something you're not and don't want to be, but others need you to be.

[8] Because this case vignette is presented at an open conference it was constructed of elements drawn together from a number of patients to de-identify any individual patient.

Patient: But it's hard to see that because I suspect the deep down I would like to be like Y and then I could have sex with X and Bill could have sex with his wife and we would all have a great time.

Therapist: Do you really want to have sex with X or is that what you feel you're supposed to think to be like Y whom you feel has the sex stuff mastered.

Patient: No. I find X quite repellent he is too fat and he smells.

Therapist: Is that really the reason? Women have been putting up with that for eternity and it hasn't put them off overall.

The patients laughs.

Therapist: I wonder if what is repellent is the supposed to rather than you being able to choose. To be able to reach a point where you know what you want to do, not just with your sexuality, but overall as yourself, such that you can choose who you wish to have sex with or not and when and why.

Pause

Therapist: And further finding yourself as a person and deciding how you wish to live your life and why. Finding yourself, your sense of I, be able to find yourself within it without a constant intrusive sense that you're supposed to be something, somebody different to fulfil the needs of other people who throughout your life have needed this of you.

The patient remains silent for about 10 minutes during which time there was quiet sobbing. Then she says in a tear laden voice:

But I feel if I can't… don't play my rôle, then there is no place for me.

Therapist: That means that you have learned that there is no place for you.

Pause

Therapist: If you are going to find a place for you it will therefore have to be in your own mind based upon your own experience of you.

Patient: But if I do that I'll be self-centered, self-justified and as self-righteous as those abominable Greens and worse the Teals.

Therapist: No you won't you will be real.

I will finish the clinical vignette there trusting that this clinical work with the I etc., is reasonably self-evident, i.e. directed towards assisting the patient to be able to focus on her sense of I and helping to begin to retrieve this I from its enmeshment with the us and possibly the them. However the analyst's transference phantasies have not been referred to in this making it not a full explication of what I have outlined, and, with some reservation, because of their personal nature, will discuss these later if you wish.

Mindful of the time let me finish with a brief overview what I have discussed.
My primary focus is upon the sense of I the retrieval of which from its enmeshment with the you and the us is, I propose, the goal of classical analysis exemplified by Lacan's ideas. However if the I has become lost in the them as in the borderline or smashed as in the psychotic then the work of retrieval is very different directing to the work of Bion and involves an acute awareness of containment of the transferance phantasies . The difference being what is projected into the analyst. In the first scenario the patient's sense of us is what is projected and the analyst is drawn into it because it feels familiar and personal and from which – the phantasies of which – they, through their understanding,

retrieve themselves and proceed with their alive and personally informed interpretations. With the latter group of patients the analyst has to recognise the sense of them, alien and disturbed and usually based on hate, that now lies in their unconscious and may lead to a misguided effort to make repair that they will live out, inside themselves, and then, with rationalised good intentions, take to their patient.
I'm sure you know the moment when you say, or maybe do, something that you know is the correct thing to say, in fact you can find yourself pushed to say it, but at the same time at some deep level you know it is wrong.

This latter is your I swamped by the them of your patient. The patient intuitively knows this, i.e. that your I also has been lost at that moment and this can lead to a sense of disaster for the patient.
Importantly, in contrast, if the therapist is able to realise what is taking place, understand the power of the patient's them that now occupies a central controlling place in them i.e. experience it and contain it, then they are able to potentially help the patient to understand the determined forces in them that are so destructive of the I.
This is a first step towards helping the patient to finding or re-finding the sense of I in themselves.

That seems like a good place to finish, thank you.

References:

Bion, W.R. 1967, *Second Thoughts*, Aroson, pp116-117

Bollas, Christopher. 1987, *THE SHADOW OF THE OBJECT Psychoanalysis of the Unthought Known.* New York: Columbia University Press. pp13-18

Fink. B. 1997, *A Clinical Introduction to Lacanian Psychoanalysis*, Harvard

Freud, S. 1923, *The Ego and the Id*, SE XIX, pp29-31

Vermote, Rudi. 2019, *Reading Bion.* London and New York: Routledge

Winnicott, D.W. 1971, *Playing and Reality*, Penguin pp131-132

1975[1956], *Through Paediatrics to Psycho-Analysis*, Hogarth Press pp300-305