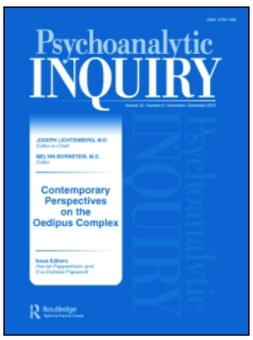

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The Empty Symbol and Its Relation to the Psychoanalytic Process

Frank García-Castrillón, Ph.D.

ABSTRACT

Analysts need to be aware that each word used by a patient is composed of a *constant conjunction* of a person's intimate emotional and historical referents, conscious and unconscious affects, memories, and conceptions and fantasies. If this conjunction does not correspond to that of the analyst, a gap develops between them. This gap in meaning is a non-understanding that emerges outside consciousness and beyond words. The author conceptualizes this relational phenomenon as the Empty Symbol.

> When you are observing the patient, you are really observing a live archaeological specimen; buried in the patient is an ancient civilization. [Bion, 1994, p. 154]

An interpersonal communication called psychotherapy

One can describe the therapeutic process as a verbal (and nonverbal) interactive dialogue between the two parties involved. The psychoanalytic situation, however, is a unique social form in which one of the two parties is endowed with a special power to influence the other through interactional processes (Hoffman, 1996).

The analyst seeks to encourage a patient to express thoughts and feelings as freely as possible. The therapist's responses to these expressions go beyond words to include bodily shifts and, especially, facial and hand gestures, all with the aim to demonstrate, clarify, and challenge the patient's habitual perceptions, emotional responses, and behavior. This combination of open communication and clinical responsiveness allows for the deconstruction of a patient's dysfunctional patterns and styles. When successful, such deconstruction is followed by the emergence of new, more functional forms of behavior and expression, which are then reinforced through the therapist's confirmation (Blanchet et al., 2005).

These new forms of relating to one's self and others, however, cannot be dictated to patients from the outside. Patient and therapist must each develop representations and conceptions that are in harmony with (but not necessarily symmetrical to) a context of shared meanings. Metaphorically, the "walls of the patient's mental house are pulled down to build a new and more functional architectural space. The price: [paid by both patient and analyst is] living among 'debris' for several years" (García-Castrillón, 2009, p. 278). I offer some examples of this process.

A patient of mine, a 30-year-old man who taught philosophy in high school, suffered from sexual impotence for years because of his anxiety when approaching women and his identification with *castrati*. (*Castrati* were male children who were castrated to keep their voices high so they could sing women's roles in the Italian opera in the seventeenth and eighteenth centuries.) He felt like a *castrato* because his mother had wanted a daughter, and hence treated him like a girl. He finally was able to have a sexual experience with a woman three years later, but it took three years of sifting through his "debris" to achieve a successful experience.

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A second patient was a 20-year-old woman who had hypersexual tendencies. Her father, who showed cruel behavior toward her, abandoned her and her cancer-stricken mother while she was still young. The patient had frequent flashbacks of a memory of her father trying to leave while she literally clung on to him, begging him to stay. In her frequent and risky sexual relations, she would idealize her partners at first, and then would feel abandoned. She would repeat this process, every time flashing back to the image of her young self trying to convince her father to stay. It wasn't until after four years of "sifting through debris" with her that we were finally able to establish a positive relationship in the therapy, which in turn helped her forge positive relationships in the outside world.

It is crucial to recognize the unconscious aspect of clinical exchange. Unconscious processing, located in the right hemisphere of the brain,[1] can process information captured through the senses at a rate of 11,000,000 bits per second. At the same time, the processing capacity of the conscious part of the mind, located in the left hemisphere, is 50 bits per second at the most. For example, in daily life, after a few minutes, a person who wishes to buy a house has formed a reliable opinion of it because his or her unconscious has processed up to 6 billion bits of information. If this person had to rely on conscious capacities, it would take him or her up to four years to process this volume of information.

Cognitive scientists (Wilson and Baumeister, 2005) discovered that we are primarily unconscious, emotional decision makers. In this sense, recent studies on "cortical blindness" (Tamietto and de Gelder, 2010; Sinke et al., 2012; Burra et al., 2013; Seirafi, De Weerd, and de Gelder, 2013) show that our brain digests much more information than we know. de Gelder, who participated in most of these studies, has been exploring blindsight for years. She conducts experiments where a cortically blind person can negotiate all sorts of obstacles without bumping into them. Even though the visual cortex is impaired, unconscious visual circuits come into play. Besides the visual pathway subordinate to the visual cortex (the newest one from an evolutionary point of view), there are other, phylogenetically older pathways that can visually process emotional stimuli. For instance, in one experiment de Gelder shows scary objects to three blind patients. While these patients say that they cannot see the objects, they do display an emotional reaction to them, and the reaction is recorded with small electrodes attached to facial muscles. This experiment demonstrates blind people's ability to "see" emotions on the faces of people whom they cannot actually see. de Gelder has shown that this ancient system is fully functional in human beings with normal eyesight. Before we realize we have seen something, before we are even aware that we saw it, the brain has already reacted. Seeing, however, is not the same as knowing that you saw! What would happen if we were able to apply these researches to the interaction between the analyst and the patient? Maybe we would be able to understand many of our therapeutic failures and successes.

In this context, it is questionable to consider a therapeutic process as determined only by the explicitly spoken dialogue between patient and therapist. Moreover, analysts have recognized that verbal interpretation is not the only tool for therapeutic change. Consequently, unconscious factors are essential to the therapeutic process and its unfolding. Psychoanalytic listening is guided, largely outside the analystcs awareness, by internally established, nonconscious hypotheses based on cultural and theoretical frames of reference. The lenses of culture impose upon one a particular way of seeing, perceiving, interpreting, judging, and acting in the face of events. Not only do analysts belong to a culture, but that culture also resides within each of them.

A personal experience may serve as an illustration. A few years ago, I took a summer course at Penn State University. Class participation is highly valued at US universities. A professor criticized Asian women students because of their silence. One of these students insisted that she was actively participating by listening and thinking. Her notion of participation was different from the American professor's, which involved speaking, doing, and so on. One can see how the professor's cultural ethnocentrism led him to misjudge the other.

[1]Allan Schore (2012, p. 290) stated: "The right hemisphere has been linked to implicit information processing, as opposed to the more explicit and more conscious processing tied to the left hemisphere."

We struggle to engage in open dialogue about the content of our psychoanalytic theories, but we remain less aware of the unconscious aspects of the way we hold our theories. It has been documented that analysts unconsciously engage in *belief perseverance* (Lord, Ross, and Lepper, 1979), "the tendency to attend to facts supportive of previous existing beliefs while ignoring others" (Cozolino, 2010, p. 137). In the analytic field, Chessick (1992) claimed that each orientation tends to prove its own psychoanalytic theory by way of examples that confirm its thesis, but does not investigate cases that contradict it.

Furthermore, we are all social creatures, and social psychologists have revealed consistent perceptual and cognitive biases in judging others and ourselves. We tend "to explain the behavior of others based on aspects of their character or personality, while explaining our own behaviors as a result of external factors" (Cozolino, 2010, p. 136). Clinically, when patients are stuck in a negative therapeutic reaction, we may see this reaction in the light of envy, attacks on linking, massive projective identification, or *discrediting the analyst*. We rarely consider the role our own attitudes and attributes play in eliciting a patient's perceptions and responses. For this reason, when patients say they do not understand me, I take their claims seriously. I try to find the healthy core or the undistorted aspect of this assessment.

An interaction I had with a suicidal patient constitutes a good example of this dynamic. This woman emailed me to cancel one of our therapy sessions. I received this email, but did not let her know I had. At her next hour, she started yelling at me as soon as she came in. She claimed I was cruel because I had not responded to her email. Her daughter's therapist, she added, was nicer to her daughter than I was to her because he had texted her daughter back in response to a cancelling message.

At first I thought this was a classic case of a simple transference on to me of the anger she had experienced from her abusive father when she was a child. Later, however, she asked me directly if I would have wanted a response from my therapist if I had been in her shoes. Her question brought back memories of my own experience as a patient when I was a teenager. I vividly remember the worst session of my life, when my analyst would not respond to me. My patient's comment, therefore, completely changed my mind, because I would, in fact, have wanted a response from my psychotherapist. Perhaps this woman was not as out of touch with reality as I had thought.

Initially, Kleinian theories on envy and on "attacks on linking" dominated my mind (Bion, 1959, p. 308). Her continuous devaluation of the analyst made me think of destructive narcissism. Moreover, it was precisely due to the emergence of her plausible and open negative response that we were able to analyze, as H. Rosenfeld (1971) pointed out, both the "real" and the transference-based aspects of her "negative therapeutic reaction" (p. 10). I always keep in mind the idea of Joan Riviere (1936): "Nothing will lead more surely to a negative therapeutic reaction in the patient than failure to recognize anything but the aggression in his material" (p. 311).

In addition, there are significant differences between male and female neurologically based emotional processing that have not been sufficiently factored into the clinical theories to date. For instance, the *mirror neuron system*, which is larger in women, allows one to feel others' emotions, thus erasing or blurring the boundaries between self and other (Ramachandran, 2009). The temporoparietal junction system, by contrast, analyzes and seeks solutions to emotional difficulties. Unlike the mirror neuron system, it clearly separates self from other, which prevents the other's emotional processes from interfering with our analytic search for solutions.

In both men and women, there is a first moment when the other's emotions activate mirror neurons. In women this system remains activated for a long time; in men it is quickly replaced by the *temporoparietal junction system*, which analyzes and seeks solutions to emotional difficulties. The prevailing system in men is designed to find solutions. The prevailing system in women, by contrast, is intended to establish links with others. Likewise, under stress, men tend to withdraw whereas women seek social support (Mather et al., 2010).

In other words, if my wife tells me about a problem she encountered at work, my male mind will want to provide a solution when what she is expecting is emotional support. Similarly, if a female

patient brings up a problem she experienced in her everyday life, my male mind will want to provide a solution (frequently in the guise of a theory-based interpretation that solves my problem of formulating the dynamics involved) when what she is asking for, and may need, is emotional support.

These findings brought to mind two patients (a man and a woman) who sought help regarding their recent separations. These patients led me to consider the idea that when they consult a professional, women tend to seek someone who will share their emotional difficulties, but men want someone who will help them find solutions to those difficulties. I am not saying that these discoveries constitute psychoanalytic knowledge. Still, they may help us understand why we feel more at ease with a man, a woman, a child, or a teenager, whether or not their emotional processing modes coincide with ours.

Although theory and logic help one to think and understand, they may also hinder the ability to recognize patients' individuality and unique messages. To illustrate this idea, I mention the research conducted by Haynal-Reymond et al. (2005). In an effort to develop new techniques for the prediction of suicide risk, fifty-nine patients admitted to the Geneva University Hospital after a suicide attempt were videotaped while interviewed by a psychiatrist. After the interview, the therapist was asked to assess the patients' risk of suicide.

Twenty-four months later, the researchers identified ten repeaters. They coded the facial behavior of doctor and patient according to the Ekman and Friesen's "Facial Action Coding System" (1978) and analyzed differences in the therapist's performance with each group. Results indicated an average activation of all coded units, peri-ocular activation and duration of her gaze straight at the patient, which were all significantly higher, distinguishing correctly 81.8% to 90.9% of the patients. By contrast, the doctor's written predictions had been wrong—she had accurately classified only 22.7% of the patients.

This discrepancy reflects the psychiatrist's unwitting perception of risk; her head and facial gestures differed depending on whether she was talking to a future repeater or to a nonrepeater. Such variation confirms that nonverbal, nonintentional, and nonconscious interactions between patient and therapist do occur. Moreover, nonverbal communication could provide important clues regarding patients' affective and emotional states, even if they did not verbally disclose their emotions and thoughts. This study shows that the doctor had an unconscious knowledge about the real emotional state of the patients. Her knowledge, however, was obscured by her theories and rational deduction, that is, by her conscious mental system. It seems that the French noble Luc de Clapiers, Marquis de Vauvenargues (1715–1747) was right when he stated that "emotions have taught humankind to reason" (see Stern, 2009, p. 466).

Conceptualizing the complexity of a patient's rendition of her internal world through the narrow passage of reasoned-out theory produces only partial knowledge of that world (García-Castrillón, 2005). It is in this context that Bion's (1970, p. 43) idea that the analyst's listening attitude must be "without memory, desire, or [theory-driven] understanding"[2] acquires full meaning. An attitude that recognizes the need, at times, to suspend theory and logic will make it easier for us to grasp the messages patients send to us.

Empty symbol? Language as a substitute for experience

Using medicine as an analogy, one could say that until not long ago verbal interventions and, more specifically, interpretations were considered the active ingredient of the analytic process. The analytic attitude and frame, in turn, were the "excipients"—the vehicles that facilitated absorption of this explicit, verbal, ingredient. This attitude derived from the idea of a radical "di-vision" between mind and body, the assumption that people convey most messages through words, and Western civilization's emphasis on the "left-brain world vision," that is, its favoring the verbal and analytical over the emotional and experiential (McGilchrist, 2009, p. 158).

[2]Grinberg (1980) related this methodological approach to psychoanalytic work to Freud's notion of suspended attention.

Needless to say, our talking cure—making conscious the unconscious—is critical to our task, and its importance cannot be diminished. A large part of analytic work consists in gradually integrating, linking, emotions to thoughts, naming them with words, and binding affects to words. This activity recalls Marcel Proust's (1981) statement in *Remembrance of Things Past*: when sorrows (emotions) become ideas (words), they lose some of their power to wound our heart.

Drawing an example from everyday life, one could ask if a 7-year-old boy knows how long a kilometer is. Adults have a rough sense of this distance because they drive, walk, or ride. In other words, they have an experience of it. In school, however, students learn that a kilometer equals 1,000 meters. Does this statement mean anything to that boy? Does it mean anything to the children who see it written on the blackboard? At school students were taught the meaning of *1 km* with formal, abstract language represented (symbolized) on the chalkboard. There was barely any reference to real-world objects or situations.

Conceptually, during our first years of life our brain is not able to learn or think abstractly (Vollmer, 2005), for it was designed, instead, to help us survive real-life situations. Humans' first language (an organized combination of symbols) develops thanks to the sensory-motor interaction between mother and infant. By way of a developmental process, the mother provides meaning to her baby's internal and external worlds (Brinich, 1982). For a native English speaker, the words *kiss* and *hug* are associated with experiential interactions bearing deep, intense emotional implications. Learning a second language later in life may be considered an intellectual achievement, Nonetheless, from a developmental point of view, because it is not rooted in an emotional, meaningful sensory-motor interaction, this mode of learning produces a kind of empty system of verbal symbols.

For instance, English is not my native language. Even though I learned to end my emails to my American colleagues with the words *best regards*, these words mean nothing to me. To be more accurate, I learned this formal closing as an adult, and although I understand it rationally, it has no emotional meaning. This is what I call an *empty symbol*—a symbol that was not learned through active sensory-motor exchanges. The difference between the two language learning modes is similar to the difference between learning math as a child by playing with objects in a real interactive situation, and learning math as an adult through a formal, abstract language devoid of concrete elements.

Language is a relatively new development for humans. If the course of human evolutionary history had been sixty seconds long, we would have had the ability to speak for only the last second and a half. Much of our learning, then, is nonverbal, implicit, and procedural. I suggest that it is our analytic attitude as a whole (of which our verbal interventions are a component) that constitutes the active ingredient that triggers deeper insights, emotional regulation, and cognitive change.

Researchers (Wilhelm, 2012) have conducted studies on time and color perception and on the influence of grammatical gender in different languages. (For instance, Spaniards tend to describe a bridge, a masculine word, with masculine attributes such as strong, solid, and dangerous. In German, instead, the word is feminine and is usually laden with feminine features such as elegant, beautiful, and slim.) This research suggests that even when people are speaking about the same things, they evoke different representations.

Such discrepancies open up a path for psychoanalytic research. For many patients, talking in therapy is the equivalent of using a second language. Each family, like a language group, has its own culture, its own meanings, not only for words, but also for the language of relational interaction. People believe they know what they are saying, but their statements are subject to two constraints. I am referring to the impact of unconscious processes and the influence of unconsciously held beliefs. But there is also the gap—frequently left unacknowledged—between the therapist's family-acquired and professionally acquired language, and the patient's family-acquired and life-acquired language.

What do the therapists' words conjure in their patients' minds? Do they evoke the meaning we are trying to convey? This issue comes to the fore when a patient starts the session by saying, "As you told me the other day, I have to stay calmer when I interact with my children." Heavens! Did I say that? Did I command him to stay calm? It would never occur to me to tell my patients what to do. This is, at least, what I thought about my interventions! These instances provide opportunities to

inquire into the ways in which our messages are processed and ponder why they are processed in that particular way.

Brain representations of the same word vary from one person to the next. For instance, the concept *pencil* encompasses every writing tool we have ever used. The same is true for any word—hug, kiss, or love. I am dealing here with conceptual semantics (Heim et al., 2009). I have studied (and experienced!) how the same word may evoke different emotional and historical referents in different subjects. I was born in Montréal and lived there for a few years. Despite being Spanish, my parents spoke to me in English to help me adjust to life in Canada. On my return to Spain, I had a hard time in elementary school because my Spanish was not good enough. Even as a teenager, I realized that although I understood certain Spanish expressions, I still misinterpreted them. For instance, I played basketball quite well, and one of my teammates would say to me, "*Qué hijo de puta eres*" (literally, "what a son of a bitch you are"). This expression conjured in my mind the following *constant conjunction* of associations:

- He is insulting me;
- He does not want to be friends with me;
- He is challenging me;
- He does not like me at all;
- He hates me; and
- He may hit me.

Over time, I realized that, like almost every Spaniard, in the right context (which it was), my friend would have wished to convey the following cluster of associations:

- You should know I admire you;
- You arouse positive emotions in me;
- My admiration for you sometimes makes me envious; and
- I want to be your friend.

In this way, conscious and unconscious affects, memories, conceptions, and fantasies may be activated and stimulated in a patient's mind that the therapist may fail to grasp, for each word is composed of a constant conjunction of each person's emotional and historical referents. People all group their experiences in a unique way. As a result, in the space of the consulting room, misinterpretations may result from a failed encounter that affects both participants in the psychoanalytic *mis/understanding*.[3]

Analysts must hence take into account how patients understand the words they utter, or at least keep in mind that there could be a gap. These words contain an array of concepts, and patients may not apprehend all of them emotionally. For instance, therapists all too often rely on common knowledge to make interpretations of the weekend break. This knowledge takes the content of the patient's experience and thinking for granted. As a result, stereotyped interpretations are formulated without taking into account how the experience and the notion of absence and wait operate in that particular person.

I had a patient (a 29-year-old engineer) to whom I offered a stereotyped interpretation regarding his tendency to remain silent on Mondays. I saw him three times a week (Mondays, Wednesdays, and Thursdays), and I was concerned that he might feel abandoned due to the weekend break:

> Frank: Is there something behind your silence?
> Patient: [Remains silent for a few minutes.]
> Frank: Usually you talk a lot during our sessions, especially Wednesdays and Thursdays, and it seems really productive.

[3] I use here the Spanish word *des/encuentro*", which bears a wider range of meaning than mis/understanding; a *desencuentro* is also a failed or missed encounter. Each participant in the conversation is taking a different *interpreting path*, which gives rise to the inability to understand.

Patient: [Remains silent for two or three minutes.]
Frank: It seems that your silence is becoming a habit on Mondays.
Patient: Yes, that's true.
Frank: Maybe you're angry because of the interval between our Thursday and Monday sessions.
Patient: No, no, that's not it.
Frank: Maybe you feel abandoned to some extent.
Patient: No, really, I don't feel abandoned by you. I'm not mad at you. During the weekend I talk with you inside me as a way to cope with anxiety. In my internal therapy I'm in tune with you, but it takes a bit of time to switch from that dialogue to the conversation with the real you.

This made me think that patients identify specifically with certain attributes we bring to the treatment. I remember that what helped me with my second psychoanalyst was less the content of our sessions than the high regard he consistently showed for me.

The fundamental role of human communication is to affect others' state of mind. A meeting of minds occurs when the representations developed in the minds of those who are engaged in a dialogue become compatible enough to fulfill the goals that prompted communication. In my psychoanalytic practice, I pay particular attention to this meeting of minds in the case of patients with severe illnesses (*deficiencies* or pre-Oedipal pathology). In these patients, primal communication aspects (gestures, tone and musicality of language, and timing of interventions, among others) play a relevant role because the illness-generating deficiencies preceded language development.

I had an anorexic patient with whom I was very aware of the primal communication aspects of our dialogue. Ana, now fifteen years old, sought treatment two years ago because of her anorexia. In the assessment interview, we observed that she and her mother had established a heavily codependent relationship. Ana remembers that when she went to friends' birthday parties, her mom would stay while the other moms just dropped their children off. The mother was controlling and demanding, and Ana did her best to fulfill her high expectations. She was obedient and a good student, and always agreed with her mother, who did not appreciate the otherness of her daughter. Instead, she heavily emphasized what they had in common to the exclusion of her daughter's sense of self. This changed when Ana developed anorexia at the age of thirteen in an attempt to create a separate space for herself. Her changed eating habits aimed to communicate her desire not to become like her mother. She said to me, ´´I don't want to be like my mom, twenty kilos heavier."

The therapeutic bond was very difficult to establish. I did not want to create a space where she felt interrogated or pressured. Therefore, I softened my approach by being very cognizant of my speech and maintaining a relaxed intonation. We now know that the prosodic aspects of language (tone, phrasing, and rhythm) contribute to meaning even before the development of linguistic skills. Syntax and vocabulary come later. I drew this strategy from my own experience. I remember how calming it was to hear my mother singing sweetly to me when I was anxious. I used the same gentle and affectionate attitude with Ana.

A young couple consulted me in search of support to process the experience of being told that their one-month-old daughter would not make it to her first birthday. The mother was reluctant to confront her own emotions in a psychotherapy. She showed a cold attitude toward the process and even toward me, but came anyway because of her husband's insistence:

Mother: We're ready. The next time she has an emergency, we have decided we won't pursue medical treatment.
Father: She's suffering a lot.
Mother: We're going to celebrate her life after she's gone. She deserves a celebration. It's been a privilege to have her among us all this time. [Mother begins to cry.]
Frank [becoming tearful]: That's a nice way of honoring her.[4]

[4]When this session took place, I was about to travel to the University of Alabama to give a talk about "The Psychology of Learning a Second Language." I usually feel sad leaving my children for the weekend because I do not see them often during the week. The situation with the young couple also triggered my feelings of separation and loss. We shared the feeling of loss (albeit to different extents), and my ability to empathize with the mother in this way enabled her to begin to trust me.

This was the first time we really connected. At the end of the session, when they were about to leave, the mother turned around and asked me, "*Can you treat her older sister?*"

Active ingredients of therapeutic effectiveness

Psychotherapy research (Strupp and Hadley, 1979) suggests that the relationship between practitioner and patient—referred to as nonspecific factors—accounts for therapeutic effectiveness better than the application of a particular technique. This finding does not preclude the specification of some of these factors. I highlight three important ingredients: (a) synchronization (especially the reparation or re-synchronization process); (b) the active role of the *silent* frame; and (c) the analytic attitude of respect.

Synchronization

Tronick's (1989, 2004, 2007) research establishes the significance of mother–infant synchronization to ensure a proper development. In the absence of the mother's response, the infant becomes anxious and disorganized. Analysts may suggest that patients show their most infantile, less resolved aspects in therapy and, in a way, therapists, who represent the maternal container function, must act as a mother by synchronizing with the patient's immediate subjective experience.

It is worth recalling here my first assessment interview with a 40-year-old patient who had a long history of psychotherapy due to an obsessive-compulsive disorder. He said to me,

> Dr. Castrillón, I'm not coming here to be cured. I'm not coming so that you'll behave like the aloof hospital doctor who visits a patient's room every two or three days, reminds him of his diagnosis, tells him how he's progressing, changes the dosage on his medication, and disappears from the room in his white coat. What I need is a female nurse who will take care of me every day, who will be by my side when I'm suffering and instill hope in me when I feel that everything is going wrong.

Nonetheless, one cannot assume an idyllic relationship of perfect synchrony between mother and infant or between patient and therapist. What is crucial to the therapeutic process, in my experience, is the quick reparation or restoration of attunement when the latter breaks. Such restoration is a major therapeutic factor. Misinterpretations and lack of understanding between patients and therapists abound. It is incumbent on therapists to serve as a model to overcome these failed encounters and renegotiate the relationship so that the transference-countertransference knot may be undone.

One of my patients called to cancel a session, and I did not call her to acknowledge her message. During the next session, she was visibly upset and possibly distressed. She took me to task for my lack of response. I believed that a more conventional approach of staying silent and waiting for her to freely associate or interpreting the cause of her distress would have been a significant technical and human error. For instance, I could have interpreted that she had grown up feeling that her parents did not pay enough attention to her because she was the youngest of five siblings. Instead, I said to her: "I'm sorry, my mistake. I'll do my best to make sure it doesn't happen again."

In this context, attention to the transference-countertransference dynamic fulfills not one, but two essential purposes. It addresses the chronic dysfunctional relational patterns that emerge between patient and analyst. Yet it serves, above all, to alert the analyst to the need to respond to the patient's real-life struggles. Furthermore, it is a prerequisite that must be continually considered to secure patients' improvement. A therapist's lack of response to real life stress generates a vacuum in patients' minds that tends to be filled with anxiety and negativity.

In this sense, Karlen Lyons-Ruth's (2010) presentation on the effects of the mother–infant relationship on infant development made me think that the worst mother is not the one who shows more or less pathological personality traits. Rather, the worst mother is the one who is absent, who does not respond. Lack of response generates disaster and chaos in the baby's mind due to the absence of a

structuring, organizing mother. In *La separación de los amantes* [Lovers' Separation] Igor Carusso (1968) underscored that the real tragedy of losing a lover's love is feeling that one gradually disappears, dies in the other's mind. The feeling that we are living in the other's mind is life-giving.

Children probably jump barriers, break family rules, fail at school, and even get sick to demand the presence of their parents, who are engrossed in their work. It is worth recalling here some of Donald Meltzer's ideas. In his clinical seminars (Meltzer, 1997), he used to say that he preferred to refer patients to young analysts because they were able to express concern and become more emotionally involved in the mental state of their patients. Likewise, Jonathan Slavin (2016) pointed out that therapy "happens in real time in one's life, and should aim to resolve these issues without delay." That is why analysts must not lose track of patients' specific demands in each specific moment so that they can more easily satisfy the need for synchronization or restore it when it is lost.

These demands for therapists' responsiveness to real-life issues are sometimes obscured by our expectations, our therapeutic goals, our theory of technique, or even our tiredness! I think that one of the reasons behind the lengthening of traditional psychoanalytic treatments is that, on occasion, analysts adopt the *nonresponse* attitude. This attitude, in my opinion, is one of the causes of negative therapeutic reactions and unfavorable regressions, as Tronick's (1989, 2004, 2007) experiments showed.

Analysts sometimes forget how vulnerable they were when they faced their first therapeutic process as patients and their need to find a containing response in any of its possible modes. They should also remember that children see their parents as a mirror that provides them with an image they can ultimately identify as their own. If a mother looks at her child with profound displeasure, the child will finally see and feel such displeasure and will say to itself, "That's me, the displeasure; I'm a displeasing being" (García-Castrillón et al., 2007). In other words, as Malcolm Slavin (2013, p. 297) pointed out, "The vital Otherness from which we construct a human self (a psychosocial identity…) is inevitably highly colored by the experiences embedded in those others whose identities must be absorbed to shape our own."

Likewise, patients look at their analysts to see what their analysts see. If we are able to value the healthy aspects of our patients, these aspects will gradually become an active part of their personality. Conversely, if what they get from us is silence and lack of response, their emotional demand for help will turn into a strong sense of shame and/or guilt. This feeling results from having shown their deteriorated and undervalued internal objects without being contained, in keeping with Steiner's (2006) description of narcissistic humiliation. Goethe (1917) intuited these ideas and elegantly stated them: "'When we take people,' thou wouldst say, 'merely as they are, we make them worse; when we treat them as if they were what they should be, we improve them as far as they can be improved.'"

As I now am mindful of the destructive potential of lengthy silences, when I take on new patients I explain to them how I use silence as a tool. I do not take for granted that they understand that when I choose to stay silent I am making space for them to freely associate. Making this explicit allows them to talk about whatever comes to their minds without worrying about my lack of intervention.

Although I have spoken about the need to handle silence carefully due to the risks it entails, I point out that it also opens spaces for patients to explore their internal world anew. I offer an example. I had a young patient who was in her senior year in high school. She had started treatment due to excessive academic stress and a certain rivalry with her gorgeous sister (my patient was short and slightly overweight). After four months of therapy at a frequency of two sessions a week, I said to her at the beginning of her hour:

> Frank: Now that you have overcome most of your anxiety, I will talk less during the sessions so that we can further explore and delve into other aspects of you.
> Alexandra: I don't understand what you're trying to do, but I'm fine with it.
> [She spoke of different things over the course of the session, while I maintained this new exploratory attitude and was silent for longer periods of time. What follows is her statement at the end of the hour.]

> Alexandra: Oh … I forgot to tell you. My parents are finally letting me dress however I want. I'm almost 18. I was really tired of hearing them tell me how to dress all the time!

I think that the patient was not just communicating an external experience. She was also conveying her own perception of the analytic situation. She was happy that I was finally letting her speak more and play with other ideas and fantasies, a shift that allowed her to feel more mature.

Safe, silent *frames/settings*

Bleger (1966) defined the psychoanalytic situation as comprising two elements, namely, process and frame. The process is what analysts study, analyze, and interpret. It can, however, be examined only when the same constants—those that make up the frame—are maintained. The frame,[5] then, is a nonprocess composed of constants within whose boundaries the process unfolds.

Maintaining fixed rules regarding the number, duration, and time of the sessions, the form of payment, and so on is not enough to build a safe setting/frame. The latter must be generated and promoted by a reliable analytic attitude (the analyst's internal setting, that is, the setting as a structure in the mind of the analyst; Parsons, 2007). To develop this attitude, analysts must have resolved their pathological aspects in their own analytical process, or at least be aware of them so that they do not reenact them in the context of transference-countertransference dynamics.

Everybody needs a stable, predictable, and safe frame for a healthy development, as has been proved by the extensive body of research into attachment styles in the field of developmental psychology. Therapists who provide their patients with a frame that draws clear interpersonal boundaries are perceived and internalized as sane and stable. This is especially important for many patients who have sought therapy because of a history of insecure attachments and unstable contexts and relationships. Consequently, a safe frame might be considered a strong healing factor, as it gives patients an opportunity for a new beginning—a corrective emotional experience. Additionally, the extent to which therapists either follow or deviate from the safe frame informs patients about therapists' personal and interpersonal difficulties. If they deviate from this frame, practitioners may unconsciously trigger paranoid anxiety in their patients, thus hindering the revelation of the latter's innermost fears and preventing them from integrating those fears into their conscious mind. For this reason, the impact of the verbal content on patients is quite milder than the effect of therapists' management of the frame.

A clinical example will illustrate the intersection of frame-related issues and synchronization. I recently had an engagement that forced me to miss a session with a patient. Given my knowledge of her history of abuse and nonrecognition, I made a conscious choice to apologize to her at the beginning of the next session to synchronize with her need, and she was very understanding. In that same session, however, she began to talk about her abusive husband and mother; she had unconsciously associated her experience of a deviation of the frame with past experiences of abuse. Even though she had consciously excused my behavior, the latter had triggered feelings of neglect and nonrecognition, without being able to speak about it. This reminds me Christopher Bollas´ (1987) famous idea about the "*unthought known*" to represent those experiences in some way known to the individual, but about which s/he is unable to think. The unthought known refers to preverbal, unschematised early experience/trauma that may determine one's behavior unconsciously, barred to conscious thought.

Respect: Not only an ethical but also an epistemological principle at the core of psychic change

Respect is the dynamic core of maturity and the appropriate functional focal point of interpersonal relations. Respect means knowing or acknowledging the total object with no intention of changing it

[5]Lemma (2014, p. 225) suggested that "the body of the analyst may be helpfully conceptualized as an embodied feature of the setting." This approach may be especially useful to understand patients who develop a symbiotic transference and who feel any change in the analyst's body as deeply destabilizing.

internally or externally. Respect acquires identity, energy, and expression from the distinction between the subject and the respected object. In other words, you and I are not identical, similar, or different; we simply are. We coexist—you and your world, I and my world. The more I can be who I am, the more I will respect your being who you are.

Respect can manifest itself through an internal and external attitude of tolerance. It demands neither agreement nor attunement with the object; it admits disagreement. Tolerance facilitates mutual collaboration and does not imply passivity. On the contrary, it is an active stance whereby subjects consider the object's actions, take them into account, try to understand them, and choose their response, which can entail participation or inhibition.

Having described our approach to respect, I can say that a respectful analytic attitude is not just a key aspect of a safe frame but essentially generates it. From the first encounter, therapists must treat patients as their most deserving guests (Bettelheim and Rosenfeld, 1994). Such behavior must be a prerequisite if analysts want patients to allow them into their internal world. Only with respect can a trusting patient–therapist bond develop. One must fully recognize the otherness of the other, that is, one must acknowledge the other as a separate entity with his or her unique history.

In this sense, respect is both an ethical and an epistemological principle. The process of getting to know the patient begins with a strong sense of self-respect, which implies recognition of one's capabilities and, above all, of one's limitations, of one's lack of knowledge. If analysts are able to come to terms with these limitations, they are ready to grasp the patient's innermost aspects. Epistemology assumes that a certain distance must separate subject and object for knowledge to emerge. If I recognize my own limitations, I will be open to learning from my patients, to being transformed by their presence; I will take what they say seriously and/or will take them seriously when they say I misunderstood their words. In order to know, we must have a strong sense of not knowing, and we may only achieve such a sense if we recognize, tolerate, and integrate our own limits.

Nonetheless, there is a refined, active narcissistic zone in each of us that denies the other (the possibility that otherness could even exist), thus hindering our ability to get to know that other as a separate entity.

Epilogue

What I have tried to convey in this article is the need to look beyond the cognitive, conscious aspects of interpretation. It is the affective, relational, and unconscious aspects developing between therapist and patient that are at the core of psychic change. I have introduced the idea of the empty symbol as a relational concept to be explored in depth, and also the idea of respect as an epistemological principle, an essential tool that gives us the unique opportunity to know a patient. The French psychoanalyst S. Nacht (1969, p. 597) wrote:

> It seems to me what is most important is not so much what the analyst says, as what he is. It is precisely what he is in the depths of himself—his real availability, his receptivity and his authentic acceptance of what the other is—which gives value and effectiveness to what he says. The communication from one unconscious to another … between therapist and patient permits the latter to perceive the profound benevolent attitude of the physician. Thus the old wound due to frustration, the instigator of the infantile neurosis, will be erased. The cure will then be possible.

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