Listening to Inner Spaces: Making Contact with Depth in Ourselves and in Our Patients

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I'd like to offer a few reflections to you today on how we listen in psychotherapy.

As I do so, I remain fully cognizant of the fact that I'm speaking to a room of professional listeners so what I'm about to say may be a bit presumptuous. But in a conference on Contemplative Psychotherapy, I thought it an appropriate risk to shift our attention for a bit from the instrumentality of our work—"What do I do with my patients? And, what do I say to them?" To something that must necessarily precede these questions—"How do I listen? How do I receive? How do I experience? How do I make contact and create safety and intimacy?"

Since the time of Freud we have referred to psychotherapy as the "talking cure"—but with the evolution of contemporary attachment theory, regulation theory, the advances in neuro-imaging, my own sense is that psychotherapy is not really a "talking cure" but, more so, an attuning one, a "listening" one. The kind of listening I'm referring to is more than simply remaining mute while looking attentive, but is a listening that requires the ability to attend imaginatively not only to another's words, but to the fullness of his or her communicative essence. We certainly attend to the person's words, but we attend to more. We attend to the spaces in-between their words, to their breath as they speak, to the movements of their fingers as they clutch their chair, to the dancing of their eyes as they receive or avert our gaze. And, as we attend to them, we attempt to enter their world. We not only come to know about their pain and suffering, but we may feel it too, we participate in it--we hope to know it from the inside. In this kind of participatory listening, we actually come to "speak their words" (Friedman, 1985, p. 81).

So, how is this kind of listening different from ordinary, everyday listening? How does it come into being? And, how does this listening call us to respond? I want to explore these questions by offering some thoughts on two primary modes of listening that we may bring to our work.

I'm sure we all have some awareness of how our own listening capacities have evolved since the first time we sat with a patient. And, perhaps we even have some explicit awareness of what we've done to train ourselves to listen differently, to listen better. Getting good supervision, our own therapy, perhaps. Reading, attending seminars? Let's try to recall the beginning of that evolution. Let me ask you to think back to the first time you sat with a patient. Is that experience accessible? If so, let's begin to recall what it may have been like. How were we able to listen to that patient? Can we recapture in our body's memories what feelings arose for us then? Was there anxiety? Fear? Confidence? Overconfidence? To where was your attention drawn during that first session? To what did you attend? Was there any sense of urgency? Or some pressure to be helpful? What was going on in your inner space? Was it busy? Cluttered? Was there an anticipation of what you might say next? And, What did you do? Speak more than you listened? Flood the room with questions, perhaps? Did you mobilize to problem solving mode? Offering advice? Looking to fix what you saw as broken? Was your listening defensive in any way? Might have you communicated through your direct interventions or non-verbals the limits of what was permissible for the patient to bring into the room? Was making contact with the patient's deeper realities and pain, perhaps, too overwhelming a thought for you to approach? Was the threat of intimacy and the responsibility that comes with that, too hard to fathom? How may have we distanced the patient? Perhaps, miss his or her faint hope of finding someone who could provide shelter and who could create a space for his or her emerging voice to begin to make a sound?

These struggles are rather emblematic of the experiences of the novice and I was certainly guilty of struggling with much of what I just described?

I can recall quite vividly, as if it were yesterday, how poorly I was able to listen when I first sat with patients some 22 years ago. I remember the anxiety I felt when I sat for the very first time with my first patient. In hindsight, I don't think I heard much of what he said. He seemed scared to be there—or maybe that was just me being scared. In my therapy skills intro class, I had just learned that there was a RIGHT way to sit with patients: SOLER, Remember S-O-L-E-R?: Square, Open, Leaning, Eye contact, Relaxed. And so I spent the entire session obsessing about whether I was SOLERING. Was I sitting square or open enough? Was I leaning in too much? Was I relaxed? Saying to myself: Ok, relax!!, relax!! Of course, it made it worse. And so, I had this incredibly loud internal dialogue that filled my inner space. Then there was the tape recording…"Oh My God! What will my supervisor think when she hears this. She'll know how incompetent I am? I'll be told I have no future in this work!"

My awareness of the possibilities for my listening changed dramatically when, relatively late in my formal training, I encountered one of those rare kinds of supervisors—one who had a seeming simplicity, unpretentiousness, and calmness about him. While he usually said very little in supervision, there was a deeply felt sense of his moment-to-moment presence. When he did speak, I felt him making contact with me very powerfully. In him, I experienced a palpable commitment to both me and my patients and for our mutual growth. As we listened to the tapes of my work, what quickly became clear was that he was attuned to something very different than what I paid attention to. What he heard was not just what the patient was saying about himself, but what we were interactively creating with each other. In fact, at times, our listening focus—where we placed our attention—seemed to be incredibly discrepant—almost as if we were listening to and talking about two different patients. Whereas my attention was like that of a laser beam focused directly at the content of the patient's narrative—following every fact, every detail in the story—my supervisor seemed to have little use for a laser beam. As I think about it now, for him, his listening was more like having one of those huge satellite dishes—you know, like the ones we see at NASA—that absorb millions and millions of discrete signals from which themes and patterns are identified. Whereas I looked for meaning in the patient's words, he found meaning not only in the obvious—the words—but also in their tone of voice, in their pauses and silences, in the tension or feeling in the room that was felt through the recording; he found meaning in what I said and in my silences, and through the affect I communicated or perhaps let spill over. And, he listened to me in supervision in the very same way.

I learned that there was a different way of listening not only through what he taught me explicitly, but through my experience of being listened to in a new way. It wasn't that after my work with him, I was able to listen as deeply as he did, or with the same kind of complexity and sophistication, but my imagination as to what was possible had been expanded exponentially. I eventually learned that if I am able to listen beyond the surface content of my patients' spoken words, to the spaces in-between, to the muffled murmurings of their hearts, to the soft utterances in their tears, and help them find meaning amidst the chaos they may feel, I can be of infinitely greater help in liberating them from those forces that diminish their potential and constrain their lives. This kind of listening was certainly something I wanted to achieve and have been striving for ever since.

And so, given where you started, where are you today? How has your capacity to be receptive, to listen to the multidimensionality of your patients' communications evolved since then? Has your listening evolved as you've matured professionally and personally? Or, perhaps, as a result of having become more seasoned as a human being through your own suffering? What were those factors or practices in the refinement of your own listening?

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Examining how we clinicians listen to our patients, regardless of how seasoned we may be, is difficult to do. It is difficult because in any honest self-examination we potentially open ourselves up to

some wounding. For we therapists, there is significant ego-involvement in our capacity to listen and receive. This is what we do for a living. This is our professional identity, if not more. There's also another piece to this. Listening is actually also emblematic of something deeper and perhaps more personal. Isn't how we listen to others a primary, if not the primary way, we make contact with them? Is not how we listen to and receive another a primary context for how we bring ourselves into relationship with them? Doesn't how we listen speak to our ability to connect and even participate in the life of another and create intimacy? I think it does.

There's a corollary to this line of thinking that I'd like to briefly introduce here, and that is: Our ability to make contact with the depths of others and be able to listen to their inner spaces more accurately and fully, actually begins with our capacity to make contact with and listen to the depths of our own inner spaces. If there is noise, or clutter, or chaos, or rigid tensions, or fears, or pain that is not adequately modulated, our inner space will be overflowing, making little clearing for another. The extent that I am able to listen to myself, to sit with the reality of who I am—my woundings, my scars, my failings, my darkness, as well as the light that dwells inside—and not distance myself from those parts that I've wanted to keep hidden, will be the extent to which I can be with my patients in more honest and authentic ways. To the extent that we can learn to honor and embrace those more painful parts of our lives so will we be better able to make room for the real human experience of others. As our own capacity to not fear what lay in our depths increases, not only can we become more self-accepting, but we can be better able to receive our patients—with all of their shadowy and primitive sides—with much less trepidation or fear of being engulfed by their pain. To the extent that we can do this will be the extent to which we can create the relational space for our patients to be heard and for them to unfold.

And so, because we do this "listening thing" implicitly everyday in our work as a matter of routine, we can easily take it for granted. What I'd like to do with the remainder of our time is to begin to make explicit what, up to now I've mostly implied.

Orienting Assumptions about the Therapeutic (or Healing) Process

Let me offer a brief sketch, first, of a few loosely connected assumptions I make about psychotherapy and the healing process. These assumptions will provide a context for my remarks on listening that follow.

- First, broadly speaking, my view is that patients come to us in various degrees of dis-integration. Their hurts and traumas, relational, chronic or acute, have helped them to develop means of protecting their sense of self by cutting themselves off from parts of their inner experience. They have learned to cope with their pain by often splitting it off from awareness. Relegating it to places that make it inaccessible and, therefore, unable to be suffered through. The paradox of needing to protect their vulnerable core, of course, can preclude that core from growing into a more coherent, integrated whole.

- Second, I think of our depths as the reservoir, of not only pain and darkness, but also of richness and untapped potentiality. This is the seat of our deep wisdom. Therefore, when we're disconnected from our depths we alienate ourselves from the truth of who we are and from our gifts as human beings (McGilchrist, 2009).

- Third, our limited capacity for listening is responsible for much of our suffering. The failure to be heard is hurtful. It wounds us at our core. The child, whose inner life and needs are not heard well enough and appropriately responded to, feels his inner life to be filled with badness and, through the

trauma of absence, feels his existence to be tenuous and invalid. And so he turns away from that pain-filled or emptiness-filled internal space. Since, we human beings are essentially social, "not being heard by others diminishes our capacity to hear ourselves" (Levin, 1989, p. 105). Therefore, how we listen is responsible for creating what our listening actually hears. "Our listening has the power to cause or to alleviate the very suffering it is hearing" (Levin, 1989, p. 106).

- Fourth, Listening well is therefore essentially communicative for us — for we therapists, it **IS** *the doing of the therapy.* The communicativeness of listening is no less important than the communicativeness of speaking because the process of listening *can* be, for both sides, an act of constituting new understandings, new meanings, and new needs (Levin, 1989).

- Fifth, the patient always communicates to me how he needs me to be of help to him. Therefore, my job is to cultivate in myself the capacity, sensitivity, and openness to the hearable. Our patients are, in fact, our best supervisors--our unconscious supervisors. Their derivative communications are replete with wise directives for what they need from us for their healing.

- Sixth, Our patient's pain is often expressed through unspoken cries. Often their pain can't yet be organized and thought into words, and thus, be spoken. The work of psychotherapy, then, is to make contact with their inner space and listen not just for the patient's voice as it may be mute, but to the echoes that reverberate in our meeting each other. In doing so, we are able to interactively regulate those affectively charged internal states and help create internal linkages that invite the patient to greater integration.

- Seventh, in my view, the patient's healing takes place through two basic means: first, through the cognitive insight achieved by the patient—the coming into awareness of her repeating dysfunctional patterns and their accompanying distorted attributions; and, second, through the internalization of the therapist's internal structures--as mediated primarily through the therapist's personal integrity and commitment. That is, our patients take us in through their experience of our compassionate gaze that holds them steady amidst the chaos and the unknown, and it happens through the experience of the echoing and responsive resonance of our listening. So, if it is I who am to be internalized and be used to build new and more enduring internal structures, it matters who I am as a person. My ability to be present, my ability to tolerate and hold the patient's pain, my ability to manage the frame, my honesty, my commitment to my own inner work, my vulnerability, my maturity, my humanness. It all matters. It matters who we are. Our patients see through our defenses, and will neither reveal their deeper natures to us, nor take us in, if their unconscious perceptions of us reveal to them persons who ask not of themselves, what they ask of their patients.

- And finally, great insight and understanding, particularly of those parts hidden away in our depths, is always deeply disturbing for both patient and therapist and so, there is always a risk, in those difficult moments, for both participants to collude and not go deeper inward. To make contact with truthful realities is always hurtful for the patient and therapist to experience. This is why mutative interpretations can be so difficult for the therapist to speak and for the patient to hear. And so, *truth* can be easily avoided.

There is much more to add to this brief sketch, but hopefully these few points will offer some context as we proceed.

Ego-Rational Listening

So let's return to the two modes of listening to which I've alluded. First, borrowing from the contemporary existential philosopher David Levin (1985, 1988, 1989; Kleinberg-Levin, 2008), is the mode I'll call ego-rational listening. The other mode, I'll call, generative listening. The former, a more common form of listening that offers help; the other, a rarer, more difficult form, a form that, I believe, ultimately offers greater possibilities for healing.

Let me say a little about each:

Ego-rational listening is a child of the enlightenment, of the scientific method given voice to by the Cartesian and Kantian philosophical traditions. It gives primacy to reason, rationality, linearity, logic, cognition. And, implicit in this tradition is the notion that we ourselves, nature, and the world can be known, mastered and controlled. This listening seeks some level of conformity to "objective" truth. The form of listening grounded in this rational method has as its point of departure one's own ego—the bounded, determined, socially constructed and conforming part of the conscious personality. The ego does not comprise the totality of the human being—but only its conscious parts.

Ego-rational listening, then, is the normal, socialized listening of everyday experience. This kind of listening seeks to structure experience as it's taking it in, and it does so in reference to ourselves—what we already know, how we already think about things—We then impose our pre-existing rational structures on our experience. Here, we listen from our point of view, we listen from our attachments to our own experience. And as therapists, this means that "We read our patients in ways that fit that experience" (Casement, 2006, p. 153).

This kind of listening, as I've already suggested, is sharply focused. It looks to find the fine detail, the piece of information, the part that will help me to know, to understand, to be in control of, to possess, to master. It creates an interactive dynamic of a subject seeking to grasp, to structure, and perhaps even dominate the object that it beholds. "And", as Levin (1988, 456) observes, "because it seeks to master and dominate, it doesn't recognize the healing gaze." There is comfort and safety in keeping object as object and seeking information about the object. And, in the interchange between subject and object, authentic connection always remains elusive. What exists is purely formal, intellectual, and perhaps, even clinically septic.

Let's step back for a moment and think about how this may play out in our work. We can even start with our case conferences. How do we listen to and talk about patients there? What's the material that's presented? Where does the participants' attention go?

My own experience is that presenters spend much of their time telling us "about" their patient—they give us facts (demographics, present concern, mental status, relationship history, and so on). We come away knowing lots of facts about the person. The problem is, that knowing facts "about" a person, isn't necessarily knowing the person. It doesn't tell us much about her subjective states, or the meaning of her suffering.

When my students first present cases in seminar with me, they often paint an incredibly detailed clinical picture of the patient. To a person, it's quite thorough and excellent. They report every fact they can remember and the specific sequencing of the patient's life: "… and then this happened when he was eight, and then his mother said this to him, and he did that, then in high school he was hospitalized, and then he was placed on meds...", we can imaging how that goes. At some point in that sequence, I'll stop them and thank them for telling us about the patient, and then ask them if they could, rather than tell us "about" the patient, share a bit of their experience of the patient. Who the patient is? What has their contact beyond the facts revealed to them? The students are usually very happy to comply with my request but what is most typically the case is that they proceed by continuing to tell me more facts about the patient. It's really hard, initially to shift gears. And so, my work with them is to

help them attune to something very different in the patient, AND, more importantly, in themselves.

My point is that information about the patient has very little to do with helping the patient heal. Hopefully, this will become clearer as I continue.

Ego-rational listening is also transactional and instrumental (Ahktar, 2007). By this I mean that this kind of listening hopes to get us somewhere; it intends to help us reach some goal. It has a direction, and there are certain steps one must take in order to get to that place. Think of the word we probably use every day—the word: "progress"—"the forward or onward movement toward a destination". How often do we speak of the patient's "progress"? Getting better. Moving from one place to another--a linear progression. We even refer to our paperwork as "progress notes"--getting somewhere. The notion is ingrained in the very substance of our clinical assumptions and practices. As a field, we've systematized this ego-rational way of listening and thinking.

Thus, when our listening is transactional and instrumental, we are listening from our own will and from our own desire. We want something "of the patient" or "for the patient". We want them to get somewhere, to get better, we want them to make progress. I hear these sentiments expressed often in supervision where the therapist will come in and passionately declare: "if I can only get my patient to _____…" you can fill in the blank. "If I can only get him to…" then all will be well. We can read this sentiment as: "If I can only get more control over my patient, if I can only get them to see things as I see them…." These are desires, well intentioned, to be sure, that start in us, with our egos. The problem is, of course, that, at the end of the day, our instrumentality and desire for our patients closes off our real receptivity. When our gaze is "attracted and moved by desire, it seeks to master and possess" (Levin, 1988, p. 239). It categorizes and objectifies. This kind of listening closes us off to the subjectivity and depth of the patient and it seals off the possibility of them revealing themselves to us more organically, authentically, and completely. The more I want from my patient, the less I invite my patient to approach me.

Finally, ego-rational listening is consciousness oriented. Its focus is more on the words than on the music—the symphony being played between the two of us in the room. It focuses on the story, the narrative, on the "what happened when". Its attention is directed at the events of the patient's life that take place outside the room—the relationships, the emotions generated by those events, the thoughts about those outside relationships. It focuses on the there and then, less so, on the here and now.

As we listen in this way, we hold on to what is communicated to us explicitly, and, because we may be drawn into the explicit and enticing parts of the narrative it may be difficult to step back and listen to the subtext of the communication, the implicit, the relational, in the hear and now.

A listening that focuses on the linearity of words, hears the representation of the patient's reality only to a limited extent. For, "Words are not the best containers or conveyors of emotions and subjective states" (Etezady, 2007, p. 137).

Carl Rogers (1980, p. 13) in his characteristic elegant way of capturing therapeutic experience alludes to this form of listening when he observes:

> But what I really dislike in myself is when I cannot hear the other person because I am so sure in advance of what he is about to say that I don't listen. It is only afterward that I realize that I have heard only what I have already decided he is saying: I have failed really to listen. Or even worse are those times when I can't hear because what he is saying is too threatening, and might even make me change my views or my behavior. Still worse are those times when I catch myself trying to twist his message to make it say what I want him to say, and then hearing only that.

Ego-Rational Mode of Relatedness

As I've already suggested, how we listen also creates the groundwork as to how we relate. And, an ego-rational form of listening does engender a particular kind of relatedness. First, because it is a kind of listening that is goal directed, it often fosters over-activity on the part of both the therapist and patient—because we have to get somewhere, we must hurry to reach a goal. And, as a result, it takes the patient and therapist away from the moment and from their current experiencing.

Second, because the therapist responds primarily to the patient's conscious, manifest communication, the patient attempts to further evoke direct comments and interventions from the therapist. Through this kind of engagement—which is often quite cognitive—left-brain to left-brain—little room is left for unconscious processes and contents--especially the unconscious perceptions of both parties about their relationship. An ego-rational form of relatedness typically leads to rationalized, premature, and often self-revealing interventions (Langs, 1980). It is also very typical in this scenario for the therapist to ask lots of questions, make confrontations, and offer non-neutral interventions.

Let me just address the use of questions here, briefly. My sense is that questions are often quite problematic for listening well. They tend to be disruptive to the patient's turning inward. Questions take the patient away from self, away from felt experience. They usually move the patient from a feeling place to a thinking place, from the immediacy of the moment to one more distanced. Thus they can preempt the patient's experience and shift their attention from their inner space to the surface. By helping the patient stay on the surface of her thoughts, we interfere with the spontaneous flow of material that has yet to be experienced, thought about, and organized. Questions don't allow the patient's associations to coalesce, to accumulate around images, to develop into themes (Langs, 1979). Additionally, Wilfred Bion (2005) notes that "the answer [to any question] is the disease, the misfortune" (p. 8)…It's the hurt, the pain in the patient's life that brings her to treatment. The question is the reason the patient is there in the consulting room. If Bion is right, then we know the answer to our questions before we ask them. Getting some answer to your question from your patient, he says, "is the thing that will put a stop to curiosity better than anything [else]. If any curiosity exists, getting or giving an answer will stop all involved from doing any further thinking" (p. 30).

Third, questions generally don't have empathic components, they don't communicate back to the patient the patient's feeling as apprehended by the therapist. They don't say, "I understand". And, rather than acknowledging and resting in the moment as it is experienced, it asks the patient for something else. The patient must move from where she is now and provide something to the therapist and, in this way, the communication of understanding is missed.

Finally, questions can serve as transitional objects for therapists. That is, they can protect the therapist from deeper emotional contact with the patient and what the patient may reveal in his derivative communication *about* the therapist. While questions may ask for further meaning, they may actually communicate unconsciously the desire not to *really know and experience the patient*. They can function as shields for the therapist and serve as our own defense against contact and intimacy.

We do this, of course, not out of malice or incompetence, but because we're human beings--asking questions is constitutive of everyday relating; we ask people questions in conversation. It's normal. The problem is that therapeutic discoursing isn't necessarily "everyday" discoursing. And, often, we clinicians stay in the everyday mode of discoursing with our patients because, frankly, its easier and feels more natural. We also get into the habit of asking lots of questions because this is what we have been taught: First, that information heals, and second, that patients should have answers to our questions. For example, consider that that primary question we were probably taught in our very first clinical skills course: "And, how does that make you feel?": A clichéd intervention, to be sure. When we work with patients--those who may be cut off or dissociated from their inner lives--their fluctuating affective states--we ask them for an answer to something they may not have access

to, let alone be able to put into words. And so, we put pressure on them to give us something we want or that we think is important. The practical effect here is that the therapist leads the patient, rather than allowing the patient to unfold and reveal him or herself to us as they need or are ready to.

The last thing I want to say about an ego-rational form of relatedness is that it carries with it a particular organizing assumption. That is: it assumes a specific kind of relationship between the patient and therapist—namely, that the patient is the sick member of the therapeutic dyad and that the therapist is quite well (and healed), that we have our countertransferences and characterological distortions in check and that we necessarily relate in healthier ways than they do (Langs, 1980). I'm the healthy one and my patient is the sick one. That does set up a dynamic, doesn't it? And it does put a certain kind of pressure on the patient. It denies both the health in the patient, and the sickness or suffering, if you will, in us. At the end of the day, it seems to me, that the likely reality is that we're more like our patients, than not.

Generative Listening

Let's now turn to Generative Listening.

Generative listening is a listening which is quite unnatural. It is unnatural because it is a listening that isn't just done with our ears. We use our other senses, we use our bodies, and we use, if developed, our implicit, unconscious sensitivities, our intuition, to take in what the other has to offer us. This is not a listening done with a "part of" Self, the outer ears or the ego. It is a listening that is done with the entirety of who we are, the entire Self. The Self, as I use the notion here, is our fluid, ever-evolving, ever growing, ever integrating whole—a structure not grounded in separateness or parts, but of the in-divisible wholeness of who we are (Levin, 1989). Unlike ego-rational listening, which is socially constructed and socially conforming, generative listening, doesn't fit our cognitive, scientific categories very easily, and therefore, it presents quite a challenge to try to capture it through words here. There's certainly an ineffable quality to it. It doesn't lend itself to narrative prose, for it is a listening that attunes itself to the poetry of human experience—the rhythms, syncopations, tones, inflections, that is the human journey. It attunes itself to the movements in the dance. It is the kind of listening that doesn't look for the categories that it knows. Rather, it opens itself to new wholes or gestalts. Here, understanding emerges from below, from the complex patterning of meanings that coalesce organically. Hence, unlike ego-rational listening, it opens itself to the unfolding of meaning, rather than the imposition of meaning from above.

Generative listening is a kind of listening that, by attuning to emotional connotation, has the power of generating, originating, giving birth to, and calling oneself back to one's most authentic center. It is a listening that opens both the listener and the one being heard to a more expansive space of the hearable (Levin, 1989). Rather than being a listening that seeks to grasp our attractions and push away our aversions—to be driven by our attachments—it actually works to let go of them and to allow them to "just be." And, rather than having our ego (only part of self) be the point of origination, this kind of listening happens not because the listener can hear sounds but because the listener has, in the words of the philosopher Martin Buber (1955), "turned toward the other" and has oriented her entire Self toward the meeting and receiving of that other. While this kind of listening sees and hears the linear, categorical, observable, fixed, knowledge bound, cognitive, rational, conscious, explicit, intellectual, left brain, disembodied parts of ourselves, it gives primacy to our implicit, non-linear, non-rational, right-brain, affective, embodied, aesthetic, relational, procedural, symbolic, dynamic, and unconscious side. It attunes itself to the context, the entirety, the wholeness of the other who is encountered.

This is a listening that coalesces in the body, first, in unformulated ways, then as a felt sense. It comes together in the playfulness within our own inner spaces where seeming random feelings and meanings crystalize into heretofore unthought and unspoken truths. It is a kind of listening that is characterized not by

what we commonly think of as "unconditional acceptance" of the other, but one characterized by an "unconditional receptivity" of one human being in her wholeness receiving another, in her wholeness. And, in doing so, it can hear meanings inaudible to others and, often inaudible to the person who is speaking. It can "hear repressed pain, concealed anguish, a suffering that the patient himself cannot yet hear or speak. … [It is the kind of listening] whose very act of listening can enable the other to hear herself, hear the sound…of her own most needs and desires" (Levin, 1989, p. 86). It can "hear the cry of the abandoned child inside the raging adult" (Orange, 2011, p. 65) and it can hear the faint echo of the real person buried underneath the layers of armor.

Generative listening begins with a decision which is lived through an attitude. First, the decision. This decision is one that we make in the stillness of our hearts. It's the decision to put ourselves at risk. It's the decision for uncommon and unnatural devotion. Donald Winnicott (1971/2005) addresses this in terms of the infant-mother dyad. He writes, that, in fact,

> success in infant care depends on the fact of devotion, not on cleverness or intellectual enlightenment.
>
> The good enough mother… starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's ability to deal with her failure [to adapt.] (p. 14)

Just as the good-enough mother with her infant, the good enough therapist makes a similar decision: it is the decision to go through the "unbearable" with a patient and to be willing to see the work through to the end. It's a decision to go through the patient's pain with them, to even feel it, and suffer it; to tolerate the chaos, and to tolerate what Christopher Bollas (1987) refers to as the "counterstansference state of not-knowing-yet-experiencing" (p. 203). That we continue to be unguardedly receptive in spite of the chaos that may surround us and the seeming not knowing and helplessness that we experience.

Being able to tolerate the patient's disruptive inner contents is, I believe, very much at the heart of the healing endeavor. This also means, being able to tolerate the patient's way of being with us—which may be disregulated, primitive, chaotic, rigid and the like.

This is a central component of therapeutic commitment—that we can take the risk of allowing the patient to use us as they need to without becoming what they, transferentially, wish us to be. Winnicott (1965) has written about the child needing to "destroy the object,"—and to be able to find that the "object has survived being destroyed." So too is the case with the therapist and patient. The patient needs to know, experientially, that the therapist can tolerate and manage not only positive affects directed at him, but also the more primitive ones of aggression and rage. Only in this knowledge can patients trust that the therapist will be able to contain them in spite of themselves and that the therapist will neither withdraw nor retaliate in those difficult moments of relational ruptures.

The other piece of devotion, briefly, is being able to see the treatment to its conclusion. I had a patient a number of years ago who had read Irv Yalom's (2009) book, *Staring at the Sun*. In that book, Yalom writes about a patient whom he treated on and off for over thirty years. My patient came in flabbergasted. Is that possible? Can that be possible for us? And when told, "yes, I'm available to you for as long as you need me and for as long as I'm doing this work," she began to engage with me in a profoundly different way. She felt released from the fear of opening up and then having to end. She would say, what if we open something up that I can't control and we can't put it back together? She needed to know that I could see it through with her to the very end.

The attitude that engenders this kind of listening starts with a willingness to surrender—and what do we surrender? We surrender our ego—the one I've briefly described. We find this notion of surrender, certainly in the eastern philosophical and meditative

traditions, but we also find it interspersed throughout the therapeutic literature going as far back as Jung and Freud. Wilfred Bion's (1983) classic dictum that we should approach every encounter with our patient without memory, desire, or understanding summarizes this attitude most succinctly: he suggests that we bring ourselves to these encounters without keeping the memories of what happened last week at the forefront of our mind, without having wants for the patient because these wants—our wants—become imposed on them and may, in fact, seal off their wants and needs, and without our own understanding—what our books have taught us, what our theories say is supposed to happen next, and so on. Bion (2005) says, "forget what you know, forget what you want, get rid of your desires, anticipations, and your memories, so there will be a chance of hearing these faint sounds that are buried in this mass of noise" (p. 17). And somewhere hidden amongst all this debris we can get a glimpse of actual suffering.

And so, with interest and curiosity, we let go of ourselves; we let go of our willfulness, our willing. "By giving up our willing, we actually give ourselves the possibility of being open…[it] prepares us to let-ourselves-in" (Dalle Pezze 2006, p. 109).

Now, this "surrender" this "letting go", has a partner, and we call that, "letting be". "Letting go" and "letting be" go hand in hand. Now I know these phrases are cliché but I think it crucial that we re-appropriate them clinically and work to understand their complexity and power. If I am able to let go of my bounded ego structures, then it would follow that I can also let go those of others, and simply let them be. Letting-be is "neither, cold, nor distant, nor disinterested, nor filled with instrumental calculations" (Levin, 1988, p. 244). Rather, as the existential philosopher, Martin Heidegger (1966), puts it: letting be is an encounter of being-with which cares! Letting be, is, in my words, an profound act of love. It presupposes a response-ability, the ability to respond, to the other who comes forth without needing to master, or dominate, or even change them (Levin, 1988).

Hiedegger (1962) also observes that "it requires a very artful and complicated modification of attitude in order to "hear" a "pure noise" (p. 207). We have to listen in a new way, to hear a new sound (Fallon, 2007). And so this attitude—this way of listening—is not something one learns but is something one cultivates. It is, in a very real sense, a practice—a Practice of the Self (Levin, 1989).

This practice requires, discipline, persistence, courage. Clinically, it must be willing to tolerate long periods of seemingly meaningless communication. It must tolerate ambiguity and disruption, be able to accept those moments when contact is broken, to not panic, recommit to listen some more, and allow meaning and reparation to unfold.

To embody this kind of listening, the therapist must cultivate an attunement to feeling and to the implicit. In our culture we elevate the place of reason and intellection and often see feelings and emotions merely as "confused ideas". The truth is that those feelings and emotions, when properly regulated, are sources of profound wisdom, of a knowledge much sharper and clearer than the ideas we produce by pure cognitive processes (Levin, 1988). And, the deeper meanings of these feelings are communicated implicitly, often symbolically, and unconsciously.

For us to be able to listen generatively, we must bring ourselves to a place of mindful relaxation—to reduce our tensions, lessen our grip on identity, success, goal achievement, and the like. And, as we do so, we begin to create the possibilities for "unfettered play"—playing with what comes up in our inner spaces, what emerges in the inner spaces of the patient, and what's created between the two of us. And in "play," we "just are" and we allow the other to "just be."

Generative Mode of Relatedness

Practically speaking then, the primary intervention organically emerging from a generative listening stance, is silence. Obviously, if we spend our time speaking, we're not listening. Silence is the ground for primordial emergence. Silence gently reveals inner stillness. The graceful silent gaze mirrors, it echoes back to the

patient the depth of their feeling and our participation in it; the silent gaze holds and contains. It invites the patient to begin to relinquish the defenses of everyday conversation—the back and forth—and invites them to go on, to go deeper. Heidegger (1962) observes further, that "keeping silent authentically is possible only in genuine discoursing" (p. 208). To be able to be silent, the authentic being must have something to say. It must have at its disposal, an authentic and rich awareness of its own depths. As Levin reminds us, "Silence is our listening openness, in order to hear something, we must first give it our silence" (Levin, 1989, p. 232)

If this is the case, then it follows that questions, challenges, clarifications, probings, have little place in this form of relatedness. When the therapist does speak she simply offers back to the patient his own being. Let me again quote Heidegger (in Levin, 1989), "The authentic greeting accords to the one being greeted the resonance of his own most being." Let me say that again: "The authentic greeting accords to the one being greeted the resonance of his own most being." He continues that: "this authentic greeting allows the one being greeted to shine in their own light in such a way that that person may no longer need to hold on to a false way of being" (p. 85). We greet the other, make contact with them, hear them, and offer them back their own deep essence. And as we do this, we offer them ourselves. And, in this powerful dialectic, healing transpires.

Generative listening is difficult and rare and is cultivated over a lifetime. It requires opening up one's heart and one's mind and taking in whatever the other offers us. It requires not being in a hurry to interrupt so as to understand, to question, or to rush to explain (Ahktar, 2007). It requires a mindful attitude toward the wholeness of the human being, not her symptom, her depression, her aggression, her resistance. We develop this listening, through increased awareness of ourselves and the appreciation of our interrelatedness with the person sitting across from us. Ultimately, we develop this gift of listening, as a practice of compassion (Levin, 1989) and it can only be done through a spirit of humility and gratitude.

Conclusion

Let me end with an observation made by the Swiss psychiatrist Medard Boss (1979) who describes this listening stance as one of "joyous serenity". He writes that this

> joyous serenity can give human existence the kind of receptivity that allows it to see in the brightest light the meaningfulness and connections of every phenomenon that reveals itself. Such serenity is a clearness and openness in which a human being is emotionally connected to everything he meets, wanting not to have things in his own power but content to let them be and develop on their own. Because this composed, joyous serenity opens a human being to the broadest possible responsiveness, it constitutes… [the grounding for] the happy life as well. (p. 112)

And so, with that, I thank you for your very kind attention and I wish for you a "joyous serenity" in your listening. Thank you.

References

Ahktar, S. (2007). The 'listening cure': An overview. In S. Ahktar (Ed.) *Listening to others: Developmental and clinical aspects of empathy and attunement* (pp 1-16). Lahnam: Jason Aronson.

Bion, W. (1983). *Attention and interpretation.* Northvale: Aronson.

Bion, W. (2005). *The Tavistock lectures.* London: Karnac.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* New York: Columbia University Press.

Boss, M. (1979). *Existential foundations for medicine and psychology.* New York: Jason Aronson.

Buber, M. (1955). *Between man and man.* Boston: Beacon Press.

Casement, P. (2006). *Learning from life: Becoming a psychoanalyst.* London: Routledge.

Dalle Pezze, B. (2006). Heidegger on gelassenheit. *Minerva--An internet Journal of Philosophy, 10,* 94-122.

Etezady, M. H. (2007). Relatedness and listening. In S. Ahktar (Ed.) *Listening to others: Developmental and clinical aspects of empathy and attunement* (pp 127-144). Lahnam: Jason Aronson.

Fallon, T. (2007). Listening to the child within. In S. Ahktar (Ed.) *Listening to others: Developmental and clinical aspects of empathy and attunement* (pp 77-92). Lahnam: Jason Aronson.

Friedman, M. (1985). *The healing dialogue in psychotherapy.* New York: Jason Aaronson.

Heidegger, M. (1962). *Being and time.* New York: Harper & Row.

Heidegger, M. (1966). *Discourse on thinking.* New York: Harper & Row.

Klienberg-Levin, D. (2008). *Before the voice of reason: Echoes of responsibility in Merleau-Ponty's ecology and Levinas's ethics.* Albany: SUNY Press.

Langs, R. (1979). *The therapeutic environment.* New York: Jason Aronson.

Langs, R. (1980). *Interactions: The realm of transference and countertransference.* New York: Jason Aronson.

Levin, D. (1985). *The body's recollection of being: Phenomenological psychology and the deconstruction of nihilism.* New York: Routledge.

Levin, D. (1988). *The opening of vision: Nihilism and the post-modern situation.* New York: Routledge.

Levin, D. (1989). *The listening self: Personal growth, social change, and the closure of metaphysics.* London: Routledge.

McGilchrist, I. (2009). *The master and his emissary: The divided brain and the making of the western world.* New Haven: Yale University Press.

Orange, D. (2011). *The suffering stranger: Hermeneutics for everyday practice.* New York: Routledge.

Rogers, C. (1980). *A way of being.* Boston: Houghton Mifflin.

Winnicott, D. (1965). *The maturational process and the facilitative environment.* New York: International Universities Press.

Winnicott, D. (1971/2005). *Playing with reality.* London: Routledge.

Yalom, I. (2009). *Staring at the sun: Overcoming the terror of death.* San Francisco: Jossey-Bass.