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Bion's therapeutic applications

Gavin Ivey *

Wilfred Bion is regarded as a psychoanalytic purist and his austere portrayal of the analytic aim and attitude is often considered to make impossible demands on patient and analyst alike. Not surprisingly, the applicability of Bion's theory and recommended practice to once-weekly psychotherapeutic work is often questioned. Bion is thus ambivalently regarded by psychotherapists as the embodiment of an analytic ideal, whose developmental theories are important, but whose practical utility is doubted, especially in the context of the typical therapeutic setting. This paper seeks to challenge these assumptions by presenting the once-weekly therapy of a woman with attenuated mentalizing capacity and a tendency to destructive acting out. The therapy was guided by the application of central concepts, models and 'technical' principles emerging from my understanding of Bion's work. The aim of the paper is to demonstrate that Bion's utility is not confined to formal psychoanalytic settings and that his work may be usefully applied in more modest psychotherapy contexts.

Introduction

What use is Bion to psychotherapists? This is not a rhetorical question and it certainly does not presume a positive answer. Bion's conceptualization of psychoanalysis continues to be controversial and poses significant theoretical and technical challenges to psychoanalytic practitioners. If this is true for analysts working within the traditional analytic setting, it is even more so for psychotherapists, many of whom lack formal psychoanalytic training and see patients once or twice weekly. What use is Bion in this context?

In my work as an individual adult psychotherapist, Bion's presence as an increasingly internalized object has significantly influenced my therapeutic approach. This paper was prompted by putting the question, 'What use is Bion?' to myself and seeing what answer evolved. I don't presume to say what use Bion may be to anyone else. Not only are there divergent interpretations of his work and its clinical relevance, but there are also no 'Bionians' to tell us how to interpret and use him. Anyone who invokes Bion in order to tell us how to think and act as therapists betrays Bion's radical individualism and insistence that we

* Email: **Gavin.Ivey@vu.edu.au**

think for ourselves and find our own way as psychoanalytic practitioners. He once wrote, 'The way that I do analysis is of no importance to anybody excepting myself, but it may give you some idea of how you do analysis, and that is important' (Bion, 1994, p. 206). It is in this spirit that I want to reflect on Bion's application in my own psychotherapy work and invite others to think about his possible relevance to theirs.

The method I will use is to provide a few detailed vignettes from a two-year-long, once-weekly therapy with a female patient, illustrating how the therapeutic interaction evoked and animated concepts central to Bion's psychoanalytic theory. 'Cathy' was a well-educated professional, living with her female partner. She described herself as being 'depressed', not 'feeling myself', and lacking in motivation. She was irritable and prone to aggressive outbursts and her abuse of alcohol and recreational drugs was interfering with her work life.

She associated these problems with 'something missing', and with heavy irony referred to 'a hole in me so big that the wind blows through it'. The precipitant was the sudden death of her idealized mother some years earlier from a brain embolism. Her response to this loss was dramatic. She describes becoming 'hysterical and breaking things'. Subsequently, she appears to have become hypomanic and, in her words, 'very promiscuous and out there'.

Cathy had a gruff, no-nonsense manner and spoke proudly about her 'masculine energy' and the status accompanying this in her social circle. She was able to 'outdrink most men' and these binges were accompanied by drug use, 'laddish' exhibitionism and sexual encounters with other women. These encounters took a sado-masochistic form, with Cathy always the one in control. While appreciative of her more stable and quiet partner's qualities, Cathy found herself resenting their 'white picket fence existence' and her sense that they were becoming like 'an old married couple'. She had been in therapy briefly before, which she ended because it was 'unstructured and the therapist just sat and looked at me, instead of showing her expertise'.

It is early on in our therapy. Cathy slouches into my room, chewing gum. She sits in the chair opposite me, a strongly built, tattooed figure. Her leg jerks impatiently and the metal studs on her boot rattle against the delicate French polish of the armchair. From the start the therapeutic setting has presented her with difficulties. She refuses the invitation to begin the session by saying whatever comes to mind. Instead, she looks impatiently at her watch, irritably twitching her foot. The tension mounts.

Minutes pass and the atmosphere begins to feel unendurable. In exasperation she breaks the silence: 'What do you want me to talk about? I don't have anything to say'. Each session begins in this same tense atmosphere, which feels like a battle of wills. In a previous session she agreed with my suggestion that what was happening between us was some sort of power play revolving around who spoke first, but this failed to make any difference or generate any fresh material. What is she saying to me? What am I to say to her?

Listening vertexes and selected facts

The most significant impact of Bion on my own work is in terms of how I listen to what is happening in each session and how I go about making sense of this. Every event may be interpreted from a multiplicity of perspectives, or vertexes, as Bion (1965) calls them. The term vertex, however, is not quite synonymous with perspective or 'point of view', because these terms delimit the understandings we arrive at to a visual modality. Psychoanalysis, by virtue of its focus on unconscious psychic life, is by definition the science (or art) of the un-obvious. For this reason I try to observe and listen to the patient's expressions with multiple meanings in mind, actively proliferating the interpretive possibilities, rather than assuming any one meaning to be obvious.

The patient associates her symptoms to 'something missing'. What is missing? Perhaps her hypermasculinity is a defence against the acknowledgement of a missing penis. Perhaps what is missing is a good internal object that her idealized mother was a substitute for. Perhaps it is an internal capacity to contain and process difficult feelings that is missing; or possibly an expert mother-therapist who demonstrates an ability to do something for her that her baby-self is yet incapable of. You will notice that each of these interpretive possibilities or vertexes reflects a particular psychoanalytic paradigm – and we needn't only restrict ourselves to those mentioned. Which is correct? Perhaps all of them, but a more important question is which vertex best corresponds to the patient's unconscious state of mind at any particular moment in time.

I remind myself that anything that appears obvious is an indication that my mind is saturated, instead of open to absorbing other possibilities. Maintaining multiple vertexes against the therapist's need for security, the need to know – or the patient's need for us to be knowing – requires discipline and a willingness to tolerate painful states of uncertainty on behalf of the therapeutic couple.

However, these co-existing meaning possibilities are not endless and don't all exert an equal gravity on the therapist. At some point discrete pieces of information, impressions, and thoughts about one's experience of the patient start to coalesce and concentrate into an emotionally compelling meaning, the nucleus of what will become a verbal interpretation. Other interpretive possibilities are momentarily eclipsed by a clarity of understanding that feels truthful. Bion (1962) referred to this understanding as a selected fact. At this point we can say to ourselves: 'Whatever I didn't know about my patient before, there is something significantly and inescapably true that I know about her now'. This is not an intellectual construction and is thus distinguished from an 'overvalued idea' (Britton & Steiner, 1994). Rather, it is announced by an emotional quickening in the therapist, a sense of apprehension, relief, or wonder.

We return now to the session. I note the commingling of fear and hostility, Cathy's tattoos, her strong frame, her mounting irritation and the thud of her boot studs on my chair, a dryness in my throat and pressure in my chest, her refusal to freely associate. She wears a vest, exposing her muscular arms. I suspect she is

physically stronger than me. I remember her relating how she hated being a little girl and how she had terminated treatment with her inexpert previous therapist. I feel she doubts whatever expertise I have as well.

I say to Cathy that there is something about my invitation to just say what comes to mind that brings out fear and hostility. She replies that what comes to mind are things so irrelevant and mundane that they could not be of value. 'It's like talking about domestic trivia, like shopping lists: peas, carrots, toilet paper. You know, it's like the mindless things that *housewives* talk about, swapping recipes and shit. Surely therapy can't be about *that*'. She adds that she regards this kind of feminine conversation with contempt, and says that her communication style is 'masculine – I only talk if I've got something to say'.

Hearing the sarcasm and dismissive tone in her words has alerted me to my own irritation. I frequently make the kind of shopping lists she describes, and my enjoyment of cooking often finds me swapping recipes with people, mainly women, in my social circle. I recall her irritation at her partner, described as more feminine than Cathy, who asks her about her day when she returns home. I suddenly have an image of myself as a dowdy housewife in a small dingy kitchen. I am tentatively trying to start a conversation with a surly and incommunicative husband who has just returned home from his important work and merely wants to drink beer and read his newspaper. With this fantasy my own tension dissipates and I suddenly understand what is happening between us.

Bion's analytic attitude and its implications for therapeutic listening

What allows or facilitates the emergence of a selected fact? The first precondition is a listening stance or cultivated state of mind that, for Bion, defines the analytic attitude. Bion (1992) depicted this state of mind negatively, in terms of what therapists have to give up, rather than what they have to acquire.

He exhorts us to abandon all understanding, memory, and desire. This unusually definite pronouncement sounds more like an injunction than a recommendation. Why is Bion so insistent about something so apparently counterintuitive and controversial? His rationale is simple and premised on a single psychoanalytic aim: to pursue what is unknown about the patient at all times. The focus, Bion says, should thus be on 'the unknown personality and not what the analysand or analyst thinks he knows' (1970, p. 87).

If one accepts this premise, then Bion's interpretation of the analytic attitude follows logically. Memory, understanding and desire direct us to who we knew the patient to be in the past (our memory of her), who our preconceived ideas and theoretical models suggest she is (our understanding of her), and who we want her to be in terms of our countertransference wishes (our desire of her). What is consequently occluded is the truth of who the patient *really* is in the present, i.e. her unknown personality.

I think that there is more than a touch of hyperbole in Bion's statement. However much we attempt to empty our minds of preconceived meanings and

assumptions, this is impossible to accomplish. As the philosopher Gadamer (1997) argued, understanding arises from the modification of our pre-existing cultural, personal, and theoretical interpretations of the world, rather than the substitution of correct for incorrect understandings.

When Bion advocates abandoning understanding, I read this to mean, as far as is possible, *suspending* our theoretical or taken-for-granted interpretations about what is happening in a session in order to allow for unexpected understandings to emerge. No analyst has ever been as suspicious of psychoanalytic knowing as Bion was, and so invested in finding an antidote to it. Hence the following statement:

I want you to join me and try to achieve the same depths of ignorance I have managed to reach, to get back to a frame of mind which as nearly as possible is denuded of preconceptions, theories, and so forth (Bion, 1976, p. 307).

You will note that this state of ‘highly polished ignorance’ (Caper, 2001) complements the notion of generating multiple vertexes mentioned earlier. Actively entertaining other possibilities helps us to keep our cherished theoretical prejudices at bay.

Regarding the issue of memory, suspension of remembering, rather than the banishment of memories, also seems more applicable to Bion's caution against recalling the patient's history and session details. Thus he notes that ‘A bad memory is not enough: what is ordinarily called forgetting is as bad as remembering. It is necessary to inhibit dwelling on memories and desires’ (Bion, 1970, p. 41). The word ‘dwelling’ is important here. The spontaneous recall of something in a session is therapeutically significant, but this is only made possible by not intentionally trying to remember information about the patient. Contributing to my evolving experience of Cathy in the session is the consciously unbidden emergence of discrete memories that are relevant to our interaction precisely because I do not try to remember them.

As far as desire is concerned, we cannot, I think, abandon all desire in relation to our patients for three reasons.

First, because this would make indifference the optimal mode of therapeutic relating, which obviously it is not. We must want something for our patients and from our relationship with them to stay interested in them.

Second, no matter how well analysed we may be, our own unconscious wishes and conflicts will be activated by the patient's relationship with us and influence our feelings toward her.

Third, by noting and observing whatever desire spontaneously arises in us as we sit in session we may be alerted to the patient's unconscious attempt to communicate with us by inducing certain fantasies, action tendencies or emotional responses.

Joseph Sandler (1992, p. 196) calls this ‘free-floating responsiveness’, and cautions that any attempts by the analyst to restrict this ‘by consciously banishing anything from his mind’ is counteranalytic. Such responsiveness would presumably include spontaneously emerging desires, but these should be the

product of the specific analytic interaction, rather than any pre-existing and pressing counteranalytic need or conflict that the therapist may have.

The most common counteranalytic desires that regularly emerge in both trainee and experienced therapists are to cure the patient of her suffering, to change the patient's 'dysfunctional' attitudes or behaviours, to alleviate the therapist's anxieties, and to get the patient to view the therapist in a positive light. These and the other counteranalytic desires we are prey to reliably interfere with the desired state of floating emotional responsiveness. For this reason Bion (1990) retains Freud's original definition of countertransference and insists that the therapist cannot use his countertransference precisely because he is emotionally invested in remaining unaware of it.

However, we can use our emotional reactions to the extent that they become evident to us. My anxiety and irritation, my wish that my patient would stop 'attacking' the chair and the therapeutic setting, that she would be more open and less disparaging, all of these feelings and wishes construct me as a particular kind of figure in relation to her. They are thus analytic instruments rather than mere countertransference reactions, and I will get back to them in a moment.

Projective identification, reverie and containment

The aspects of the analytic attitude mentioned above constitute the first precondition for the therapist's recognition of the selected fact. The second, which both refers to and justifies the therapist's emotional responsiveness, arises from Bion's (1962) famous 'interpersonalization' of Melanie Klein's concept of projective identification. Patients' projections into us are variously motivated, but invariably serve to communicate specific transference phantasies and experiences that the patient cannot think about and emotionally process. Their communicative potency inheres in the fact that the projective phantasies are accompanied by specific behaviours that have an affective impact on the therapist. The therapist is emotionally enlisted into an interpersonal dramatization of the patient's internal world, and hence the transference, by virtue of the pressure on him or her to realize the patient's projections.

It can thus be seen how Cathy's contempt for the analytic setting, her intimidating body-language and her derogatory feminization of me elicits feelings and images consistent with her phantasies. I momentarily feel like a boring housewife, anxiously and unsuccessfully attempting to engage a dismissive husband, with nothing to offer him but my mundane feminine domesticity.

Luzuriaga (2000, p. 148) makes an important point when she states that while Bion's theories are substantially based on Klein's projective mechanisms, Bion insists that we 'live them emotionally' by allowing ourselves to be penetrated by the patient's mental contents. The therapeutic utility of projective identification relies on what the therapist does with the projections internally, and how he or she subsequently engages with the patient. For this reason, the concepts of containment and reverie are therapeutic corollaries of projective identification.

This conceptual triad, based on Bion's developmental model of how thinking arises, has profoundly changed our understanding of the therapeutic process and the therapist's role in facilitating change in the patient.

The patient has the phantasy that some distressing experience or part of herself that she cannot tolerate and give meaning to is extruded and located in us. Ideally, instead of evacuating the projected content or reacting to alleviate the corresponding distress, we do something else: we suffer the experience induced in us and gradually give meaning to it in the context of our interaction with the patient.

The contained projections are transformed in the refinery of the therapist's mind through the process of being tolerated, symbolized, and thought about. This process is what Bion (1962) calls reverie, an evocative term that highlights its dreamlike aspects and distinguishes it from the rational work of formulating explanations.

The dreamlike quality of reverie is evident in its pictographic manifestation and chains of personal associations triggered in the therapist's mind. In this session the vivid and spontaneous image I have of myself as a housewife, together with the related thoughts of my 'domestic' activities, allow me to identify my experience as reverie, rather than the wanderings of a distracted mind. Although fleeting, it was this reverie that 'gathered' all my preceding impressions, memories and feelings into a compelling revelation of what was happening between us.

While the patient may observe that the disturbance induced by her behaviour has been tolerated and modified, the therapist's verbal interpretation of what has happened is probably necessary for her to acknowledge and retrieve the projected, but now significantly transformed, part of herself. This requires the patient's recognition of some previously unconscious reality and the realization that the therapist is indeed separate from her.

Interpretation as an expression of emotional truth

Bion was convinced that every therapy session must be a personal encounter with an evolving psychic truth, and that this can never occur through the formulaic application of any psychoanalytic theory or technique, including his own. The verbal interpretation, which should be the culmination of the containing process, rather than a substitute for it, involves a statement of this intersubjectively derived truth. When I felt I understood what had happened in the session, and after my emotional arousal had subsided, I said to Cathy that if she just reported what was on her mind it would feel like giving up control, which she associated with a highly-valued masculine identity. This was threatening because it meant contacting a more vulnerable and feminine side of herself, which she despised and refused to own. I added that she was relating to me as the 'housewife' embodiment of these feminine qualities. She responded that this was probably true, although it made her feel very uncomfortable.

Much has been said about the mystical aspects of Bion's notion of truth. I personally don't find this clinically useful. Rather, what I find essentially important is Bion's (1992) claim that a personal encounter with the truth of one's emotional life is a precondition for positive psychic growth. While truthful encounters may occur in a variety of contexts, the analytic setting and attitude is purposefully designed to facilitate such encounters, the therapist's countertransference notwithstanding. I think that truth in this context is neither more nor less than the emotional reality of what is happening both internally and interpersonally at any given point in time. In the psychotherapy context this is merely another way of designating the selected fact.

While different theoretical constructions of our interaction are possible, what was true became vividly evident in my emotional responsiveness and reverie. For Cathy, 'giving in' to my invitation to freely associate would mean surrendering her defensive masculine identity and becoming a 'housewife', a degraded image of feminine weakness and worthlessness. Instead, she split this off and projected it into me, making me and my analytic attitude the embodiment of her despised femininity.

While this understanding conforms to a number of psychoanalytic models, it was not the product of any psychoanalytic theory. I can retrospectively summon evidence from Cathy's history and relationships to support my claim that this understanding was plausible, but its truth status in the session was emotionally immediate and not rationally constructed.

In subsequent sessions she would recall that her parents had intended to give her a boy's name prior to her birth and that, as a little girl, she had inserted objects into her underwear, refusing to accept the fact that she did not have a penis. We might construe this as further evidence of penis envy and suggest that a castration complex lay behind her refusal to submit to her male therapist by free associating and thus 'opening herself' to phallic interpretive penetration. While possibly accurate, this theoretically based understanding is not true in the way a selected fact is true: it does not capture the lived emotional experience of the analytic pair at this particular session moment

and hence cannot be used for psychological work (Ogden, 2003).

Perhaps the biggest error we commit is to make theoretical interpretations, rather than enduring the persecutory experience of ignorance and uncertainty that is typically a prerequisite for the emergence of a true understanding.

Two further qualities of such true understandings deserve mentioning. First, such truths are discovered in the therapeutic interaction and are not the therapist's creation. Any attempt by the therapist to produce true understanding will interfere with its discovery.

Second, a true understanding that pertains to the patient at one point in time might not be true of the same patient at another, even if the patient's behaviour appears to be similar or even identical. This dynamic status of truth is behind Bion's claim that the patient we saw last session is not the same patient we meet in the next. Recalling the patient from last session interferes with the reality, and hence the truth, of who she is in this session. To illustrate, Cathy comes to a subsequent appointment and behaves as she did in the one reported. She complains about having to start the session and says that she has nothing to say. What is happening here? Has our work not softened her resistance? Was my interpretation not sufficiently clear? Do I need to repeat it? I catch myself and keep quiet, waiting to see who today's Cathy is.

With implicit reference to some recent dramatic and self-destructive sexual behaviour she says she has nothing to talk about because she has been 'responsible and now nothing is wrong'. The responsible Cathy present today feels empty and impossible to connect with; while I'm left thinking about the disruption of our contact she stares vacantly out of the window.

It occurs to me that the dramatically disruptive part of her, which she presents as the problem, is actually a decoy, while the really problematic part is the responsible, empty, and incommunicative Cathy here today. I present this to her and she becomes interested, saying that she is addicted to the drama because it makes life exciting. I suggest that it would be useful to find out more about this responsible self that her dramatic character protects her from. She scowls and says this would be a complete waste of time. After a few minutes silence, which feel less resistant, she says, 'I really should think about things more. But it's like rooms in my mind that I can't get into. I can't make links or connections between ideas. It's like everything is covered in oil – nothing sticks or penetrates'.

This interaction reveals that at this moment it is not her split-off femininity that makes her resistant to free association, but rather some difficulty with the activity of thinking itself.

Thinking and its difficulties

The question of what thinking means and requires of us is Bion's most significant contribution to psychoanalysis. Freud was concerned with the nature, origin, and fate of thoughts that were rendered unthinkable because of the anxiety they evoked in the thinker. Klein was concerned with how thoughts attached to parts of the self were split-off and located outside of the self, and the result of this for the thinker's internal world.

Bion's life project, however, was to understand how thinking comes about, its role in psychic development, and how difficult it is to sustain in the face of painful realities. It is this enquiry into thinking – or the refusal to think – as a means of engaging with, or disengaging from, psychic reality, that is the key to understanding how the various aspects of Bion's work fit together.

Bion argued that thinking is never distinct from feeling and is neither the simple consequence of neurological development, nor an individual achievement. His theory of thinking can be summarized in six related postulates: (1) thinking evolves to contain and transform painful feelings; (2)

it requires a capacity to tolerate the painful awareness of a reality that does not conform to our wishes; (3) it is an intersubjective accomplishment initially dependent on

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another's containing mind; (4) it is driven not simply by the need to adapt to reality, but by the need to know the truth about oneself; (5), it exists in constant tension with the counterposing desire to avoid thinking through various defensive measures; and (6) the ability and willingness to think about our feelings is a hallmark of psychological health.

I will not discuss Bion's theory of thinking in general, but rather use this case study to refer to some significant therapeutic implications of it. In the previously reported session, Cathy refused to free associate because this threatened her defensive masculinity. She coped with the threat by making her split-off femininity my problem via projective identification. However, in this session she cannot free associate because her ability to think is compromised.

Bion was primarily interested in psychotic patients who hated reality so much that they attacked the ego capacities that made them aware of it. However, it is useful to consider that *thinking itself*, rather than the problem posed by *specific thoughts*, is a common problem with a wide variety of patients whose personalities are not dominated by psychotic aspects. In this session Cathy is initially thoughtless, her mind defensively vacant, a state Bion calls –K (avoidance of knowing one's emotional reality).

I have to think on behalf of both of us and do what she cannot do at this moment; I link two contradictory experiences of her and suggest how the one may be defending her from the other. She experiences this as momentarily useful and starts articulating her 'addiction to drama' – a shift from –K to K, but again becomes defensive when I invite her to explore what the drama protects her from. This is temporary, though, and she then uses my communicated thoughts about her to make a very astute self-interpretation: she wants to think but is aware that something interferes with her ability to 'make links or connections between ideas'.

You will appreciate the paradox: Cathy, starting to search for the truth about herself in the session, thoughtfully comments on her compromised ability to think. Her self-reflective observation captures an important therapeutic transition. She has never before been concerned with her inability to think but, instead, has resorted to drugs, alcohol, risky sex and 'drama' to escape the pain that needs to be endured if it is to be thought about.

I have deliberately not mentioned historical details about the developmental context of Cathy's difficulties as these would suggest a historical explanatory focus that detracts from the here-and-now focus of the therapeutic interaction. However, an impaired maternal container can be inferred from Cathy saying, 'I grew up sorting out problems in my head – feelings weren't really spoken about or processed. I was emotionally mute, a bit of a quadriplegic'. I should say, though, that the mother Cathy idealized at the beginning of treatment, changed significantly as Cathy began to reappraise their relationship, recalling incidents that were realistically disturbing and sinister.

Our therapy and its containing function helped her to tolerate the mental pain and over the months her drug use ceased, her alcohol abuse and aggressive

reactivity decreased, and she gradually lost interest in the sexualized dramas that were previously needed to make her feel alive. Did tolerating mental pain help her to think, or did thinking help her to tolerate mental pain? Both are true. The containing function of our therapy made her mental pain more tolerable and thus thinkable, while thinking about it strengthened her precarious internal containing function.

From this vertex it is the process of thinking rather than the repressed thought content that is the focus of the therapist's attention. Does the container-contained model then also imply that the goals of psychoanalytic treatment are different from those suggested by classical psychoanalysis? Ogden (2009a) suggests this explicitly: 'Thus, the goal of the psychoanalytic process is not that of helping the patient resolve unconscious conflict (or any other emotional problem); rather, the aim of psychoanalysis is to help the patient develop his own capacity for thinking and feeling his experience' (p. 103).

This certainly echoes the popular trend toward mentalization-based treatment, where mentalization is not understood in the narrow sense but in terms of

A general class of mental operations, including representation and symbolization, which ... lead to a transformation and elaboration of drive-affect experiences into increasingly organised mental phenomena and structures (Lecours & Bouchard, 1997, p. 858).

In these terms the aim of psychoanalytic treatment is to transform intolerable internal happenings – that can only be obliterated, evacuated, acted out or somatized – into experiences that may be represented, symbolized, and thought about. While compromised mentalization, or the inability to think about feeling, tends to generally characterize certain psychological disorders, poorly mentalized pockets of experience emerge in every psychotherapy patient. The therapeutic goal with all patients, therefore, would be to strengthen their containing function, thereby increasing their ability to tolerate and mentally metabolize painful feeling.

However, I think that Ogden's claim over-emphasizes what is discontinuous in pre- and post-Bion psychoanalysis, rather than preserving the continuity-discontinuity paradox or caesura that is integral to both Bion's psychoanalytic approach and the psychic reality it is concerned with. Bion (1965) states that the psychoanalyst 'tries to help the patient to transform that part of an emotional experience of which he is unconscious into an emotional experience of which he is conscious' (p. 32). This classical psychoanalytic goal thus co-exists with the goal Ogden identifies. Was Cathy's therapy about strengthening her capacity to think about feeling or was it about introducing her to unconscious experience and helping her to work through its associated conflicts? Of course, it was both.

Towards the end of our therapy Cathy begins a session in silence again. She looks at me and protests that she is not thinking of anything relevant, just a film she saw recently. I smile, which she takes as a challenge and proceeds to tell me about the film directed by Steven Shainberg (2006), in order to illustrate the irrelevance

of such thoughts. The story, based on the life of American photographer Diane Arbus, concerns a woman whose comfortable middle-class existence masks her passionless marriage and arrested creativity. She meets a strange neighbour, who lives in the apartment above and suffers from hypertrichosis. While initially disturbed by him, her unfolding and emotionally charged relationship with this enigmatic 'hairy man' challenges her taken-for-granted assumptions about life and unblocks her creative vitality. Cathy's tears and her understanding of the symbolism arrive simultaneously at this point in her narrative. This moment captures the compressed history of our therapy and what Cathy has accomplished. No interpretation is necessary.

Conclusion

I realize that I have not addressed the obstacles to Bion's applications in the limiting context of the therapeutic setting. In fact, these are consistent with the general obstacles of working analytically while seeing patients face-to-face once or twice weekly. In summary, this setting restricts the amount of unconscious data that we have to draw on, makes transference-countertransference phenomena harder to detect, is not properly conducive to reverie, and puts pressure on us to address the conscious issues and life difficulties that preoccupy our patients. However, as I hope this paper illustrates, we can productively draw on key elements of Bion's analytic approach, despite the limitations of the setting.

Finally, while I have emphasized certain aspects of Bion's work that I've found helpful, other therapists may well emphasize different aspects. Perhaps the one thing that really matters in this regard is that we appropriate Bion in a critical, thoughtful, and personal way that vitalizes our work, rather than merely adopting his theories and language because of his idealized transference status in the psychoanalytic world. In the last paper he wrote, 'Making the best out of a bad job', what Bion said about Freud applies equally to Bion himself: 'Will psycho-analysts study the living mind or is the authority of Freud to be used as a deterrent, a barrier to studying people? The revolutionary becomes respectable – a barrier against revolution' (Bion, 1994 [1979], p. 331).

References

- Bion, W.R. (1962) *Learning from experience* ed. , New York: Basic Books
[→]
Bion, W.R. (1965) *Transformations* ed. , London: Heinemann Medical
Books [→]
Bion, W.R. (1970) *Attention and interpretation* ed. , London: Tavistock
Publications [→]
Bion, W.R. (1990) *Brazilian lectures* ed. , London: Karnac Books
Bion, W.R. (1994 [1976]) *Evidence Clinical seminars and other works* ed. ,
London: Karnac Books
Bion, W.R. (1994 [1979]) *Making the best of a bad job Clinical seminars
and other works* ed. , London: Karnac Books
Bion, W.R. (1992) *Cogitations* ed. , London: Karnac Books
Britton, R. Steiner, J. (1994) Interpretation: Selected fact or overvalued idea
International Journal of Psychoanalysis 75:1069-1078 [→]

- Caper , R. (2001) The goals of clinical psychoanalysis: Notes on interpretation and psychological development *Psychoanalytic Quarterly* 70:99-116 [\[→\]](#)
- Gadamer , H.-G. (1997) *Truth and method* 2nd revised ed. ed. , New York: Continuum
- Lecours , S. Bouchard , M.-A. (1997) Dimensions of mentalisation: Outlining levels of psychic transformation *International Journal of Psychoanalysis* 78:855-875 [\[→\]](#)
- Luzuriaga , I. (2000) Thinking aloud about technique *W.R. Bion: Between past and future* ed. Bion Talamo , P. Borgogno , F.Merciai , S.A.London & New York: Karnac Books
- Ogden , T. (2009) Bion's four principles of mental functioning *Rediscovering psychoanalysis: Thinking and dreaming, learning and forgetting* ed. , London & New York: Routledge [\[→\]](#)
- Ogden , T.H. (2003) What's true and whose idea was it? *International Journal of Psychoanalysis* 84:593-606 [\[→\]](#)
- Ogden , T.H. (2009a) *Rediscovering psychoanalysis: Thinking and learning and forgetting* ed. , London and New York: Routledge [\[→\]](#)
- Sandler , J. (1992) Reflections on developments in the theory of psychoanalytic technique *International Journal of Psychoanalysis* 73:189-198 [\[→\]](#)
- Shainberg , S. (2006) *Fur* ed. , Edinburgh, Scotland: Picturehouse Studio

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