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Working with patients with disruptions in symbolic capacity[1]

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Abstract: This article focuses on understanding and working with patients who have poorly developed symbolic capacity, or for whom symbolic capacity has been disrupted due to trauma, particularly as it pertains to the use of reverie and interpretation in the analytic process. Many patients who present for Jungian analysis will initially present with deficits in symbolic functioning. This situation results in necessary limitations or modifications in utilizing traditional Jungian techniques such as dream analysis, active imagination, sand tray and other expressive art techniques. The initial phase of analytic work with these patients requires a focus on developing their symbolic capacity before traditional Jungian techniques can be utilized effectively. During the paper Jung's concept of 'the symbolic attitude' will be examined as well as the conceptual models of Wilfred Bion and other post-Bionians who outline theories and method for cultivating symbolic capacity and reflective functioning in patients for whom these capacities are impaired or poorly developed.

Keywords: Jung, Bion, concrete thinking, interpretation, symbolic capacity, symbolic attitude, reverie, reflective function

Introduction

Symbolic capacity is at the very core of C.G. Jung's analytical psychology. The ability to relate to myth, image, symbol and the imaginal realm are all dependent on the notion of symbolization and the patient's symbolic capacity indicates the psyche is mythopoetic, meaning that the psyche creates personal myths which are symbolic metaphors for ways of being, understanding, experiencing. Symbols originate from an in-between place, a place between body and spirit, and have the capacity to engage and integrate, not only feeling and thought but also soul. Without the capacity to form symbols there is little possibility of something coming alive. Symbols allow us to see, feel and speak about a living connection between elements of experience and form

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the building blocks for transformation and the unfolding of the individuation process.

The focus of this paper is on understanding and working with patients who have poorly developed symbolic capacity, or for whom symbolic capacity has been disrupted due to trauma, particularly as it pertains to the use of interpretation and reverie in the analytic process. Many patients who seek psychotherapy or analysis will initially present with deficits in symbolic functioning. This situation results in necessary modifications of traditional Jungian techniques such as dream analysis or active imagination. The initial phase of analytic work with these patients requires a focus on developing their symbolic capacity before classical Jungian techniques can be utilized effectively.

This paper will briefly review Jung's understanding of symbol and his concept of 'the symbolic attitude'. Additionally, I will examine the characteristics of concrete thinking and the impact of these characteristics on the analytic process. I will also examine methods for cultivating symbolic capacity and reflective functioning in patients for whom these capacities are impaired or poorly developed. These themes are a continuation and extension of thoughts from my book *Interpretation in Jungian Analysis* (Winborn 2018a), as well as ideas from previous papers, 'The colorless canvas: non-representational states and implications for analytical psychology' (Winborn 2017) and 'Whispering at the edges: engaging ephemeral phenomena' (Winborn 2022).

Defining symbolic capacity

With this introduction, I will briefly review the concepts underlying the symbolization process. So, bear with me as I survey concepts that may seem elementary.

Symbols are generated unconsciously. All symbols begin as images of some kind, not just visual images, but also acoustic, somatic, olfactory or kinesthetic symbols. Not all images that we experience become symbols, rather images exist as potential symbols. Jung indicates that a symbol is 'the best possible expression of a complex fact not yet clearly apprehended by consciousness'. (1916/1957, para. 148). He goes on to say:

> By a symbol I do not mean an allegory or a sign, but an image that describes in the best possible way the dimly discerned nature of the spirit. A symbol does not define or explain; it points beyond itself to a meaning that is darkly divined yet still beyond our grasp and cannot be adequately expressed in the familiar words of our language.
>
> (1926, para. 644)

Additionally, 'Symbols were never devised consciously, but were always produced out of the unconscious by way of revelation or intuition' (Jung 1928, para. 92). And finally, 'Whether or not something is a symbol depends

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primarily on the attitude of the consciousness that contemplates it' (Jung 1921, para. 818). This last quote is directly related to the topic of symbolic capacity. Clearly, from Jung's perspective, there must be a receptive conscious capacity present in the patient for an image to become a living symbol.

Jung (1928) identifies that one of the main functions of symbols is the conversion and canalization of psychic energy, 'I have called a symbol that converts energy a '*libido analogue*'. By this I mean an idea that can give equivalent expression to the libido and canalize it into a form different from the original one' (para. 92). However, in addition to the primary function identified by Jung, symbols have an important unifying function. Symbols link together the body and the outer world, emotion and representations, and the past, present and future. When a person experiences early developmental disruption or trauma this unifying function fails to develop or is damaged (Bonomi 2004).

Symbols and the transcendent function

The transcendent function is a psychological function that arises from the tension between consciousness and the unconscious and supports the union of opposites. It expresses itself via the symbol and facilitates a transition from one psychological attitude or condition to another. According to Jung (1916/1957):

> The shuttling to and from of arguments and affects represents the transcendent function of opposites. The confrontation of the two positions generates a tension charged with energy and creates a living third thing… a movement out of the suspension between opposites, a living birth that leads to a new level of being, a new situation. The transcendent function manifests itself as a quality of conjoined opposites.
>
> (para. 189)

Metaphor and symbols

Symbols inherently rely upon metaphoric processes. Metaphor can be defined as the utilization of one conceptual/imaginal domain to map or articulate the characteristics and experience of a different conceptual or imaginal domain. In the use of a metaphor there is the juxtaposition between different domains resulting in a transfer of meaning from one to the other. Therefore, it transfers meaning, or serves as a bridge, between domains of experience (e.g. conscious to unconscious, cognitive to somatic, somatic to affective, past to present, or present to future), linking realms in ways not previously seen, and transforming meaning by means of novel re-combinations between domains.

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Recent research from neuroscience clearly demonstrates that humans are neurologically optimized to implicitly respond in a powerful, empathic and affective manner when we encounter metaphor. The brain, body and affective pathways are activated in a significantly different and broader manner than when we encounter ordinary prose (Winborn 2014, 2020).

The close relationship between archetype, symbol and metaphor can be seen in this passage from Jung (1959):

> An archetypal content expresses itself … in metaphors. If such a content should speak of the sun and identify with it the lion, the king, the hoard of gold guarded by the dragon, or the power that makes for the life and health of man, it is neither the one thing nor the other, but the unknown third thing that finds more or less adequate expression in all these similes, yet – to the perpetual vexation of the intellect – remains unknown and not to be fitted into a formula…. Not for a moment dare we succumb to the illusion that an archetype can be finally explained and disposed of. Even the best attempts at explanation are only more or less successful translations *into another metaphorical language*.
>
> (paras. 267, 271, italics mine)

Symbolic attitude

The symbolic attitude is the phrase Jung uses to describe someone with the capacity for symbolic process. He determines that:

> The attitude that takes a given phenomenon as symbolic may be called … the *symbolic attitude*. It is only partially justified by the behaviour of things; for the rest, it is the outcome of a definite view of the world which assigns meaning to events, and attaches to this meaning a greater value than to bare facts.
>
> (Jung 1921, para. 819)

Jung (1959) emphasizes the autonomous nature of psychic reality, saying 'The unconscious is a living psychic entity which, it seems, is relatively autonomous, behaving *as if* it were a personality with intentions of its own' (para. 1418, italics mine). Notice that Jung is not saying the unconscious is a personality with intentions of its own, but that it appears to behave in that way. This simple phrase, '*as if*', appears throughout Jung's writing and refers to an ability to grasp that each experience has multiple possible meanings.

Reflective function

Jung (1937, para. 246) hypothesizes the existence of a reflective instinct, that is, the tendency to search for meaning, as one of five primary instincts for all human beings. The capacity for reflection is a necessary component in the

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development of symbolic capacity. Fonagy (2000) and others use the terms 'mentalization' and 'reflective function' interchangeably to refer to the patient's capacity to reflect upon, understand and make inferences about one's own experience and motivations, as well as the experience and motivations of others. Or to put it more simply, the capacity to 'think about thinking' (Fonagy 1991, p. 639).

Tuch (2011) refers to this function as the capacity for metacognition, i.e. that an individual can 'think about why he thinks and how he thinks about what he thinks … Metacognition is accordingly both a form of symbolic thought and a facilitator of symbolic thinking' (pp. 767-68). Similarly, Bion (1962/1983), in his model of the psyche, proposes a theory of thinking which focuses on the individual's capacity to digest experience, not only the capacity for reflection about experience but the capacity for the mental representation of experience as well. Bion refers frequently to 'thinking' in his writing, but his concept of thinking is not synonymous with cognition or intellectual acts. He uses the term 'thinking' as a shorthand for the capacity *for being* through the reflective, embodied experiencing of emotion. Hence, the capacity to process emotional experience is the foundation from which increasingly complex forms of reflection emerge, such as Jung's concept of the symbolic attitude.

A short example of the emergence of reflective function: a patient of mine, a man in his fifties who I've been seeing on a weekly basis for four years. He holds a doctorate degree and is a professor at a university. He presented during a major life crisis that impacted him psychologically, professionally, personally and financially. Despite his high level of intelligence and capacity for intellectual activity, he has demonstrated little capacity for reflecting on his own experiences or the motivations and feelings of others. His limitation in reflective function manifests in many ways. He has trouble recognizing or understanding the motivations of others. He has difficulty recognizing and modulating his affective states. Often, he has trouble recognizing how others were reacting to his manner of interacting or affective state. Several times he said, '*If I get excited about talking about something I don't know how to stop*'. In the abstract he is able to recognize that this is probably irritating for those he interacted with, but he did not know how to recognize it or modulate it. In a humorous tone I said to him, '*You might consider stopping after you've said three sentences and looking to see how the other person is reacting*'. He took this quite literally and began referring to it as '*the three-sentence rule*'. He regularly acted on impulses that created disruption in his life. While these limitations alone did not create the external chaotic crisis in his life, they certainly contributed to making his crisis worse in many ways. Recently, he came into a session and told me he had just come from lunch with an acquaintance. He said:

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I was thinking about how I was processing the conversation with him. I realize that I don't really have friends and I'm not comfortable with conversation. It was interesting to me because we don't know each other well but he [the acquaintance] *just launched right into talking about television shows he finds interesting and even talked some about religion. It went fine, but I was having a bit of difficulty listening because I was trying to think about something interesting to say.*

While his own internal processes interfered with his capacity to engage in spontaneous conversation with his acquaintance, this is the first time in our sessions that he could reflect on his thoughts and experience while they were occurring, and to continue reflecting on them after the encounter.

The dilemma in analytical psychology

Clearly, symbolic capacity is central to Jung's model of the psyche and his approach to psychoanalysis. Analytic interpretation, dreamwork, active imagination, expressive art work, and the use of archetypal amplification all presume a functional symbolic capacity. However, many of our Jungian training programmes provide little training in terms of evaluating a potential patient's level of symbolic capacity, although some, such as The Society of Analytical Psychology (SAP), do incorporate this material into their curriculum. Most candidates receive extensive training in dream interpretation, the importance of engaging the image, and the use of active imagination, but they often do not receive differentiated training about when it is appropriate to utilize these techniques, or who these techniques are appropriate for. Most candidates receive a rich and essential exposure to myths, fairytales, systems of religion and alchemy, but often without much instruction on how to determine which patients might benefit from a mythopoetic approach and which patients might experience archetypal amplification as intimidating or as a failure of the analyst to acknowledge and empathize with their subjective affective situation.

Tuch (2011) points out that most analysts listen preferentially for the potential symbolic meaning in the patient's communication. Tuch goes on to indicate that this frequently results in a mismatch between the analyst's effort to unravel hidden symbolic communication while the patient feels they are simply stating a belief about something they hold to be true. Often this results in a subtle power struggle between patient and analyst, with the patient struggling to hold onto their perception of truth. Naturally, this occurs to some degree in any analytic process, but when the patient lacks the capacity to consider their experience from a symbolic perspective, the struggle becomes more destructive. Similarly, Josephs (1989) indicates that when analysts 'interpret the concrete attitude in terms of its defensive and symbolic meanings, they misconstrue a developmental necessity as a resistance' (p. 494). Bonovitz (2016) describes these analytic difficulties as enactments on the part of the analyst who has difficulty keeping the developmental limitations of the patient's psyche in mind.

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When teaching and supervising, whether it is explicitly said or implicitly communicated, I often encounter the assumption that a symbolic approach, especially with the introduction of archetypal themes, can be applied universally to all patients. Many candidates become anxious during the control stage of training around their search for 'analytic patients', implying that there is a pool of individuals already prepared to undertake an analytic process, rather than thinking of analytic capacity as something that the patient develops through the analytic process.

The fundamental assumption of symbolic capacity present in Jung's model of the psyche, and in the way it is taught, creates a dilemma for Analytical Psychology. That is, we fail to develop an approach for facilitating the psychological development of patients who seek psychotherapy or analysis but because of limits in their psychological capacities, cannot initially participate in symbolic activity. This lacuna in Jung's symbolic theory and its application has also been pointed out by Fordham (1998), Bovensiepen (2002), and Willemsen (2014).

I propose that an analytic process can be undertaken with almost anyone, provided analysis is broadly defined as the development of an individual's psychological capacities and a deepening understanding of themselves, rather than narrowly defining analysis as involving the capacity to engage in dreamwork and other symbolic activities. I believe that everyone should be given an opportunity to participate in an analytic process and that an analytic process can be undertaken with a wide variety of individuals, if we maintain awareness of what their psychological capacities and limitations are. Rothstein (1995) and Levine (2010) argue that most patients do not arrive at the consulting room ready to engage in analysis; instead, they propose that the analytic capacity of the patient is created or developed through the process.

Disruptions in symbolic capacity

In my practice, I estimate that approximately eighty percent of my patients initially present for analysis without an ability to work symbolically, even though they may record their dreams and express interest in Jungian or psychoanalytic ideas. The traditional assumption underlying most analytical perspectives holds that one of the primary therapeutic tasks is the uncovering of unconscious material: material which reflects a psychological conflict or carries the possibility of enlarging the conscious perspective of the analysand. However, as the scope of analysis has widened over the past sixty years, there has been a gradual shift from an exclusive focus on the identification of psychic presences which have been forgotten, repressed or disguised towards an increased focus on the creation of psychic structure that is undeveloped, missing or functionally impaired. We now see more children, adolescents and adults who are not able to adequately use their symbolizing

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function, because they have experienced disruptions with caregivers in early childhood, environmental deprivation, traumatic experiences of violence or loss, or chronic physical illness (Willemsen 2014; Bovensiepen 2002; Potamianou 2015; Weiss 2021).

Bonovitz (2016) indicates that the ability to play with metaphor and symbols requires a sufficient degree of secure attachment involving continuity and predictability. Similarly, Potamianou (2015) indicates that a lack of appropriate external boundaries in the early environment creates insufficiencies in internal mental boundaries necessary for the emerging capacity to make differentiations which are a 'precondition for complexification in human mental development' (p. 948). However, as Willemsen emphasizes, 'Many of the experiences of early development may not come into the patient's awareness. The affect belonging to these experiences is not part of the unconscious but rather of implicit memory, also known as the non-conscious, procedural or body memory; [therefore] the affect might remain unavailable to conscious thought' (2014, p. 707).

Continuum of symbolic capacity

It is now clear that both symbolic and non-symbolic modes of functioning are present in everyone, although one or the other often predominates in our patients. As Sandor-Buthaud (2002) puts it, 'There exists a tension of opposites between the concrete and the symbolic' (p. 538). Or as Tuch (2011) puts it, 'The capacity for symbolic thought – the opposite of concrete thinking – is not an all-or-nothing matter' (p. 766). If we are genuinely interested in individuation as a lifetime, developmental process, we will also see value in assisting patients with limited symbolic capacity move towards greater complexity of experience. A central task for the analyst involves recognizing what level of symbolic capacity the patient functions at, matching their interventions to their level of symbolic capacity, and facilitating the development, or expansion, of their symbolic capacity.

To illustrate, a male patient in his fifties who has a university education. Despite his chronological age, his early presentation in analysis was of someone caught in perpetual adolescence in terms of his perception of his life and the world around him. He reported his dreams, but never seemed to derive much significance from them. Nothing emerged in his dreams that became a living symbol for him. About five years ago, after I'd already been seeing him for several years, he uncharacteristically began a session in silence. Because the previous session had seemed significant to me, I eventually broke the silence and asked him what he had been thinking about in terms of our previous session. He looked completely shocked by my question and replied with all seriousness, '*I'm supposed to think about what we talk about in here between sessions*?' I highlight this moment to illustrate how his reflective

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function was essentially non-existent at that point. Not only could he not reflect, but he also hadn't yet conceived that reflection was even necessary. Although his capacity for reflection has increased over time, I hadn't observed a capacity to participate in working with his dreams. Recently he brought in a dream in which he was bringing frozen food to a birthday party for the father of a deceased friend. I mused aloud, '*Oh that's interesting that you're bringing frozen food*'. He said, '*Yes, I thought that was strange too*'. I said, '*The frozenness of the food reminds me of how your emotions sometimes feel frozen and unavailable to you. The frozenness also reminds me how often your life seems frozen, in suspended animation, as though you're waiting for something to happen that will prompt you into action, but that prompt never quite arrives*'. My patient thought a moment and simply said, '*Or maybe both are true*'. In this instance, it was my turn to be surprised. During all our years together he had never introduced the idea that an experience or a theme from a dream could have more than one possible meaning. While it may seem like a very small step after so many years in analysis, in that moment I knew he had reached a new level of symbolic functioning I had not previously experienced with him.

What is concrete thinking?

Put most simply, concrete thinking is 'a failure to symbolize and differentiate' (Tuch 2011, p. 770). That is, to differentiate self from other, inner from outer, conscious from unconscious, real from imagined. As Tuch (2011) puts it, 'Failure to discriminate symbol from symbolized is the essence of concrete thinking. The concrete thinker lacks access to differentiated symbols with which to take a metaphoric leap away from tight adherence to concrete reality in order then to reapproach the matter from a different angle' (p. 773).

Childhood thinking is characteristically concrete, and the persistence of such thinking into adulthood reflects a failure to develop a more complex and nuanced subjective theory of self-experience. The concrete mode of experience is one of psychic equivalence, where ideas are dealt with as direct replicas of reality; 'a preoccupation with events as facts rather than possibilities' (Bonovitz 2016, p. 283).

Naturally, this makes the working within the transference/countertransference field difficult because the patient is unable to entertain the possibility that some of their feelings about the analyst could contain residues of significant relationships from earlier life. Two brief examples follow from my practice of concrete thinking in the transference/countertransference field. In both of these instances I had become aware that the patient was tracking my behaviour and movements in a way that I didn't understand. When I inquired about what was happening internally, one patient responded:

> '*When you cross your legs, I try to shift subjects because I think you're getting bored with what I'm talking about*'.

Another patient responded:

> '*When you dress up, you're telling me to be more formal and to keep myself in check but when you dress more casually, I know it's okay to be more relaxed in here*'.

Clearly, both patients were taking in shifts in my appearance and movement in a very concrete manner while implicitly making modifications of their behaviour in response.

For patients who think concretely, experience is processed as a static given – '*it just is*' rather than '*it's as if*'. The concrete thinker primarily thinks in literal terms, for example, if a car appears in their dream, they have significant difficulty imagining that the image of the car could refer to anything other than a car they owned, a car they desired, or a car they had seen recently. Ambiguity and complexity are generally threatening, confusing or meaningless for the individual who experiences life concretely. As a result, concrete thinking reifies experience, turning less tangible experiences into 'things' that can be handled, manipulated or known. Words are not utilized as vehicles for understanding, but as tools to utilize for actions (Tuch 2011).

Concrete thinking pushes towards immediate actualization (action) or discharge of an urge, whereas symbolic thought permits some delay and reflection before the felt need for action is acted upon (Tuch 2011). Finally, concrete thinking is often an underlying or contributing factor for other conditions, such as somatization, obsessive-compulsive disorder, alexithymia, eating disorders, perversions and addictions (ibid.). Often the body becomes the only avenue available for the expression of implicit or unconscious experience when concrete thinking predominates (Potamianou, 2015).

Object relations and symbolic capacity

The development of good object relatedness is closely tied with the development of the capacity to think symbolically. Wiener (2012) reflects this in the following statement, 'My own view is that we need an approach to the symbolic that respects not only the psyche's capacity for image-making but also acknowledges that a symbolic capacity inevitably emerges in relationship' (p. 660). Plaut (1966, p. 113) indicates that, the capacity to imagine constructively is closely related to, if not identical with, the capacity to trust. Trust and the capacity to imagine and symbolize are both severely disturbed by defects in early relationships. A good enough parent-child relationship is an essential ingredient, if not the actual cause, of the development of both capacities.

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Internal representation and the capacity for symbolic thought are not innate givens. These capacities begin with a 'good enough' external object (parental figure or other primary caregiver) which forms the foundation for the need of a representation of the object to stand in for the object when the object isn't present. As the work of Melanie Klein, Susan Isaacs, Margaret Mahler, Esther Bick and Frances Tustin (among others) has established, patients with concrete thinking and a disrupted capacity for representation have often experienced prolonged absence or lack of emotional responsiveness, most often with their primary caregiver in infancy. As a result, the internalization of the first object is disrupted. Internalization of the initial object is the foundation upon which all other representational and symbolic processes are based (Bovensiepen 2002; Bonomi 2004; Willemsen 2014; Potamianou 2015; Weiss 2021).

Working with patients with disruptions in symbolic capacity

Treating patients who function at the concrete level is often difficult. It can be frustrating for the analyst who naturally desires to move towards deeper engagement and meaning with their patients. Long periods can pass in which the patient resolutely finds ways to avoid moving beyond surface content and inundates the analyst with detailed and repetitive narratives from their outer life, resulting in a gradual numbing of the analyst's mind and their ability to think reflectively about the patient. As Birksted-Breen (2012) indicates:

> Concrete thinking attracts concrete thinking. When the analyst forgoes the basic temporal attitude of 'suspension', the analytic structure collapses; the analyst also resorts to concrete thinking and an absence of the third position, thus leading to impasse…
>
> (pp. 821-22)

Tuch (2011) has a similar perspective:

> What often proves maddening about concrete patients is the way in which their thinking challenges the analyst's ability to retain his or her ability to think symbolically …. No matter how well developed an analyst's capacity for symbolic thought, every analyst retains a propensity to lapse into concrete thinking – it's our cognitive heritage – and this propensity leaves the analyst vulnerable to regressing under the 'right' circumstances.
>
> (p. 783)

With patient's operating from a concrete position, the analyst's general stance must shift, along with their approach to interpretation. Contrary to some perceptions, an interpretation isn't everything that is verbally presented to the patient in a session. It is a specific type of verbal interaction which sets it

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apart from other types of therapeutic utterances (Winborn 2018a). Interpretation is the verbal expression of what is experienced with and understood about the patient's psychological situation, including the field constellated by the analytic dyad. Fordham (1978) defines the function of interpretation as follows: 'It connects together statements of the patient that have a common source unknown to the patient. When the analyst tells the patient about the source, he makes an inference that goes beyond the actual material at hand' (p. 113). Elsewhere Fordham (1991) describes the elements of an interpretation:

> An interpretation is composed of that part of the patient's unconscious digested and thought about by the analyst. The result is then communicated to the patient in such a way as to give meaning to the patient's material. To do this it must have a clear structure and contain a verb.
>
> (ibid., p. 169)

With patients functioning non-symbolically, the initial focus is not around uncovering and integrating material hidden from consciousness through various defense mechanisms. Likewise, the initial focus is not on symbolically interpreting material arising from dreams, fantasies, or implicit communications. When interpretations are made, they should be kept short, focused on affect and sensation, and organized around a circumscribed theme. We should avoid interpretations which are intended to facilitate the withdrawal of the patient's projection onto another person. Projections cannot be withdrawn without some capacity for symbolic function, because the withdrawal of a projection involves being capable of experiencing their perceptions as subjective rather than factual. Also, transference interpretations should be avoided or used minimally because they implicitly ask the patient to question the reality of their perceptions about the person of the analyst.

When the transference situation is addressed, it should be addressed from 'inside' the patient's affective experience of the analyst. Steiner (1994) referred to this approach as 'patient-centered' interpretations versus 'analyst-centered' interpretations and Riesenberg-Malcolm (1995) refers to this as interpreting within the paranoid-schizoid position versus the depressive position. For example, if a patient voices a sense of abandonment from the analyst for taking a vacation, the analyst should not make a developmental-symbolic interpretation, such as '*I believe you're feeling abandoned by me because it reminds you of the way you felt abandoned by your father when your father left the home at the time of your parent's divorce*'. Instead, with a concretely organized patient, a more digestible intervention would be, '*It must feel terrible to feel left alone while it seems I'm off enjoying myself and you wonder whether I have any thoughts about you while I'm away*'. This intervention is more readily taken in by the concrete patient because it does not ask them to alter their perceptual truth of feeling abandoned, but it does

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create an opportunity for them to feel understood and accepted in their feeling of abandonment while also providing an additional perspective on the analytic relationship.

The analyst's approach to dealing with the concrete patient is much like the approach recommended by analysts engaging with non-representational states (Botella & Botella 2005; Levine, Reed & Scarfone 2013). The analyst helps the patient give colour and form to the somewhat colourless canvas of their psyche. The analyst's interventions are also intended to stimulate the patient's curiosity about how they experience or perceive their world, i.e. what may be inferred beyond their concrete surface responses. The activity of the analyst becomes more focused on making observations about affective, sensory and somatic states rather than making full interpretations about the unconscious dynamics influencing a dream or conscious situation. As Lemma (2014) puts it, 'the analyst needs to focus on the patient's sensoriality before analysis can proceed along more standard lines and the sensoriality can then be transformed into thoughts' (p. 237).

The analyst utilizes observations and inferences in an attempt to constellate the patient's curiosity about the patterns being observed. Developing curiosity in the patient regarding their subjective experience is the necessary initial step in developing that patient's reflective function and ultimately their symbolic capacity. Often the patient's curiosity is initially directed towards the analyst's thoughts as they begin to wonder how the analyst conceived of these thoughts about them. Therefore, there is benefit to the patient when the analyst is able to 'think aloud', sharing some of their reverie about the patient's experience. But it is not only the content of what is shared while thinking aloud, thinking aloud also serves as a model for the reflective function of the analyst's mind. If the analyst is able to do this experientially, without falling into the seductive pitfall of attempting to 'teach' the patient how to think reflectively, then the analyst's reflective function becomes available for internalization by the patient. Ultimately, curiosity becomes the pathway out of the concrete mode of existence.

Additionally, the analyst's role is incubating and articulating that which is not yet formed and only experienced implicitly or dealt with concretely by the patient. However, the analyst must resist the urge to fill the sense of emptiness or concreteness in the analytic field with meaning deduced from sources outside the immediate analytic experience, such as amplification with archetypal narratives. Often interpretive material derived from collective sources can be experienced by the patient as a psychic intrusion or empathic break, rather than as a containing experience that facilitates the development of symbolization and reflection.

When dreams are brought into sessions by patients functioning at the concrete level, I avoid engaging in a classical approach to dreamwork, i.e. inquiring about the residue of the day, gathering associations, offering archetypal amplifications, attempting to understand the dramatic structure of the dream, and attempting to create a collaborative interpretation of the

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dream. With concrete patients, I avoid engaging in a stepwise approach to the dream as I would with a patient functioning at the symbolic level. Instead, I have adopted a process that draws from an approach outlined by Robert Bosnak (1986) in *Tracking in the Wilderness of Dreaming*. Bosnak focuses his attention, and the patient's attention, on the atmospheric, sensory and affective qualities of the dream, i.e. the phenomenological experience inside the dream rather than the 'meaning' of the dream. He advocates attempting to subjectively identify the emotional nodal centre of the dream and to circumambulate around that centre, in an attempt to deepen the patient's sensory-affective-somatic response to the dream. Bosnak did not develop this process to address the analytic situation with concrete patients, but nonetheless it works well with concrete patients because the process does not require them to relate to the dream in a symbolic manner, nor does it require them to understand the various elements represented in the dream from a perspective outside their own concrete orientation. For example, if someone functioning concretely brought a dream in which they were frozen, I would not ask them for their associations with frozenness, offer archetypal amplifications around the theme of frozenness, or make a historically based interpretation like, '*I think your emotions feel frozen because you felt they were rejected by your parents while you were growing up and you felt you needed to freeze them in order to prevent them from being damaged further*'. Instead, I would begin by simply inquiring, '*What was it like for you being frozen*?' This allows the patient to 'engage' or 'approach' potentially symbolic material without having to defend their understanding of a dream element.

With patients functioning at the concrete level, if I offer an amplification, it is typically drawn from film, television, novels, or something occurring in the patient's immediate cultural milieu. Amplifications from these sources still have the benefit of introducing metaphorical interaction but are more readily assimilated by the patient.

What follows is a brief clinical excerpt from a supervised case illustrating some of these ways of working with patients functioning on a concrete level. The patient is a male in his forties who works in information technology. He is divorced and has children. He is currently in a long-term relationship but has few friends and struggles with feeling connected to co-workers. In his long-term and work relationships, he often feels misunderstood or demeaned.

P: I've been feeling sort of depressed lately, and I don't know why. It started this last Sunday.
A: Hm. Was there something going on then?
P: No … not really. I talked to Sarah about it; she kept asking, 'what are you feeling?' And I would say, well, nothing really. It's not like I didn't want to tell her, I just didn't know how to describe it.
A: How do you feel it physically?
P: Just sort of dead. It's a deadness.
A: Where in your body do you feel deadness?

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P: All over; just all over.
A: Your whole body feels dead? Like you don't feel anything?
P: Well, I feel like an emptiness; a hopelessness.

To this point the supervisee is doing quite well in terms of helping the patient focus in on the sensory elements of his depressed feeling and assisting him in developing a more refined sense of his depression. However, as the exchange continues, the supervisee loses focus and begins to substitute her perspective for the patient's.

A: Well, that's some feeling. Where do you feel that?
P: In my heart; like a tightness, sort of. It is so hard to tell you what my feelings are. Why is that?
A: It's hard to put words to feelings! That's why I think it can help to know where the feeling is physically, then put words to it. So, I wonder if your feeling was like anxiety?
P: Kind of… it's not like I'm in my shell; it's different than that. But I feel it at work and other times too. Just this emptiness, even boredom.

In the second section the supervisee tells the patient that his non-feeling is a feeling, thereby disavowing his subjective truth. She also re-labels his stated depressed mood as anxiety, again moving away from the patient's subjective truth. Given what we know from the patient's background and difficulties with symbolization, it would have been more useful if the supervisee had stayed within the patient's perceived truth and said:

It seems like the feelings of deadness, emptiness and hopelessness have been with you for so long that you don't know when or how these feelings began. I have the fantasy these feelings began before you could even speak, as though you felt shut off and alone in a small room, not having anyone present to meet you in your distress. And I think your hopelessness is the hopelessness that arises when you fear no one will ever return to meet you in your distress.

Reverie

Reverie is a term introduced into the analytic vocabulary by Wilfred Bion (1962/1983). From Bion's perspective, reverie is the primary way of accessing, perceiving, experiencing and working with the states and psychic elements not explicitly articulated or fully sensed by the patient (Sullivan 2010; Winborn 2014; 2018b). He associates reverie with the state of mind the mother has with her infant, allowing the infant's unspoken needs and experiences to occupy her mind and generate appropriate emotional and physical responses, referring to this state as the container/contained experience in which the infant is contained by the container formed in the mother's psyche, just as the patient's experience is contained by the analyst's state of mind.

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Component elements of reverie

Reverie is opening to one's own internal stream of consciousness and unconscious promptings – opening to ideas, thoughts, feelings, sensations, memories, images, urges and fantasies. Reverie also involves being receptive on many levels to the experience and communication, both explicit and implicit, of the other person's presence in the room. It includes a sensitivity to the emerging potentiality of the 'analytic third'. The potential range of reverie stretches from the strange or horrific, to the ordinary, and at times opens to glimpses of the transcendent. Ogden (1997) describes reverie as:

> an experience that takes the most mundane and yet most personal of shapes. … They are our ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions, images emerging from states of half-sleep, tunes, and phrases that run through our minds, and so on.
>
> (p. 158)

Bonovitz (2016) and others (Tuch 2011; Junior 2015) propose that the analyst's capacity to engage in reverie during analytic sessions is essential to transforming concrete thinking into symbolic thinking. Bonovitz (2016) argues:

> the analyst's ability to grab hold of fleeting associations and memories that have not been fully processed not only expands his own mind but also facilitates symbolic functioning in the patient's mind. By using the imagistic and sensorial substrates of these remembrances to further symbolize personal experiences, the analyst may gain entrée into the patient's mental life.
>
> (p. 280)

He goes on to say:

> It is the processing of these fleeting memories in the analyst and the capacity to hold on to the images that emerge from them that allow the analyst to begin to see more of what is not being said in the field between analyst and patient.
>
> (ibid., p. 282)

Recognizing the shift from concrete to symbolic

How do we recognize when a patient is developing the capacity for reflective function and symbolic capacity? Often, as in two of the cases mentioned above, I recognized the shift from the way the patient was previously participating in the sessions. The shift contrasted with my previous experience of them. However, sometimes the shift is still developing but is prefigured in a

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dream, as in the following: The patient, a neurologist, presented with high levels of stress, intense anxiety, feelings of dread, and obsessional thought patterns. While she was extremely intelligent and successful in her career, her relationship with her emotional life was extremely undeveloped. Her emotions seemed confusing and frightening to her and she had trouble understanding how her early life experiences influenced how she experienced her current life. Approximately 10 months into analysis she presented the following dream: '*I had a bizarre dream. I was doing electrostimulation brain mapping of a patient's language areas. And then I was doing the same mapping on myself*'. This electrostimulation is a procedure which she does routinely before her patients (usually children) undergo brain surgery. Conducting the procedure is always an anxiety provoking process for her because she is fearful that the patient's speech capacities will be damaged by the surgery if she doesn't map their language function accurately.

While this dream could be analyzed and interpreted through Jung's associative method, I found it more useful to take the dream as an indication that her reflective function and symbolic capacity were beginning to '*operate*' and to '*map*' her emotional speech patterns around her previously inchoate anxiety. I simply said to her, '*I think you're beginning to map out areas of anxiety that you previously had no language for*'.

Conclusion

While it may seem a somewhat thankless and less enjoyable task to work analytically with patients functioning at the concrete level of experience, the emotional reward experienced when seeing the emergence of the patient's reflective function can be just as deep as when a patient brings in a significant dream that seems to outline their psychological trajectory in vivid detail. My hope for this paper is threefold: 1) that it has provided an opportunity to engage in reflection about the fundamental assumptions within Analytical Psychology, assumptions which predispose us to privilege the search for symbolic engagement, over and above the current psychological capacity of the patient; 2) that the case examples have provided adequate illustration of how concrete thinking appears in the consulting room, as well as illustrating how it looks when the concrete patient begins to develop nascent reflective and symbolic capacities; and 3) that you will carry away some ideas about how to shift your analytic stance when you encounter someone functioning at the concrete or pre-symbolic level. In many respects large sections of our population across the world have regressed in their capacity for reflective thought and symbolic processing, particularly as authoritarian and totalitarian movements are on the rise around the world, and as truth, knowledge and facts are increasingly questioned or attacked. The need for analysts willing and able to engage with patients who think concretely is greater than ever.

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Translations of Abstract

Cet article se concentre sur la compréhension et le travail avec des patients dont la capacité symbolique est mal développée, ou pour qui la capacité symbolique a été perturbée par le traumatisme. Ceci concerne tout particulièrement l'utilisation de la rêverie et de l'interprétation dans le processus analytique. Beaucoup de patients qui viennent pour une analyse Jungienne montrent initialement des déficits dans le fonctionnement symbolique. Ceci a pour conséquence des limitations nécessaires ou des modifications dans l'utilisation de techniques traditionnelles Jungiennes telles l'analyse des rêves, l'imagination active, la thérapie par le jeu de sable et autres techniques d'expression par l'art. La phase initiale du travail analytique avec ces patients requiert de mettre l'accent sur le développement de leur capacité symbolique avant que les techniques Jungiennes traditionnelles puissent être utilisée de manière efficace. Dans l'article, le concept Jungien 'd'attitude symbolique' sera étudié ainsi que les modèles conceptuels de Wilfred Bion et d'autres post-Bioniens qui présentent des

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théories et une méthode pour cultiver la capacité symbolique et le fonctionnement réfléchi chez des patients pour qui ces capacités sont déficientes ou mal développées.

Mots clés: Jung, Bion, pensée concrète, interprétation, capacité symbolique, attitude symbolique, rêverie, fonction réfléchie

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Dieser Artikel konzentriert sich auf das Verständnis von und die Arbeit mit Patienten, die eine schlecht entwickelte symbolische Fähigkeit haben oder bei denen die symbolische Fähigkeit aufgrund eines Traumas gestört wurde, insbesondere in Bezug auf die Verwendung von Reverie und Deutung im analytischen Prozeß. Viele Patienten, die sich zur Aufnahme einer Jungianischen Analyse bereitfinden, werden zunächst mit Defiziten in der symbolischen Funktion vorstellig. Diese Situation führt zu notwendigen Einschränkungen oder Modifikationen bei der Verwendung traditioneller Jungianischer Techniken wie Traumanalyse, aktive Imagination, Sandspiel und anderer expressiver künstlerischer Techniken. Die Anfangsphase der analytischen Arbeit mit diesen Patienten erfordert eine Konzentration auf die Entwicklung ihrer symbolischen Fähigkeiten, bevor traditionelle Jungianische Techniken effektiv eingesetzt werden können. Im Text werden Jungs Konzept der 'symbolischen Haltung' sowie die konzeptionellen Modelle von Wilfred Bion und anderen Post-Bionianern untersucht, die Theorien und Methoden zur Kultivierung symbolischer Fähigkeiten und reflexivem Funktionieren bei Patienten skizzieren, bei denen diese Fähigkeiten beeinträchtigt oder schlecht ausgebildet sind.

Schlüsselwörter: Jung, Bion, konkretes Denken, Deutung, Symbolkraft, symbolische Haltung, Reverie, reflektierende Funktion

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Questo articolo si concentra sulla comprensione e sul lavoro con pazienti che hanno una capacità simbolica scarsamente sviluppata, o per i quali la capacità simbolica è stata interrotta a causa di un trauma, in particolare in relazione all'utilizzo della reverie e dell'interpretazione nel processo analitico. Molti pazienti che chiedono l'analisi junghiana presenteranno inizialmente dei deficit nel funzionamento simbolico. Questa situazione si traduce in limitazioni o modifiche necessarie nell'utilizzo delle tradizionali tecniche junghiane come l'analisi del sogno, l'immaginazione attiva, la sabbiera e altre tecniche di espressione artistica. La fase iniziale del lavoro analitico con questi pazienti richiede un focus sullo sviluppo della loro capacità simbolica prima che le tradizionali tecniche junghiane possano essere utilizzate in modo effettivo. Nell'articolo verranno esaminati il concetto di attitudine simbolica di Jung, così come i modelli concettuali di Wilfred Bion e altri post-bioniani che hanno delineato teorie e metodi per coltivare la capacità simbolica e la funzione riflessiva nei pazienti per i quali queste capacità sono compromesse o scarsamente sviluppate.

Parole chiave: Jung, Bion, pensiero concreto, interpretazione, capacità simbolica, attitudine simbolica, fantasticheria, funzione riflessiva

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Статья посвящена тому, как понимать и работать с пациентами со слабо развитой способностью к символизации либо с ее нарушениями вследствие травмы, и, в частности, как использовать ревери и интерпретации в аналитическом процессе. Многие пациенты, приходящие на юнгианский анализ, поначалу демонстрируют дефицит символического функционирования. Вследствие этого необходимы ограничения либо модификации в использовании таких традиционных юнгианских методов, как анализ сновидений, активное воображение, песочная терапия и других методов творческого самовыражения. На начальном этапе аналитической работы с такими пациентами необходимо сосредоточиться на развитии их способности к символизации и только после этого можно эффективно использовать традиционные юнгианские методы. В статье рассматривается юнгианская концепция "символической установки", а также концептуальные модели Уилфреда Биона и постбионианцев, предложивших теории и методы развития способностей к символизации и рефлексивному функционированию у пациентов с их нарушениями либо недоразвитием.

Ключевые слова: Юнг, Бион, конкретное мышление, интерпретация, способность к символизации, символическая установка, ревери, рефлексивная функция

El presente artículo se focaliza en la comprensión y trabajo con pacientes que han tenido un desarrollo limitado de su capacidad simbólica, o para quienes, la capacidad simbólica se ha visto perturbada debido a un trauma, particularmente en lo que se refiere al uso del reverie y de la interpretación en el proceso analítico. Muchos pacientes que se presentan para un análisis Junguiano, presentan inicialmente deficitis en su funcionamiento simbólico. Esta situación tiene como resultado limitaciones necesarias o modificaciones en la utilización de técnicas Junguianas tradicionales como el análisis de sueños, la imaginación activa, la caja de arena y otras técnicas artísticas y expresivas. La fase inicial del trabajo analítico con estos pacientes requiere hacer foco en el desarrollo de su capacidad simbólica antes de que técnicas Junguianas tradicionales puedan utilizarse efectivamente. Durante el escrito se examina el concepto de Jung de `actitud simbólica`, así como los modelos conceptuales de Wilfred Bion y otros post-Bionianos quienes describen teorías y métodos para cultivar la capacidad simbólica y el funcionamiento reflexivo en pacientes para quienes estas capacidades se encuentran perturbadas o poco desarrolladas.

Palabras clave: Jung, Bion, pensamiento concreto, interpretación, capacidad simbólica, actitud simbólica, reverie, función reflexiva

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与象征能力受损的病人工作

本文聚焦于如何理解象征能力发展不足的病人， 以及因为创伤而损害了象征能力的病人， 及与这些人的工作， 特别是当涉及到在分析中使用遐想和诠释的时候。许多进行荣格分析的人， 一开始都会呈现出象征功能的不足。这种情况导致在利用传统的荣格技术， 如梦的分析、积极想象、沙盘和其它表达性艺术技术时遭到必然的限制或改动。与这些病人进行分析初始的阶段， 需要我们聚焦于发展他们的象征能力， 然后才能后效地使用传统荣格流派的技术。文章讨论了荣格关于“象征性态度”的概念， 以及

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威尔弗雷德-比昂和其他后比昂主义者的概念模型，他们概述了对于象征能力和反思功能受损或发展不良的病人，如何培养他们这些能力的理论和方法。

关键词: 荣格，比昂，具体思考，诠释，象征能力，象征态度，遐想，反思功能

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