

## ‘I DO NOT KNOW’: PSYCHOANALYSIS IN THE UNKNOWN

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In clinical psychoanalytic work, as analysts or supervisors, we often encounter a perplexing phenomenon: despite painstaking efforts, when everything seems to have been explored—when the pain has been seen and understood, when the way personal history weaves the fabric of the psyche has been laid bare—the patient, after a fleeting moment of relief or epiphany, finds their symptoms/ compulsive behaviours resurging, their suffering persisting, and their struggles remaining unchanged. It is as if all the insights and realisations gained earlier have vanished without a trace, leaving the inner world empty, as though nothing had ever transpired.

This is profoundly bewildering and disorienting. We feel at a loss, unsure of what more can be done or how to help the patient, as if trapped in quicksand or stranded in a silent desert. When confronted, patients often express that what they know or understand feels utterly useless: ‘I know this sounds absurd, but I don’t know why,’ ‘I just have to do this,’ ‘I just don’t want to get better.’ It is as if they are facing an unfathomable void, a black hole that defies comprehension and change.

Here I will introduce Vermote’s (2013a) integrative model of psychic functioning for dealing with the unknown or the unthought. Drawing on Matte Blanco’s and Bion’s writings, Vermote identifies three distinct zones or modes of psychic functioning to describe the scope of psychoanalytic work and the range of possible psychic changes, each characterised by varying degrees of differentiation, different major psychoanalytic models, and different clinical implications for the analyst:

Mode 1 — Reason (reason as a secondary process) — Oedipal, understanding Ucs system (Freud, Klein).

Mode 2 — Transformations in K (knowledge) – Container-contained, reverie, dream-work, alpha-function (Bion, Marty, de M’Uzan, Bollas, Botella & Botella, Ogden, Ferro).

Mode 3 — Transformations in O — when dealing with the most unthought, unknown, undifferentiated zone of psychic functioning (Winnicott, Milner, late Bion, late Lacan).

Vermote 2013a:18. Cf. 2013b; cited in Eshel, 2019:53

Ofra Eshel delves into Freud’s psychoanalytic concept of the unconscious, incorporating Vermote’s second and third models into what she conceptualises as the unrepressed unknown/unconscious:

The unrepressed unknown/unconscious of non-neurotic patients and states of mind: consists of psychic material that could not be repressed, but is dissociated, split-off, and

may become unrepresented...It ranges from the unrepressed realm, level I, that is traumatically dissociated and unknown, to the deeper unrepressed and unrepresented realm, level II, of the most unknown and unknowable, unthinkable psychic reality; the deepest traumatic and non-communicating issues of human life.

Eshel 2019: 262

### **The repressed unconscious**

The Freudian repressed unconscious consists of psychic material that could have been repressed, in which ‘the interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind’ (Freud 1953 [1900] SE V: 608), it is an epistemological exploration for the recovering of repressed material through the interpretation and analysis of the transference and the interpretation of dreams. This is the most differentiated mode of analytic functioning.

What we are in search of is a picture of the patient’s forgotten years ... we are reminded that the work of analysis consists of two quite different portions, that is carried on in two separate localities, that is involves two people, to each of whom a distinct task is assigned.... We all know that the person who is being analysed has to be induced to remember something that has been experienced by him and repressed;...the task performed by the analyst, has been pushed into the background. The analyst has neither experienced nor repressed any of the material under consideration; his task cannot be to remember anything. ... His task it to make out what has been forgotten from the traces which it has left behind or, more correctly, to construct it.

Freud 1964 [1937] SE XXIII: 258-59

It is well established that in the psychoanalytic work concerning the repressed unconscious, the analyst’s stance is clearly defined by abstinence and neutrality. This dynamic involves two people, separately, that occupying distinct positions, each assigned specific tasks. The analyst serves as both observer and guide. The work at the level of the repressed unconscious constitutes an epistemological exploration - offering interpretations for the patient to think, reflect upon, gain insight from, and ultimately achieve revelation.

Interestingly, from the very beginning of this 1937 paper, Freud appears intent on expanding the conceptual boundaries of his foundational psychoanalytic term repression.

It is familiar ground that the work of analysis aims at inducing the patient to give up the repressions (using the word in the widest sense) belonging to his early development and to replace them by reactions of a sort that would correspond to a psychically mature condition. With this purpose in view he must be brought to recollect certain experiences and the affective impulses up called by them which he has for the time being forgotten. We know that his present symptoms and inhibitions are the consequences of repression of this kind...

Freud 1964 [1937] SE XXIII: 257-58

Why did Freud propose using the word (repressions) in the widest sense? I suspect that in writing so, he intentionally left theoretical space within his framework—not merely suggesting that repression, as conventionally understood, causes patients’ forgetting, but also implying that other operative mechanisms might render early experiences inaccessible. In any case, since the patient is in unconsciousness, fundamentally unable to know. Freud seemed to have intuitively known that there existed something he had not yet clearly defined—an unknown dimension of the psyche—and provisionally employed the term repression to gesture toward this yet-to-be-expanded psychoanalytic conception.

So what exactly was this unknown that Freud intuitively knew? The following passage captures his contemplation:

So the ego can be split.....Its parts can come together again afterwards...that pathology, by making things larger and coarser, can draw our attention to normal conditions which would otherwise have escaped us. ...If we throw a crystal to the floor, it breaks...It comes apart along its lines of cleavage into fragments whose boundaries, though they were invisible, were predetermined by the crystal’s structure. Mental patients are split and broken structures of this same kind. Even we cannot withhold from them something of the reverential awe which peoples of the past felt for the insane. They have turned away from external reality, but for that very reason they know more about internal, psychical reality and can reveal a number of things to us that would otherwise be inaccessible to us.

Freud 1964 [1933] SE XXII: 58-9

Freud continued to construct his understanding of the inaccessible within the edifice of the repressed unconscious, as if he were dimly hinting that he had seen the invisible in the psyche and known of the existence of that which remains inaccessible. Since those suffering from a mental illness ‘can reveal a number of things to us that would otherwise be inaccessible to us’, might we not reasonably speculate that there must also exist something inaccessible to both patients and analysts?

Drawing ever closer to—or becoming aware of—an unknown realm that even he did not fully comprehend, Freud penned a remarkably experiential words in his ‘Lecture XVIII: Fixation to Traumas - The Unconscious’:

.....that these symptoms of obsessional neurosis, these ideas and impulses which emerge one knows not whence, which prove so resistant to every influence from an otherwise normal mind, which give the patient himself the impression of being all-powerful guests from an alien world, immortal beings intruding into the turmoil of mortal life - these symptoms offer the plainest indication of there being a special region of the mind, shut off from the rest.

Freud 1963 [1916-1917] SE XVI: 278

Freud began to transcend the role of mere observer and investigator, immersing himself in the

patient's experiential world. These symptoms, ideas and impulses were experienced by individuals as emerging from which one knows not whence—like 'guests from an alien world', 'immortal beings intruding into the turmoil of mortal life'. This led him to postulate that within the patient's mind, there existed a distinct region that stood shut off - fundamentally incompatible with the rest. Notably, Freud deliberately chose the term shut off rather than repressed to characterise this phenomenon. Freud observed:

It is only after we have disposed of everything that has to do with the work of interpretation that we can begin to realize the incompleteness of our psychology of dreams .....For it must be clearly understood that the easy and agreeable portion of our journey lies behind us. Hitherto, unless I am greatly mistaken, all the paths along which we have travelled have led us towards the light—towards elucidation and fuller understanding. But as soon as we endeavour to penetrate more deeply into the mental process involved, every path will end in darkness.

Freud 1953 [1900] SE V: 510-11

Throughout the vicissitudes of psychoanalysis, the Freudian concept of repressed unconscious has undoubtedly maintained its central position and continues to hold most significant importance even today. However, Freud himself (1961 [1923]) articulated the existence of a 'third unconscious' that is not repressed:

We recognize that the *Ucs.* does not coincide with the repressed; it is still true that all that is repressed is *Ucs.*, but not all that is *Ucs.* is repressed. .... [W]e find ourselves thus confronted by the necessity of postulating a third *Ucs.*, which is not repressed.

Freud 1961 [1923] SE XIX:18

While what is repressed is unconscious, the unconscious encompasses more than just the repressed. Here we return to Freud's initial proposition that the term repression should be used in the widest sense. Tracing this trajectory, we can observe how Freud progressed from a vague perception—intuiting something unknown temporarily labelled as repression—to eventually arriving at the conceptual discovery of the third unconscious.

But what exactly is this third unconscious? This brings me to André Green's seminal work *The Work of the Negative* (1999), where he rigorously examines the 'negativity' of the unconscious. Green argues that the unconscious is not merely repressed content but, more fundamentally, a structural absence—one that cannot be fully translated into consciousness through interpretation. He critiques classical psychoanalysis for overemphasising the return of something repressed while neglecting the non-representational essence of the unconscious itself. For Green, the unconscious is not just a repository of desires but also raw psychic material that cannot be symbolised—a primordial realm characterised by blankness (1999) or negativity. It is, in essence, an unknown domain where nothing has yet happened—a void preceding representation.

## The unrepressed unconscious

Winnicott (1974) explained his expansion of unconscious in his paper ‘Fear of Breakdown’, proposing that the most catastrophic psychic events may remain unconscious not because they are repressed, but because they were so unbearably traumatic that they could not be experienced and thought at the time:

The unconscious here is not exactly the repressed unconscious of psychoneurosis, nor is it the unconscious of Freud’s formulation of the part of the psyche that is very close to neuro-physiological functioning. Nor is it the unconscious of Jung’s which I would call: all those things that go on in underground caves, or (in other words) the world’s mythology, in which there is collusion between the individual and the maternal inner psychic realities. In this special context the unconscious means that the ego integration is not able to encompass something. The ego is too immature to gather all the phenomena into the area of personal omnipotence.

Winnicott 1974: 104

Freud, Winnicott, and Bion used strikingly similar language when describing the unthinkable unknown, unconscious of early breakdown and catastrophe. ‘But we may say of it in a certain sense that it has never had a real existence. It is never remembered, it has never succeeded in becoming conscious’ (Freud 1955 [1919] SE XVII: 185). ‘The construction of a symptom is a substitute for something else that did not happen’ (Freud 1963 [1916-1917] SE XVI: 280). ‘...something that is unconscious and unknown because it has not happened’ (Bion 1970: 35).

The patient needs to ‘remember’ this but it is not possible to remember something that has not yet happened, and this thing of the past has not happened yet because the patient was not there for it to happen to.

Winnicott 1974: 105

Ofra Eshel writes in her paper ‘The Vanished Last Scream’: ‘...where unthinkable terror lies buried unknown, unexperienced, un-lived, and unrepresented’ (Eshel 2019: 111). She argues that traumatic event leading to breakdown or terror did not happen for the patient because they occurred too early and were too overwhelming and agonising to bear. As a result, this traumatic event is expelled or erased for not experiencing it.

Winnicott wrote: ‘the original madness or breakdown of defences if it were to be experienced would be indescribably painful’ (1989 [1965]: 127). Bion wrote: ‘the blast of an experience of this kind when you are actually there, when you are really exposed to it. It is, I can only say, “indescribable”’ (Bion 2013 [1967]: 85).

To survive and protect the psyche from annihilation, the individual must expel this devastating traumatic event/experience—even has to erase or delete it completely. The consequence is that, for the patient, it is as if this event never occurred at all. Yet the cost is that its effects persist, haunting the individual's life in spectral ways. This belongs to the realm of severe disturbance and psychotic states of mind—not neurotic any more. It is not repressed but rather dissociated,

split off, or even entirely vanished into a zone of non-existence: what might be called the unrepressed traumatic unknown/unconscious. Winnicott, grounding his thinking in the mother-infant relation, constructed a psychoanalytic approach:

.....that for Freud there are three people, one of them excluded from the analytic room. If there are only two people involved then there has been a regression of the patient in the analytic setting, and the setting represents the mother with her technique, and the patient is an infant. There is a further state of regression in which there is only one present, namely the patient, and this is true even if in another sense, from the observer's angle, there are two.

Winnicott 1992 [1954]: 286

In this context, Winnicott views regression in psychoanalysis and it bases on mother-infant relationship and 'there is only one present, namely the patient' (Winnicott 1992 [1954]: 286). The analyst becomes the environment, the holding setting, not as a separate individual. This fundamentally differs from Freud's conceptualization of distinct separated analyst-patient roles.

Ofra Eshel thinks that the unrepressed unknown/unconscious belongs to what Winnicott termed the 'unthinkable states of affairs' of early breakdown and Bion's 'catastrophic emotional explosion', the unthinkable cannot be thought - they exist in stark contrast to content that seeks to be understood, known, or interpreted - and can only be experienced. Thus, the crux of psychoanalytic work lies in the analyst's capacity to 'be at-one-with' (Winnicott 1971; Bion 1967, 1970) the patient's most traumatic emotional reality. This approach, as I understood, there is no separate 'subjectivity', but analyst and patient become an indivisible unity, without decisive distinction. Ofra Eshel concludes: 'Analytic work in the unrepressed unconscious entails being in various degrees of patient-and-analyst state of oneness and transformations in oneness, moving from patient-and-analyst two-in-oneness to at-one-ment with the patient's unrepressed and unrepresented psychic reality' (Eshel, 2023: 150; 2024).

### **Case illustration**

Note: This case was drawn from my supervisee's working with her patient. **E** represents the therapist, and **A** the patient. This treatment lasted for six years and is currently ongoing, with two interruptions in the first two years, both lasting four months.

A was a researcher, who was born in a highly unstable family. Both parents were factory workers. Her maternal family was particularly chaotic—her mother, suspicious of the father's infidelity, engaged in obsessive surveillance. A witnessed her mother's insane behaviours, describing her mother as mentally abnormal and crazy. The father, often absent due to construction work, rarely returned home, while the mother searched for him relentlessly. Due to the volatile parental relationship, A's mother was inconsistently present postpartum, only providing irregular breastfeeding. In such bad situation, A was primarily raised by her paternal grandparents, fed with formula. Her

parents divorced when A was three, shortly later reconciled, then they divorced again when she was twelve. Though her father promised to care for her, he remarried very soon, leaving A alone with her grandparents. Several years later, he had a daughter with his second wife. A's mother remarried three times later.

A felt her maternal lineage as 'mentally abnormal' and had little contact with her. Her closest bonds were with her grandparents, but she felt neglected. She compulsively takes care of them all the time—traveling home during holidays to clean, organize her grandparent's house, and host visiting relatives in her city.

A firstly sought therapy with E in late 2019 amid a failing marriage, and paralyzed by anxiety of being unable to complete a research project. After eight weekly sessions, she stopped the treatment because she was able to focus on her project since her senior peer is present.

Four months later, A briefly resumed the sessions because her project stalled again, and her senior peer left their institution, leaving her alone, causing her intense anxiety. She met the therapist E once and stopped again. Later E knew that two months later she would complete the project.

Then in August 2020 patient A returned to therapist E for treatment.

Initially, her liberation from paralysis and inability to function—enabling her to complete her project—stemmed from the presence of a supportive figure in her life: her senior peer. As the therapeutic process unfolded, the deeper longings and pains within her gradually surfaced.

By the third year of therapy, she began experiencing an intense craving for companionship, and gained the strength to leave her bad marriage.

In the fifth year, a primordial, previously inaccessible fear emerged: A developed irrational, compulsive cleaning behaviours—an uncontrollable need to repeatedly tidy her rooms, as if driven by a pervasive, incomprehensible terror that is unable to understand and explain.

In this situation, the therapist approached me for supervision. At that point, she felt her work blocked somewhere and couldn't understand what was happening. She confided that her supervisor's interpretive position was of little help to her patient, so she hoped I could supervise her work from a different perspective.

To explore this point deeply, I selected a fragment from a session in 2025 — the sixth year of therapist E's work with patient A:

**'I do not know': a fragment in one session**

1A: I do not know. It feels like that I simply do not want to do something even though I know that I can. It's not only this thing. There are many things in life that I know I should

be able to do, but just do not want to. As if I simply want to let myself stay in the bad state.

1E: Can you tell me more about that?

2A: It's like this week I'm still affected by the mice in the house. This has driven me to the point of neurasthenia. I am very alert to every sound in the house. Any noise makes me anxious—sounds from the pipes, noises from next door, any little sound jolts me wake up from my sleeping, making me worry that a mouse might be there in the house or is crawling in from somewhere. I bought sticky traps and scattered mouse repellent all over the house, under the bed, and everywhere, then the smell was so strong that became suffocating. I learned online that it is harm to humans, so I swept it all out and threw it away. I've been preoccupied with this issue. In my plan, I should have started preparing my resume and finishing my article when I was back after Spring festival. But I've been caught up in all these household chores—washing bed sheets, cleaning, even throwing away the old pot for buying a new one, getting rid of the oil container...I do not know why, but I somehow feel compelled to do these things...

2E: Mice, germs, toxic substances entering the home, the house—pollution can infiltrate everywhere. You have to make all your efforts as possible as you can to keep them out.

3A: It feels like I also don't allow myself to have money, as if I do not want to let myself become better.

3E: Where did these thoughts come from?

Then she mentioned some details on how she could not let her become better, when she was in hometown during spring festival, she spend much money, and lost lots of money on playing cards.

4A...I thought about my mom...After she divorced my dad, she was with two old men, and both of them got testicular cancer.

4E: Are you saying she carried some kind of germ that caused them to get cancer?

5A: I do not know.

5E: What do you think about testicular cancer?

6A: She was just really bad, lots of messy. Even when she had me, it was a pregnancy before marriage with my dad. They only got married because I was on the way. She said she had me because she had sex with my dad after pregnant. She went to the toilet and then gave birth to me, so I was born with white semen on my head.

6E: What do you mean? Were you born in the toilet?

7A: The toilet I'm talking about wasn't like the ones we have now. It was an old-fashioned dry latrine, separated from the faeces and urine by just two boards.

7E: Wait, are you saying your mom told you that you were born in a toilet?

8A: She seems do not know the exact details, but she just said that I was born because she had sex with my dad. So when I was born, there was still semen on my head.

8E: It goes against common sense. A foetus is enclosed in the womb and protected by amniotic fluid. When a baby is born, the white substance on its head is called *vernix caseosa*, which serves as a protective layer. It couldn't possibly be semen on the baby's head.

9A: That's what she said. When I was giving birth to my daughter, I thought maybe she could at least offer some advice, but she said she couldn't remember, '...I just went to the toilet, then gave birth to you, and there was semen on your head'.

9E: This is clearly not the fact. But if what you're describing is something like a dream, combined with the mice and the dry latrine, it reminds me of the scenarios in your dreams and some details on the way to your wedding.

Patient A presented a catastrophic perception underlying ordinary daily scenes, characterised by a fragmented and distorted sense of objective external reality. This marks the point where the treatment began to access the core of trauma, as patient A's innermost pain and struggle—which could neither be understood nor traced back to any source within objective reality—gradually surfaced.

This dialogue vividly reveals a dilemma we often encounter as therapists in clinical work: in the face of the patient's catastrophic perception, how should we make the 'right' choice? In this fragment, the therapist's dilemma is just as acute as the patient's. As therapists, we can hardly restrain the impulse to clarify and correct that arises from our existing knowledge; yet, the patient's catastrophic perception and traumatic 'unknown' urgently need is the therapist's pure presence and containment. Therapist E's responses—'Where did these thoughts come from?' 'It goes against common sense,' 'This is clearly not the fact.'—can be seen as the therapist's attempt to help the patient understand reality and alleviate realistic anxiety.

Unconsciously, this repeated a compulsive pattern: patient A, through regression, demanded to be rescued by the therapist, while the therapist, driven by the counter-transference (of her own anxiety evoked at the moment), felt compelled to solve the problem by correcting the patient's cognition. Such responses to the patient might easily be experienced as a denial of the patient's psychotic anxiety, bypassing her unconscious (the traumatic unknown) and leaving her nameless dread unaddressed.

Sverre Varvin pointed out during the supervision of this case: ‘The patient’s narrative is fragmented and was unable to present a complete picture. Upon hearing A’s words, the therapist was profoundly shocked, she insisted that these accounts could not possibly be true, and immediately felt compelled to take action. In this state, the therapist likewise could not grasp the overall situation, becoming trapped in her own anxiety, which prevented her from helping patient A regulate those extremely catastrophic anxieties’. Varvin agreed that to work with this patient, the psychotherapist must deeply understand and stay within her deepest, innermost fears.

My Swedish psychoanalytic supervisor Kristina Forss repeatedly emphasised to me: ‘The supervisor must function like a grandmother, holding both the therapist/ mother and the patient/infant in containment...You need to be there, to go to that place, to exist fully, to experience, to contain the entire situation.’ Most crucially, ‘forget everything you know... listen, be present, and just exist’.

Indeed, in this fragment of this session, the patient A’s repeated utterances of ‘I do not know’ reveal a previously inaccessible realm—one that had never been touched, experienced, or thought about. This was a domain where logical reasoning failed her, where no answers could be thought into existence. When she said, ‘as if I do not want to let myself become better’, a wordless sensation seemed to surface—as if calling forth an answer that could never be found, yet demanded to be sought. Or perhaps she is searching for someone to be present, to stay with her terror, to experience for the first time that horror and anxiety which she had never been able to experience on her own before—so that existence may start, and the process of thinking may become possible.

So, when the therapist asked her—‘Where did these thoughts come from?’—she did not know and was unable to answer this kind of question. Instead, what she did was continue to present such incomprehensible, recurring, self-destructive actions in details. Of course, from the perspective of objective reality, not only was the patient bewildered by her own actions, utterly unable to trace their origins, but the analyst too found herself at a loss—much like Freud’s observation: ‘But ...this sense had been unknown to her in both directions—both its whence and its whither’ (Freud 1963 [1916-1917] SE XVI: 277). Freud understood:

We find that the attack corresponds to a complete transplanting of the patient into the traumatic situation. It is as though these patients had not finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been dealt with...

Freud 1963 [1916-1917] SE XVI:274-5

And he further stated, ‘The construction of a symptom is a substitute for something else that did not happen.’ (Freud 1963 [1916-1917] SE XVI: 280). Therefore, we must allow the experience to become full, and let something that did not happen finally do occur—all depending on the therapist’s presence and being-there.

It is rather perplexing that regarding these events which never actually occurred, Freud once remarked: ‘...we ought to be content to explain the facts before us, and ought as a rule to avoid the additional task of making it clear why something has not taken place...’ (Freud 1955 [1919] SE XVII: 183).

Freud acknowledged the existence of this realm of what has not taken place, yet he advocated avoiding direct work within it. And yet paradoxically, this is precisely the area that demands our attention - the very core issue that contemporary psychoanalysts are increasingly focusing on, and the recurrent clinical challenge we encounter.

Our focus lies precisely on what did not happen. For where something did not occur psychically, where they never truly existed, no genuine transformation can emerge. In this domain of the not-yet-happened and unknown — where the patient has nothing to think, reality testing would become meaningless and futile — the only possible approach is the analyst's presence and being-there, staying within that catastrophic feeling, being together with the patient, till becomes it, and it is finally experienced.

What patient A needed is for someone (the analyst) to be with her, till reaching and experiencing —for the first time—that nameless dread or breakdown of early trauma (which she, as an infant, could neither bear nor experience alone). Only through such presence could this non-event truly happen and be psychically lived, finally acquiring its emotional life.

Rather, the most traumatic depths of the unknown, where the patient’s emotional reality is mostly unthinkable, unexperienced and unrepresented, necessitate going beyond the limits of the level of representations and analytic thinking to the ontological-experiential analytic work of being and becoming with-in the patient’s psychic reality, at-one-with the patient’s innermost emotional reality.

Eshel, 2023:150; 2024

The deepening of clinical work follows this path, necessitating a shift in psychoanalysis from epistemology to ontology. This shift allows the therapist to gradually relinquish epistemological impulse such as solving problems, eliminating symptoms or testing reality. She becomes more able to relax and hold the anxiety and existence of the patient (and her own), thereby sustaining an experiential therapeutic space—simply being there, existing, staying with the patient’s catastrophic anxiety. Within this space, they gradually come to experience those annihilating fears together, allowing traumatic experiences to emerge and the patient’s emotional reality to be fully lived. This shift creates the sensed possibility that the work can progress further. Given space constraints, I will not elaborate further here.

## **Conclusion**

In working with the repressed unconscious, the analyst and the patient are assigned distinct positions and different functions/tasks. The analyst primarily serves as an observer, analysing the material presented by the patient, and to some extent, assumes the role of an authority who

knows more about what has occurred than the patient.

In contrast, working with the unrepressed unconscious needs the analyst's deep participation, such as the conceptions of reverie, dream-thinking, and containing (Bion 1962, 1963), models of intersubjectivity and the analytic field (Ogden 1994; Ferro 1999), and Kohut's 'vicarious introspection' approach of self-psychology (Kohut 1971). At the deepest level—the most unknown, the unthinkable—needs the analyst's 'presencing', being there, being within, staying within the traumatic psychic reality, being/ becoming at-one-with the patient's unknown traumatic emotional reality. This is an ontological psychoanalytic work. For in this realm, that which is most traumatically unknown is unthinkable, unexperienced, and unrepresented. It entails an ontological, experiential process through which the analyst and patient together enter into this traumatic place, where it is directly felt and free in its impact and affect.

Working with the unrepressed unconscious thus transcends rational and logical thinking, goes beyond the spatiotemporal constraints of traditional clinical psychoanalysis. It fundamentally differs from working with the repressed unconscious, moving beyond Freud's assertion that 'the work of analysis consists of two quite different portions, that is carried on in two separate localities, that is involves two people, to each of whom a distinct task is assigned.' (Freud 1964 [1937] SE XXIII: 258)

In this paper, I have drawn upon the theoretical and clinical contributions of Freud, Winnicott, Bion, and Ofra Eshel regarding the 'unknown' and the 'has not happened.' While I deeply admire these pioneers, I am struck by Freud's profound intuition—how he glimpsed the edges of these insights, leaving fertile ground for future exploration. I extend my gratitude to these dedicated explorers of psychoanalysis, whose works have enriched and expanded my theoretical landscape, all these allowing me keep open to the unknown, to relinquish the authoritative stance of 'knowing more', and to serve our patients better, through humble, embodied presence.

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