

This art of psychoanalysis

Dreaming undreamt dreams and interrupted cries

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(Final version accepted 8 March 2004)

It is the art of psychoanalysis in the making, a process inventing itself as it goes, that is the subject of this paper. The author articulates succinctly how he conceives of psychoanalysis, and offers a detailed clinical illustration. He suggests that each analysand unconsciously (and ambivalently) is seeking help in dreaming his 'night terrors' (his undreamt and undreamable dreams) and his 'nightmares' (his dreams that are interrupted when the pain of the emotional experience being dreamt exceeds his capacity for dreaming). Undreamable dreams are understood as manifestations of psychotic and psychically foreclosed aspects of the personality; interrupted dreams are viewed as reflections of neurotic and other non-psychotic parts of the personality. The analyst's task is to generate conditions that may allow the analysand—with the analyst's participation—to dream the patient's previously undreamable and interrupted dreams. A significant part of the analyst's participation in the patient's dreaming takes the form of the analyst's reverie experience. In the course of this conjoint work of dreaming in the analytic setting, the analyst may get to know the analysand sufficiently well for the analyst to be able to say something that is true to what is occurring at an unconscious level in the analytic relationship. The analyst's use of language contributes significantly to the possibility that the patient will be able to make use of what the analyst has said for purposes of dreaming his own experience, thereby dreaming himself more fully into existence.

Keywords: psychoanalytic process, dreams, nightmares, night terrors, undreamt dreams, interrupted dreams, reverie

I

Psychoanalysis is a lived emotional experience. As such, it cannot be translated, transcribed, recorded, explained, understood or told in words. It is what it is. Nevertheless, I believe it is possible to say something about that lived experience that is of value in thinking about aspects of what it is that happens between analysts and their patients when they are engaged in the work of psychoanalysis.

I find it useful in my own thinking—which often occurs in the act of writing—to limit myself at first to using as few words as possible in an effort to capture essences of meaning. It is my experience that in psychoanalytic writing, as in poetry, a concentration of words and meaning draws on the power of language to suggest what it cannot say. In this paper, I begin by offering a highly condensed

statement—the analytic process, as I conceive of it—and then go on to discuss more fully that densely stated set of ideas. Since each element of my conception of psychoanalysis is inseparable from the others, there are many instances in this paper where I double back on, or jump ahead of the initial sequential statement. (Perhaps this reflects something of the nature of the movement of the analytic experience itself.) I conclude by presenting a detailed account of an experience in which the patient and I were able to think, and speak, and dream (formerly) undreamt and interrupted dreams.

II

A person consults a psychoanalyst because he is in emotional pain, which, unbeknownst to him, he is either unable to dream (i.e. unable to do unconscious psychological work) or is so disturbed by what he is dreaming that his dreaming is disrupted. To the extent that he is unable to dream his emotional experience, the individual is unable to change, or to grow, or to become anything other than who he has been. The patient and analyst engage in an experiment within the terms of the psychoanalytic situation that is designed to generate conditions in which the analysand (with the analyst's participation) may become better able to dream his undreamt and interrupted dreams. The dreams dreamt by the patient and analyst are at the same time their own dreams (and reveries) and those of a third subject who is both and neither patient and analyst.

In the course of participating in dreaming the patient's undreamt and interrupted dreams, the analyst gets to know the patient in a way and at a depth that may allow him to say something to the patient that is true to the conscious and unconscious emotional experience that is occurring in the analytic relationship at a given moment. What the analyst says must be utilizable by the patient for purposes of conscious and unconscious psychological work, that is, for dreaming his own experience, thereby dreaming himself more fully into existence.¹

III

Before I attempt to 'unpack' the preceding statement, two sets of introductory comments are necessary: the first addresses the theoretical context for the discussion that follows; the second addresses a pair of metaphors for the psychic states in which patients come to analysis and with which they struggle during analysis.

An essential part of the theoretical background for the way I conceptualize the practice of psychoanalysis derives from (my interpretation of) Bion's theory of dreaming and of not being able to dream. I have previously discussed this aspect

¹Any effort to describe psychoanalysis necessarily draws upon the reader's experience of psychoanalysis. One could write volumes on the subject of dogs, but, unless the reader has experienced a living dog, he will not know what a dog *is*. A dog *is* a dog; psychoanalysis *is* psychoanalysis; 'the world, unfortunately, is real [unwaveringly itself]; I, unfortunately, am Borges' (Borges, 1946, p. 234).

of Bion's work (Ogden, 2003a) and will only very briefly summarize the relevant aspects of that discussion here.

Bion introduced the term 'alpha-function' to refer to the as yet unknown set of mental functions which together transform raw 'sense impressions related to emotional experience' (1962, p. 17), which he terms 'beta-elements', into 'alpha-elements'. Beta-elements—unprocessed sense impressions—are unlinkable with one another and consequently cannot be utilized for thinking, dreaming or storage as memory. In contrast, alpha-elements are elements of experience that can be linked with one another in the process of conscious and unconscious thinking and dreaming (both while we are awake and asleep). For Bion,

Failure of alpha-function means that the patient cannot dream and therefore cannot sleep. [Inasmuch as] alpha-function makes the sense impressions of the emotional experience available for conscious [thought] and dream-thought, the patient who cannot dream cannot go to sleep and cannot wake up. Hence, the peculiar condition seen clinically when the psychotic patient behaves as if he were in precisely this state (1962, pp. 6–7).

There are a number of thoughts here that are essential to the conception of psychoanalysis that I am presenting. Dreaming is an ongoing process occurring in both sleep and in unconscious waking life. If a person is incapable of transforming raw sense impressions into unconscious elements of experience that can be linked, he cannot generate unconscious dream-thoughts and consequently cannot dream (either in sleep or in unconscious waking life). The experience of raw sense impressions (beta-elements) in sleep is no different from the experience of beta-elements in waking life. Hence, the individual 'cannot go to sleep and cannot wake up' (Bion, 1962, p. 7), i.e. he cannot differentiate between being asleep and being awake, perceiving and hallucinating, external reality and internal reality.

Conversely, not all psychic events occurring in sleep (even visual imagistic events) warrant the name dream. Psychological events occurring in sleep that resemble dreaming, but are not dreams, include 'dreams' for which neither patient nor analyst is able to generate any associations, hallucinations in sleep, dreams consisting of a single imageless feeling state, the unchanging dreams of post-traumatic patients and (as will be discussed) night terrors. These 'dreams' that are not dreams involve no unconscious psychological work, nothing of the work of dreaming.

IV

The second of the two sets of comments that are required prior to considering my conception of psychoanalysis concerns the phenomena of nightmares and night terrors. I find that these two disturbances of sleep serve both as examples of, and metaphors for, two very broad categories of psychological functioning. Taken together, night terrors and nightmares, as I understand them, are emblematic of the stuff that the full range of human psychopathology is made on.

Nightmares are 'bad dreams'; night terrors are 'dreams' that are not dreams. Night terrors differ from nightmares not only in terms of phenomenology and

psychological function, but also in terms of their neurophysiology and the brain-wave activity associated with them.²

The child³ having a night terror ‘awakens’ in great fear, but does not recognize the parent who has been awakened by his cries and has come to comfort him. The child eventually calms and without discernible fear ‘returns to sleep’. On ‘awakening’ the next morning, the child has little or no recollection of the night terror or of having been comforted by his parent. In the rare event that a child is able to remember anything at all of the night terror, it is a single image such as being chased or of ‘something sitting on me’ (Hartmann, 1984, p. 18). The child does not evidence any fear in going to sleep the subsequent night. There is seemingly no conscious or unconscious memory of the experience. Both from a psychoanalytic point of view and from the point of view of brain-wave activity, the person having a night terror does not wake up from the experience nor does he fall back to sleep after being calmed (Daws, 1989). A person having night terrors is unable to view them from the perspective of waking life. In Bion’s terms, night terrors are constituted of raw sense impressions related to emotional experience (beta-elements) which cannot be linked in the process of dreaming, thinking or storage as memory. The child having night terrors can only genuinely wake up when he is able to dream his undreamt dream.

In contrast, a nightmare is an actual dream (which occurs in REM sleep) that ‘*awakens the person with a scared feeling*’ (Hartmann, 1984, p. 10, my italics). On awakening, the dreamer is able immediately, or within a relatively short period of time, to differentiate between being awake and being asleep, perceiving and dreaming, internal reality and external reality. Consequently, the individual is often able to remember the manifest content of the nightmare on waking and able to think and talk about it. The child who has been awoken by a nightmare is able to recognize the person who is comforting him, and, because he can remember having had a nightmare, is afraid to go back to sleep that night, and commonly for weeks or months afterwards.

In sum, a nightmare is quite different from a night terror. The former is a dream in which the individual’s emotional pain is subjected (to a significant degree) to unconscious psychological work that issues in psychological growth. However, that dreaming is disrupted at a point where the individual’s capacity for generating dream-thoughts and dreaming them is overwhelmed by the disturbing effects of the

²Unlike nightmares, which occur in REM sleep (the sleep state in which most dreaming occurs), night terrors occur in deep, slow wave sleep (Hartmann, 1984). Although I make mention in this paper of neurophysiological data associated with night terrors and nightmares (brain-wave activity recorded in sleep studies), this data is of purely metaphorical value. The fact that brain-wave activity associated with night terrors and brain-wave activity associated with nightmares are different does not lend support to the idea that the psychoanalytic conception of night terrors and nightmares differs in analogous ways. The neurophysiologic findings of sleep researchers offer nothing more (and nothing less) than intriguing parallels between the activity of the brain and the experience of the mind, and potentially valuable metaphors for use in psychoanalytic thinking about dreaming, not being able to dream and interrupted dreaming.

³While both adults and children experience night terrors and nightmares, these phenomena are more prevalent in children; for the sake of clarity of exposition, I will speak of these phenomena in terms of the experience of a child.

emotional experience being dreamt. A night terror is not a dream; no dream-thoughts are generated; no psychological work is done; nothing changes as a consequence of the psychic event.

V

With Bion's conception of dreaming as a theoretical context and the phenomena of nightmares and night terrors as metaphors for two broad categories of psychological functioning, it is now possible to begin systematically to scrutinize the elements of the compact statement I made earlier regarding my conception of psychoanalysis.

To begin at the beginning: *A person consults a psychoanalyst because he is in emotional pain, which, unbeknownst to him, he is either unable to dream (i.e. unable to do unconscious psychological work) or is so disturbed by what he is dreaming that his dreaming is disrupted. To the extent that he is unable to dream his emotional experience, the individual is unable to change, or to grow, or to become anything other than who he has been.*

Some patients who consult an analyst might be thought of as suffering from (metaphorical) night terrors. Without being aware of it, they are seeking help in dreaming their undreamt and undreamable experience. The undreamt dreams of such patients persist unchanged as split-off pockets (or broad sectors) of psychosis (Bion, 1962) or as aspects of the personality in which experience is foreclosed from psychological elaboration. Among the disorders characterized by such foreclosure are the psychosomatic disorders and severe perversions (de M'Uzan, 1984); autistic encapsulation in bodily sensation (Tustin, 1981); 'dis-affected' states (McDougall, 1984) in which patients are unable to 'read' their emotions and bodily sensations; and the schizophrenic state of 'non-experience' (Ogden, 1980) where the chronic schizophrenic patient attacks his own capacity for attributing meaning to experience, thus rendering emotional experiences interchangeable with one another. In disorders involving psychic foreclosure, the patient's thinking is, to a very large degree, of an operational sort (de M'Uzan, 1984).

Other patients who consult an analyst might be thought of as individuals suffering from (metaphorical) nightmares, that is, from dreams that are so frightening that they interrupt the psychological work entailed in dreaming both while asleep and in unconscious waking dreaming. Frost's (1928) phrase 'interrupted cry' from his poem 'Acquainted with the night' seems particularly apt in describing a nightmare.⁴ The patient awaking from a nightmare has reached the limits of his capacity for dreaming on his own. He needs the mind of another person—'one acquainted with the night'—to help him dream the yet to be dreamt aspect of his nightmare. (A 'yet to be dreamt dream' is a neurotic or other type of non-psychotic phenomenon; an undreamable dream is a psychotic phenomenon or one associated with psychic foreclosure.) The neurotic symptoms manifested by patients with interrupted dreaming represent static stand-ins for the emotional experience that the patient is unable to dream.

⁴Frost writes: 'I have stood still and stopped the sound of feet/ When far away an interrupted cry/ Came over houses from another street' (1928, p. 234). (See Ogden, 1999a, for a discussion of this poem.)

The analyst to whom either of these broad categories of people goes for help in dreaming their metaphorical night terrors and nightmares must possess the capacity for reverie, that is, the capacity to sustain over long periods of time a psychological state of receptivity to the patient's undreamt and interrupted dreams as they are lived out in the transference-countertransference. The analyst's reveries are central to the analytic process in that they constitute a critical avenue through which the analyst participates in dreaming the dreams that the patient is unable to dream on his own.⁵

VI

The patient and analyst engage in an experiment within the terms of the psychoanalytic situation that is designed to generate conditions in which the analysand (with the analyst's participation) may become better able to dream his undreamt and interrupted dreams. The dreams dreamt by the patient and analyst are at the same time their own dreams (and reveries) and those of a third subject who is both and neither patient and analyst.

The experiment that is psychoanalysis is founded upon a paradox: psychoanalysis is an evolving set of ideas and principles of technique—more a bundle of sticks than a seamless whole—which have been developed over the course of the past century; and yet, at the same time, it is the analyst's responsibility to reinvent psychoanalysis for each patient and continue to reinvent it throughout the course of the analysis. Any mother or father who has had more than one child has learned (with a combination of shock and delight) that each new infant seems to be only a distant relative of his/her older sibling(s). A mother and father must reinvent what it is to be a mother and father with each child and must continue to do so in each phase of the life of the child and the family. Similarly, the analyst must learn anew how to be an analyst with each patient in each session.

While I view psychoanalysis as an experiment, I am not suggesting that patient and analyst are free to do anything they like; rather, they are free to do psychoanalytic work in a way that reflects who they are individually and together *qua* analyst and analysand. That is, they are not inventing a love relationship or a friendship or a religious experience; they are inventing an analytic relationship which has its own psychotherapeutic aims, role definitions, responsibilities, value system, and so on.

Though we cannot predict the nature of the emotional experience that will be generated in the work with a person who consults us, our goal as analysts is very nearly the same with every patient: *the creation of conditions in which the analysand (with the analyst's participation) may become better able to dream his undreamt and interrupted dreams.* While it may seem that the analyst is at first used by the

⁵I include in the notion of reverie all of the meanderings of the psyche-soma of the analyst including the most quotidian, unobtrusive thoughts and feelings, ruminations and daydreams, bodily sensations, and so on, which usually feel utterly unrelated to what the patient is saying and doing at that moment. Reveries are not the product of the psyche-soma of the analyst alone, but of the combined unconscious of patient and analyst (Ogden, 1994a, 1994b, 1996, 1997, 1998, 1999b, 2001). As will be shown in the clinical portion of this paper, the analyst's reveries provide a form of indirect access to the unconscious life of the analytic relationship.

patient to dream the patient's undreamt dreams 'by proxy', the analyst's dreams (his reveries in the analytic situation) are from the outset neither solely his own nor those of the patient, but *the dreams of an unconscious third subject who is both and neither patient and analyst* (Ogden, 2003b).

The analytic situation, as I conceive of it, is comprised of three subjects in unconscious conversation with one another: the patient and analyst as separate subjects and the intersubjective 'analytic third' (see Ogden, 1994a, 1999b, for theoretical and clinical discussions of the concept of the analytic third). The unconscious intersubjective 'analytic third' is forever in the process of coming into being in the emotional force field generated by the interplay of the unconscious of patient and analyst. The third 'subject of analysis' is a subject jointly, but asymmetrically constructed by the analytic pair. When the analytic process is 'a going concern' (Winnicott, 1964, p. 27), neither analyst nor analysand may claim to be the sole author of his 'own' dreams/reveries.

It is the task of the analyst as separate subject (over time) to become aware of, and to verbally symbolize for himself, his experiences in and of the analytic third. The analyst may eventually speak to the patient from that experience about his thoughts concerning what is occurring at an unconscious level between himself and the patient. In so doing, the analyst is attempting to engage the patient in a form of conscious thinking that may function in concert with, and may be facilitative of, the patient's unconscious work of dreaming. When, for periods of time, the emotional experience in the intersubjective field is of a subjugating nature, the analytic pair may be unable to think about what is occurring unconsciously between them or to do psychological work with that experience (see Ogden, 1994b, on 'the subjugating third').

VII

The psychoanalytic experiment is carried out *within the terms of the psychoanalytic situation*. Central among the terms of the analytic situation is the analyst's conception of analytic methodology, that is, the analyst's individual conception of analytic theory and principles of technique that he has developed in the course of his experience as an analysand, as a student of psychoanalysis (which is an ongoing aspect of the life of an analyst), and as a practicing analyst. (It is beyond the scope of this paper to do more than refer to a few of the elements constituting the analyst's methodology.)

Analytic methodology is founded upon the assumption that there is a 'differential' (Loewald, 1960, p. 251) between the emotional maturity of the analyst and that of the analysand, that is, that the analyst has achieved a level of psychological maturity greater than that of the analysand—at least in the areas of experience most troubling to the patient. In addition, it is essential that the analyst be capable of growing emotionally as a consequence of his experience with the patient (in conjunction with his self-analytic work) so that he becomes in the course of the analysis better able to be the analyst that the patient needs him to be (Searles, 1975).

A conception of *how* and *why* one creates and maintains the features of the 'psycho-analytical set-up' (Winnicott, 1954, p. 278) is critical to one's analytic

methodology. The analytic situation usually (but not always) involves the use of the couch, a regular schedule of sessions of a fixed duration, a privileging of emotional expression in the form of words (as opposed to action), and a movement between largely unstructured, freely associative states of mind (on the part of both patient and analyst) and more focused, sequential, secondary process forms of thinking.

A principal subject of the dialogue that takes place in the analytic situation concerns the patient's anxieties and defenses arising in response to the relationship of analyst and analysand at an unconscious level (the transference-countertransference). The transference-countertransference is viewed (in part) from an historical perspective (i.e. from the vantage point of the history of both the life of the patient and the life of the analysis). The analytic situation, though in many ways unstructured, also has a quality of directionality that is derived from the fact that psychoanalysis most fundamentally is a therapeutic enterprise with the goal of enhancing the patient's capacity to be alive to as much as possible of the full spectrum of human experience. Coming to life emotionally is, to my mind, synonymous with becoming increasingly able to dream one's experience, which is to dream oneself into existence.

VIII

In the course of participating in dreaming the patient's undreamt and interrupted dreams, the analyst gets to know the patient in a way and at a depth that may allow him to say something that is true to the conscious and unconscious emotional experience that is occurring in the analytic relationship at that moment. Psychoanalysis centrally involves the analyst's getting to know the patient—a deceptively simple idea—and the patient's coming to feel known by the analyst, as well as the patient's feeling that he is getting to know himself and the analyst. In participating in dreaming the patient's undreamt and interrupted dreams, the analyst is not simply coming to understand the patient; he and the patient are together living the previously undreamable or yet-to-be-dreamt emotional experience in the transference-countertransference. In this experience, the patient is in the process of more fully coming into being and the analyst is getting to know the person who the patient is becoming.

Succeeding in getting to know the patient in this way is fraught with difficulty. While the analyst attempts to meet each patient in each new session as if for the first time (Bion, 1978), the analyst's shedding of what he already 'knows' requires that he has, in fact, learned from his experience. Only then can he attempt to free himself of what he thought he knew in order to be receptive to all that he does not know (Bion, 1971, 1992; Ogden, 2004).

The experience of the analyst's getting to know the patient is unique to each analytic encounter, and yet is unavoidably shaped by the particular ways that the analyst has of perceiving and organizing his experience of what is happening, that is, it is experience viewed through a multifaceted, ever-changing lens informed by one's psychoanalytic ideas and experience. As Wallace Stevens put it, 'Things

seen are things as seen' (Stevens, quoted by Vendler, 1997, p. ix).⁶ The analyst's experience of getting to know who the patient is becoming is inseparable from the patient's experience of getting to know who the analyst is and is becoming. In my experience, unless the patient feels (with varying degrees of conscious awareness) that he is getting to know his analyst, there is something missing at the core of the analysis: the analytic relationship has become impersonal.

While there is a vast difference between the role of the patient and that of the analyst in the analytic relationship, I do not concur with the idea—often voiced by analysts and defensively fantasied by every analyst at one time or another—that a patient cannot 'really' know the analyst because of all that the patient does not know about what is occurring and has occurred in the life of the analyst outside of the analytic situation. What is flawed about this idea, as I see it, is that it does not sufficiently take into account the fact that, to the extent that the analyst's life experiences both within and outside of the analytic setting are significant, they genuinely change who the analyst is. That alteration in his being is an unspoken and yet felt presence in the analysis.

To the degree that the analyst is unchanged by a given set of past or current experiences which have occurred within or outside of the analysis, those experiences are either insignificant or the analyst is incapable of being affected by his experience (unable to dream it or learn from it). If the latter is the case, it is doubtful that the analyst is able to engage in genuine analytic work with the patient. Under such circumstances, the patient's statement to the analyst that he cannot 'really' get to know the analyst may be the patient's unconscious way of telling the analyst that he (the patient) feels that the analyst is unable to participate either in the process of getting to know the patient and himself or of getting to be known by the patient. In other words, the patient is feeling that he and the analyst have ceased doing psychoanalysis.

IX

In his effort to *say something to the patient that is true to the conscious and unconscious emotional experience that is occurring in the analytic relationship at a given moment*, the analyst has inevitably, inescapably entered into a struggle with language itself. Awareness of one's feeling states is mediated by words. English

⁶Central among the ideas that, for me, constitute a psychoanalytic perspective are a conception of the relationships among conscious, preconscious and unconscious aspects of mind; the concept of transference-countertransference; a conception of an internal object world; the idea of the interplay of depressive, paranoid-schizoid and autistic-contiguous modes of generating experience and their associated forms of subjectivity, anxiety, defense, object-relatedness and psychological growth; the concepts of splitting, projective identification and manic defense; the notion of the human need for truth; a conception of psychological aliveness and deadness; the concept of a psychological space between reality and fantasy in which the individual may develop the capacity for thinking symbolically, thereby coming imaginatively to life; the idea of the analytic frame; an understanding of the pivotal role, from birth onward, of sexuality in healthy development and in psychopathology; the idea of the unity of the psyche-soma in health; a conception of the way in which the development of capacities for symbolization and self-awareness are inseparable from the development of internal and external object relationships (including maternal mirroring and oedipal triangulation).

professor Theodore Baird once asked, ‘What do you need to repair a motorcycle?’ And responded, ‘You need language. You need words ... How do you know it’s a motorcycle? ... Why isn’t it a radiator?’ (Baird, quoted by Varnum, 1996, p. 115). Similarly, one needs language and words to ‘know’ (more accurately, to gain a sense of) what one is feeling (for example, to be able to distinguish between feeling alone, feeling lonely and feeling frightened).

In our effort to use language to convey a sense of what is true to an emotional experience, we find that we cannot say a feeling,⁷ but we may be able to say what an emotional experience feels like. And for that we need metaphoric language. In the very act of making this transformation from having an emotional experience to saying what it felt like, we are creating not only a new experience, but also a form of self-awareness mediated by verbal symbols (a uniquely human form of consciousness). The enrichment of this form of self-awareness (consciousness) mediated by verbal symbolization is, to my mind, one of the most important aspects of a successful analytic experience.

And yet, while metaphorically putting feelings into words is a necessary component of psychoanalysis, it is not a necessary component of every step or phase of that process. In fact, there are times when the analyst’s insistence on using words for communicating experience is antithetical to doing analytic work. Some things unsaid are ‘far more important than things that are merely said’ (Borges, 1970, p. 211). Borges was referring to his father’s unspoken wish that Borges become the writer that Borges’s father had aspired to be. In my experience as an analyst and as a supervisor, there are long stretches of time during which the patient’s healthy feelings of love for the analyst are a felt presence that is far more important than things ‘merely said’. (This situation is not to be confused with repression, splitting or any other form of avoidance of feeling love.)

X

What the analyst says to the patient regarding what he feels to be true to the emotional situation that is occurring *must be utilizable by the patient for purposes of conscious and unconscious psychological work, that is, for dreaming his own experience, thereby dreaming himself more fully into existence*. What truth there may be in what the analyst says regarding an emotional experience is of no consequence unless the patient is able to make use of it in doing conscious and unconscious psychological work. For this to occur, the patient must feel known by the analyst in a way that he has never before felt known. The analytic relationship is unique. (The invention of a new form of human relatedness may be Freud’s most remarkable contribution to humankind. Being alive in the context of the analytic relationship is different from the experience of being alive in any other form of human relatedness.) Feeling known in the analytic situation is not so

⁷The names we give to feelings—for example, feeling alone, feeling lonely, feeling frightened—are broad generic categories that do not say feelings any more than the word ‘chocolate’ says an experience of tasting chocolate. One cannot possibly communicate in words the taste of chocolate to a person who has never tasted it. Tasting, like all other sensory and emotional experiences, cannot be said.

much a feeling of being understood as it is a feeling that the analyst knows *who one is*. This is communicated in part through the analyst's speaking to the patient in such a way that what he says and the way he says it could have been spoken by no other analyst to no other patient.

I would hope that, if one of my patients were a speck on the wall of my consulting room listening to me work with another patient, the patient-on-the-wall would recognize me as the same person, the same analyst, with whom he is working in analysis, but would find that the way the patient-on-the-couch and I are talking is a way that would not suit the patient-on-the-wall. That way of being together and conversing that is being overheard would feel somehow 'off'—perhaps a bit too cerebral or too raw, a bit too serious or too playful, a bit too parental or too spousal. The patient-on-the-wall ideally would not envy the patient-on-the-couch; rather, he would feel that 'that is not for me', and, of course, he would be right—it is not meant for him.

The interpretations made by an analyst who is wed to a particular 'school' of psychoanalysis are frequently addressed to the analyst himself (to his internal and external objects) and not to the patient. When a patient feels that the analyst is speaking in a way that is not meant for him alone, he feels isolated and starved of the opportunity to speak with the analyst about what is true to what is going on in the analysis. I am reminded here of a schizophrenic patient who said to his mother, 'You've been just like a mother to me'. The analyst who is unable to speak to his patient in a way that has evolved from his experience with *that* patient (and is unique to that patient) is being just like an analyst to the patient.

XI

Now that I have taken apart my initial statement of my conception of psychoanalysis, I will put it together again so that the reader might read it as if for the first time: *A person consults a psychoanalyst because he is in emotional pain, which, unbeknownst to him, he is either unable to dream (i.e. unable to do unconscious psychological work) or is so disturbed by what he is dreaming that his dreaming is disrupted. To the extent that he is unable to dream his emotional experience, the individual is unable to change, or to grow, or to become anything other than who he has been. The patient and analyst engage in an experiment within the terms of the psychoanalytic situation that is designed to generate conditions in which the analyst (with the analyst's participation) may become better able to dream his undreamt and interrupted dreams. The dreams dreamt by the patient and analyst are at the same time their own dreams (and reveries) and those of a third subject who is both and neither patient and analyst.*

In the course of participating in dreaming the patient's undreamt and interrupted dreams, the analyst gets to know the patient in a way and at a depth that may allow him to say something to the patient that is true to the conscious and unconscious emotional experience that is occurring in the analytic relationship at a given moment. What the analyst says must be utilizable by the patient for purposes of conscious and unconscious psychological work, that is, for dreaming his own experience, thereby dreaming himself more fully into existence.

XII

Some experiences from the early stages of an analysis

A few days after Mr A and I had set a time to meet for an initial consultation, his secretary called to cancel the meeting for vague reasons having to do with Mr A's business commitments. He called me several weeks later to apologize for the cancellation and to ask to arrange another meeting. In our first session, Mr A, a man in his mid-forties, told me that he had wanted to begin analysis for some time (his wife was currently in analysis), but he had kept putting it off. He quickly added (as if responding to the expectable 'therapeutic' question), 'I don't know why I was afraid of analysis'. He went on, 'Although my life looks very good from the outside—I'm successful at my work, I have a very good marriage and three children whom I dearly love—I feel almost all the time that something is terribly wrong'. [Mr A's use of the phrases 'afraid of analysis', 'dearly love' and 'terribly wrong' felt to me like anxious unconscious efforts to feign candor while, in fact, telling me almost nothing.] I said to Mr A that his having asked his secretary to speak for him made me think that he may feel that his own voice and his own words somehow fail him. Mr A looked at me as if I were crazy and said, 'No, my cell phone wasn't working and, rather than pay the outrageous amounts that hotels charge for phone calls, I e-mailed my secretary telling her to call you'.

During that initial meeting, the patient told me that he suffered from severe insomnia that had begun when he was in college. While trying to fall asleep, he ruminates about all of the things that he has to attend to at work and makes lists in his head of things that need fixing around the house. He added that doctors had prescribed sleeping pills over the years, but 'they don't work and I don't want to get hooked on them'. [Implicit in his tone was the sentiment: 'Doctors do indeed do harm and will get you hooked if you allow them to'.]

In the course of the first 18 months of analysis, Mr A told me about his childhood in a rather nostalgic way. He had grown up in a working-class suburban neighborhood where he had a group of friends and had done well in school. The patient had put himself through college on scholarships, loans and long hours of work. He spoke briefly and superficially of his two sisters, one of whom is five years his senior, and the other two years his junior.

Mr A also talked about his work as director of a non-profit organization that assists illegal immigrants in their dealings with the Immigration and Naturalization Service. He said that, when he arrived at work each morning and looked around at the staff and at the clients 'camped out' in the lobby, he had to remind himself what he was doing there. [I was not sure what Mr A was doing in my consulting room with me. I was reminded of a story that circulated during my residency: Members of the psychiatric examining board—whatever that was—came to psychiatric clinics posing as patients in order to evaluate the residents and the residency program.]

Mr A very often began his daily sessions by telling me a dream. He said that, when he could not remember a dream to tell me, he felt as if he had not done his homework. And yet, when he was able to remember a dream, there was almost always a feeling of letdown on my part as well as his after he had told it. It was

as if his dreams held no latent content. They were dreams depicting scenes that were almost identical to emotional situations that were regular occurrences in the patient's life. Finding transference (or any other) meanings in the dreams felt like a contrivance in which the patient or I projected 'unconscious meaning' into the dream where none existed.

Toward the end of the second year of analysis I became aware of something that may have been going on for some time, but it was only then that it became available to me for conscious psychological work. The rhythm of Mr A's speech was marked by brief, hardly noticeable pauses after almost every sentence, as if preparing himself not to be surprised by me. I said to Mr A that I thought that he was having trouble knowing what to make of me. 'It may be that I'm not at all what I seem to be.' [My intervention was shaped in part by my observations of the patient's anxious pauses and by my earlier reverie⁸ concerning the patient who was not a patient.]

A few weeks after I made this interpretation, it was clear one day when I met Mr A in the waiting room that he was in great distress. He began by saying that, until very recently, he had not really known why he had come to analysis. He had thought it was to please his wife who had been pressuring him to get into analysis. Speaking haltingly, his voice choked with tears, he said, 'When I was 7 and my younger sister was 5, we played doctor. I tried to see into her privates. I wanted to find out what was in there. I used a stick in the way a doctor uses a tongue depressor. I think it happened only two or three times, but I can't be sure. I know it was more than once'. At this point, Mr A was sobbing and could not speak. After a few minutes, he continued, 'I rarely think about it and I've never thought it was a big deal—lots of kids play doctor. I don't know why I only now feel so bad about it. I was up all night last night. I didn't know what I was feeling. I felt sorry for S [he had never used his sister's name before]. I don't know if she even remembers it or how it has affected her. I only speak to her on birthdays, Thanksgiving and Christmas'.

As Mr A was speaking, I felt moved by the depth of his pain which seemed explosive and utterly unexpected by either of us. It did not seem to me that he was confessing in an effort to elicit forgiveness from me. Rather, it seemed that he was, at least in part, responding to my having interpreted his feeling that he had no idea who I was or what I was up to. He had apparently heard, and been able to make use of the unstated aspect of the interpretation, that is, that he felt that he had no idea who *he* was and what *he* was up to.

In the months that followed, Mr A began to develop a slight edge of self-awareness that first appeared in the form of a capacity for irony. For example, he opened a session by saying that the high point of his morning had been the warm welcome his auto-mechanic had given him when he dropped off his car for the third time in a month for the same problem. He was identifying with me in his use of irony; this had the feel of a boy adopting qualities of his father whom he admires. (Of course, I did not comment on the transference implications of his quip about the mechanic.)

⁸My reverie experience in the work with Mr A had been extremely sparse and difficult to utilize in the first year or so of the analysis.

Mr A, as if treading lightly on very dangerous ground, spoke of his life growing up in his childhood family. He was no longer simply a chronicler of romanticized events, but a self-observant person learning from his own verbal renderings of his experience in the very process of his speaking them to me and to himself.

I learned that Mr A's parents owned a shop where they sold and repaired small household appliances—his mother dealt with the customers while his father did the repairs at a workbench at the rear of the store. They were continually on the edge of going out of business. From the time the patient was 5, he helped out around the shop and by 7 he was doing pick-ups and deliveries. 'It wasn't an adventure, it was deadly serious business.' Fearful of losing customers, his parents grossly undercharged for their work.

The patient spoke more about his examining his sister's genitals.

P: She trusted me and went along with me in any game I invented. That's what makes this particularly ugly, the way I took advantage of her trust. I have no excuses that are worth anything to me.

A: It seems to me that you're trying to face the music.

Only after having used the phrase 'face the music' did I hear its double meaning: in facing the music, one dares to take on the reality of what is (as a fearful actor must do in facing the audience across the orchestra pit); and, at the same time, there is a beauty (music) to the experience of being honest with oneself, even though one is powerless to undo what one has done.

In the session that followed, Mr A told me that the previous night he had had a dream that was a sort of dream he had dreamt many times before (he had never told me about these dreams).

P: *It takes place in the lobby of a movie theater with big posters in glass cases. There is a popcorn and candy stand with lots of customers standing in line. But then I realize with horror that the theater is completely deserted and has been shut down for years. This time—and it's happened a couple of times before—I refuse to believe that what I had seen wasn't real.* I woke up from the dream with my heart racing, not with fear, but with anger.

A: In your dream, you hold on to your own perceptions, not to prove you're right, but to prove you are who you are.

[My interpretation felt hackneyed and dangerously close to something one might read in a self-help book. Fortunately, Mr A was able to do his own psychological work here in spite of me.]

P (in a loud, angry voice that I had not previously heard): The movie theater *worked* as a movie theater—that's not asking too much, is it?

[I felt that some of Mr A's outrage was directed at me for my impersonal intervention.]

P (more softly): I was ashamed of my parents and of myself. I wished—and still do wish—that they had been like my friends' parents who, even though they didn't

have any more money than my parents, didn't behave like animals who had all the life beaten out of them. I feel bad talking about my parents this way.

A: It's a complicated thing: even at the beginning of the dream, when you thought everything worked as it should, it was at the cost of being alone with it.

[I thought, but did not say, that he was furious at his parents, not only for their being what he felt to be shameful failures, but also for their inability, even for a moment, to dream with him something exciting, however improbable it might be.]

Mr A and I were silent for several minutes during which a subtle shift occurred that I recognized only in retrospect. During that silence, my thoughts wandered to a film that I had seen in which an actress whom I like very much is the main character. In that film, I found her particularly charming and sexy. It was not the character she played to whom I felt drawn, it was to her, the actress, the woman I imagined her to be. In the film, she sang two songs and I was amazed not only by the beauty of the sound of her voice, but also by the enormous range of her talent.

The patient told me later in the session that from the time his daughter was a baby, it had been impossible for him to hold her in his arms in a way that felt natural, much less change her diaper without feeling that he was 'being a voyeur and a pervert'.

As Mr A was speaking, my mind turned from the images and feelings associated with the patient's having played doctor with his sister to an event from my own experience of becoming a doctor. In the early weeks of medical school—I was 21 at the time, I defensively noted to myself—my group of four medical students was working on the dissection of 'our' cadaver. I remembered having lived with a great deal of fear during that period of my life.

The four of us were all business in the dissection, each alone with his terrors. There was a moment when feelings seemed to break through the guise of the ardent, confident students of medicine: we began talking to the cadaver addressing him by an invented first name as if he were alive but too shy to talk. I remembered having felt at the time that this joke was a dangerous one, as if we were violating a sacred law. At the same time, the joke, which was full of anger and fear, was a welcome release.

As I was recalling these feelings and events, I felt a deep sense of having betrayed a trust. The cadaver had been a middle-aged man, probably about my current age when he died, a man who had been generous in donating his body for medical education and research. He did not deserve to be treated like a dummy in a vaudeville act. I felt a combination of guilt in connection with what I had done and compassion for myself as a young man who was doing the best he could in the face of emotional events too disturbing to be borne alone and too shameful to be admitted to anyone else. I could still smell the thick odor of formaldehyde that had filled the room in which the 23 cadavers had been laid out on their stainless steel tables. It was an odor that was always with me because it had soaked into my clothes and into my skin. As a medical student, unable to dream this experience, I had developed a mild psychosomatic disorder. It was an undreamable emotional experience that required considerable analytic work on my part in order for me to begin to be able to dream the foreclosed thoughts and feelings.

As my attention shifted from this reverie back to Mr A, a particular aspect of what he had said recently about his childhood took on enhanced meaning for me. His mother's only friends had been her two sisters and she had made no effort to hide the fact that they were far more important to her than was the patient's father. Neither did she disguise the fact that it was the patient's older sister who captivated her in a way that the patient and his younger sister did not. Although Mr A did not say so explicitly, it seemed to me at this point that his mother had used the patient's older sister as a vehicle through whom to live the life of a girl, and then of a young woman, who she wished she had been. I began to recognize that earlier in the analysis I had too readily adopted as my own the patient's view of his parents as defeated people utterly lacking in dreams. It now seemed that it was Mr A's father who had been the defeated one and that the patient's depiction of his mother as a person without dreams had served to protect him from the even more disturbing feeling that his (external and internal object) mother had been alive—albeit primarily narcissistically—to his older sister, but not to him.

Later in the session, Mr A spoke about his inadequacies as a husband including his feeling that he is 'lousy at sex'.

P: It's like dancing. I have no sense of rhythm and I try to move my body in the way other people do, but it's not dancing. I don't feel the music.

A: I think you felt that you'd never be able to dance with your mother in the way your older sister did. It was only something girls and women knew about.

[In retrospect, I believe that this interpretation was derived in part from my reverie concerning the actress who could do everything, including sing beautifully. Although I had not been aware of it at the time that the reverie occurred, I realized at this point in the session that I had not only been admiring of the actress, I had also been envious of her for being a woman. Both the patient and I were unconsciously giving metaphoric shape to our experience of being inadequate because we would never be a girl or a woman who could captivate his mother. Both my reverie concerning the music of the actress's singing and my use of the phrase 'face the music' were parts of the unconscious context for the patient's use of music as a metaphor for his own feelings of inadequacy for not having been born a girl and for lacking whatever else it would have taken to have won his mother's love.]

P: In a way even now I feel that there's something impenetrable about women and their ties to one another. They live in a whole other reality unknowable by a man. I don't have words for it—they live inside their bodies, not on the surface of their bodies the way men do. Their pocket books are like pouches in which they carry around their secrets. I don't really believe that men, with their simple-minded uncomplicated penises, have anything to do with the mystery of making a baby. A woman's body is strange, in a way grotesque, with amazing powers.

Mr A's comments led me to think further about parts of my reverie experience. I began to be aware of a facet of meaning of the medical school reverie that I had not previously recognized. I had been feeling the unbridgeable void between me and the person on the anatomy table. He was human; I could see and touch his face

and hands. He had small, delicate hands. And yet, it, the cadaver, was a thing. I had felt deeply disturbed by my inability to reconcile the two: he was there in all his humanness, his generosity, and, at the same time, there was no one there; he was absolutely, irretrievably dead, merely a thing with whom no human connection could be made. Perhaps 'the joke', for me, had been a futile effort to mitigate the absolute quality of that divide.

My experience of dissecting the cadaver as it was taking place had held a great many powerful meanings for me, including frighteningly immediate confrontations with my own mortality, terrors associated with bodily mutilation, and feelings of loss of my capacities to feel, (to remain emotionally alive) in the face of an experience that shook me to the core. However, in the analytic session with Mr A that I am discussing, specific aspects of that set of experiences took on particular importance as dreamt, incompletely dreamt and undreamt aspects of my own psychological pain. In order to do analytic work with Mr A, it was necessary for me to make use of the unconscious experience with him as an opportunity to dream (in the form of reverie experience) some of my own 'night terrors' and 'nightmares' that overlapped with his. It is impossible to say whether the disturbing gap between me and the cadaver was part of the original medical school experience or was an emotional experience generated for the first time in the context of my work with Mr A.

A month or so after the session I have just described, Mr A and his family took a three-week vacation trip to Asia. On his return, Mr A told me that something very important had occurred during the time that he was away. He said that he had taken some instruction in Buddhist thought and meditation and had 'experienced a connection with something greater than myself in a way I have never felt before'. Mr A went on to speak at some length about the transformation that he had undergone. He no longer seemed to be speaking in a way that was specific to me (as he had in the sessions prior to the vacation break). I was not at all surprised when he eventually told me that he had decided to pursue Buddhist meditation and so this would be our last session. The rhythm of the movement of the analysis at this point had the feel of a disruption of dreaming.

I was aware practically from the start of Mr A's telling me about his response to Buddhism that I was being cast in the role of the outsider who did not have the slightest chance of competing with the enormous emotional power of Mr A's new (narcissistic object) love. An unbridgeable divide between the two of us had been created. I said to the patient, 'I won't try to talk you out of what you have in mind to do [i.e. I would not act out with him the humiliation of begging for his mother's love in the face of the impenetrable narcissistic self-involvement that he had encountered in her]. What I will do is what you and I always do and that is to put into words what's going on [i.e. I would remain myself, his analyst, even in the face of his threatening to isolate himself from me in narcissism while projecting into me the loneliness and impotence that he could not bear to experience on his own]'

I continued, 'It seems to me that I have a responsibility both to you, the person with whom I am talking, and to you, the person who originally came to see me, the person who, without knowing it, was asking me for my help in facing the music. I am responsible to both aspects of you despite the fact that, for the moment, one of

them is mute and I must do the talking for that aspect of you [i.e. I would not repeat with him the childhood scene of his mother's embracing one of her children and discarding the others]’.

In the session that followed, Mr A and I spoke about the fear he had felt of losing himself and me during the vacation break. He said that, despite the fact that in the past he had asked me to fill his sessions when he was away, he had hoped that I would know that this time I should keep them for him. ‘They’re my times and it wouldn’t feel right to have someone else here.’

A bit later in that session, Mr A told me, ‘When I left here yesterday, it felt like a weight had been lifted ... no, that’s not it ... I felt that I’d come back to myself and coming back to myself isn’t entirely a good thing, as you know. It’s been a place that’s been unbearable to be. It was good to hear your voice while you were speaking yesterday—I listened more to the sound of your voice than to what you were saying. It wasn’t just the sound of your voice, it was the sound of you thinking. When I could hear that your voice hadn’t changed, I knew that you hadn’t given my place away. It doesn’t matter whether you really have or haven’t filled the times—I know you know that’.

There was a feeling of profound affection and gratitude in Mr A’s voice as he spoke that I had not heard before—and I have no doubt that he knew I knew that too.

It seemed to me at this juncture in the analysis that Mr A’s molestation of his sister represented an acting out of intense sets of feelings that he had experienced as a child and were currently being experienced in the transference–countertransference. His repeatedly looking into his sister’s genitals seemed to me to represent an attempt to find out what was ‘in there’ (inside his mother’s body and mind), which was at once ‘grotesque’ and ‘with amazing powers’. The patient may have imagined that what he found ‘in there’ would hold the key to the mysterious emotional bond that tied his mother so strongly to her sisters and to his older sister. The molestations may also have represented angry attacks on, and forced entries into, his mother’s genitals and insides in retaliation for what he felt to be her almost complete emotional exclusion of him. And finally—and perhaps most important—the patient may have been attempting to find his place ‘in there’, a place that was meant only for him, a place that could never be taken away from him and given to someone else.

In the weeks and months that followed, as different facets of this constellation of internal object relationships came to life in the transference–countertransference, Mr A and I thought and spoke and dreamt these emotional experiences.

Translations of summary

Diese Kunst der Psychoanalyse: Das Träumen ungeträumter Träume und unterbrochene Schreie. Gegenstand dieses Beitrags ist die Kunst der Psychoanalyse in der Entstehung, ein Prozess, der sich in seinem Verlauf selbst erfindet. Der Autor legt sein Verständnis der Psychoanalyse präzise dar und beschreibt ein detailliertes Fallbeispiel. Er vertritt die Ansicht, dass jeder Analysand unbewusst (und ambivalent) Hilfe dabei sucht, seine „nächtlichen Ängste“ (seine ungeträumten und nicht träumbaren Träume) und seine „Alpträume“ (seine Träume, die unterbrochen werden, wenn der mit dem emotionalen Erleben verbundene Schmerz die Fähigkeit zu träumen überfordert) zu träumen. Nicht träumbare Träume werden

als Manifestationen psychotischer oder psychisch unzugänglicher Aspekte der Persönlichkeit verstanden, unterbrochene Träume als Reflexionen neurotischer und anderer nicht-psychotischer Persönlichkeitsanteile. Die Aufgabe des Analytikers besteht darin, Bedingungen zu schaffen, die es dem Analysanden — unter Beteiligung des Analytikers — ermöglichen, die zuvor nicht träumbaren und die unterbrochenen Träume zu träumen. Ein signifikanter Aspekt der Beteiligung des Analytikers am Träumen des Patienten realisiert sich in Form seines *Rêverie*-Erlebens. Bei dieser gemeinsamen Traumarbeit in der analytischen Sitzung wird der Analytiker den Analysanden vermutlich genügend gut kennen lernen, um etwas sagen zu können, das auf das Geschehen, welches sich auf einer unbewussten Ebene in der analytischen Beziehung vollzieht, zutrifft. Der Sprachgebrauch des Analytikers trägt entscheidend dazu bei, es dem Patienten zu ermöglichen, die Worte des Analytikers für sich zu benutzen, um seine eigene Erfahrung träumen und sich auf diese Weise vollständiger ins Sein hineinträumen zu können.

Este arte del psicoanálisis: soñando sueños no soñados y gritos interrumpidos. El tema de este trabajo es el arte del psicoanálisis como obra en curso, un proceso que se inventa a sí mismo a medida que transcurre. El autor expone de manera sucinta su concepción del psicoanálisis y brinda una ilustración clínica detallada. Ogden sugiere que cada analizando de modo inconsciente (y ambivalente) está buscando ayuda para soñar sus “terrores nocturnos” (sus sueños no soñados e insoñables) y sus “pesadillas” (sus sueños interrumpidos cuando el dolor de la experiencia emocional que se está soñando excede su capacidad para soñar). Los sueños insoñables son entendidos como manifestaciones de aspectos psicóticos y psíquicos excluidos de la personalidad; los sueños interrumpidos son vistos como reflejos de partes neuróticas y de otras no psicóticas de la personalidad. La tarea del analista es generar condiciones que permitan al analizando -con participación del analista- soñar los sueños previamente insoñables e interrumpidos. Una parte significativa de la participación del analista en los sueños del paciente toma la forma de la experiencia de *rêverie* del analista. En el curso de este trabajo conjunto de soñar en el setting analítico, el analista puede llegar a conocer al analizando lo suficientemente bien como para poder decir algo que es verdad respecto de lo que está ocurriendo en un nivel inconsciente en la relación analítica. El uso del lenguaje por parte del analista contribuye significativamente a la posibilidad de que el paciente pueda utilizar lo dicho por el analista para soñar su propia experiencia, y al soñarse a sí mismo, construirse una más plena existencia.

Cet art de la psychanalyse: rêver des rêves non rêvés et des cris interrompus. L’objet de cet article est l’art de la psychanalyse dans la création d’un processus qui s’invente lui-même au fur et à mesure qu’il avance. L’auteur décline succinctement sa conception de la psychanalyse et en propose une illustration clinique détaillée. Il suggère que chaque analysant cherche de l’aide de façon inconsciente (et ambivalente) en rêvant ses « terreurs nocturnes » (ses rêves non rêvés et impossibles à rêver) et ses « cauchemars » (ses rêves qui sont interrompus lorsque la douleur de l’expérience émotionnelle rêvée déborde sa capacité de rêver). Les rêves impossibles à rêver sont compris comme des manifestations d’aspects psychotiques et psychiquement forclos de la personnalité ; les rêves interrompus sont considérés comme les reflets des parties névrotiques et des parties non psychotiques de la personnalité. La tâche de l’analyste consiste à générer les conditions susceptibles de permettre à l’analysant – avec la participation de l’analyste – de rêver les rêves auparavant impossibles à rêver et les rêves interrompus. Une part significative de la participation de l’analyste dans l’activité onirique du patient prend la forme de l’expérience de *rêverie* de l’analyste. Au cours de ce travail conjoint d’activité onirique au sein du cadre analytique, l’analyste peut en arriver à connaître suffisamment bien l’analysant pour être capable de dire quelque chose de vrai sur ce qui est en train d’avoir lieu à un niveau inconsciente dans la relation analytique. L’utilisation du langage par l’analyste contribue de façon significative à la possibilité pour le patient de devenir capable d’utiliser ce que l’analyste a dit dans le but de rêver sa propre expérience, et de ce fait de se rêver plus pleinement dans l’existence.

L’arte della psicoanalisi: sognare sogni non sognati e pianti interrotti. Il soggetto di quest’articolo è l’arte della psicoanalisi nel suo farsi, come processo che s’inventa man mano che procede. L’autore formula sinteticamente il modo in cui egli concepisce la psicoanalisi, offrendone un’illustrazione clinica dettagliata. Egli suggerisce che ogni analizzando cerca inconsciamente (e ambivalentemente) aiuto nel sognare i suoi “terrori notturni” (i suoi sogni non sognati e che non può sognare) e i suoi “incubi” (quei sogni che s’interrompono quando la sofferenza dell’esperienza emotiva sognata eccede la capacità di sognare). I sogni che non si possono sognare sono intesi come manifestazione di aspetti psicotici e psichicamente forclusi della personalità, i sogni interrotti sono visti come il riflesso di parti della personalità nevrotiche e di altre non psicotiche. Il compito dello psicoanalista è quello di creare le condizioni che consentano all’analizzando di sognare – con la partecipazione dello psicoanalista stesso – i sogni che prima non poteva sognare e i sogni

interrotti. Una parte significativa della partecipazione dello psicoanalista ai sogni del paziente prende la forma dell'esperienza di rêverie dello psicoanalista stesso. Nel corso di questo lavoro onirico congiunto nel setting psicoanalitico è probabile che lo psicoanalista incominci a conoscere l'analizzando sufficientemente bene, tanto da riuscire a dire qualcosa di vero relativamente a ciò che sta accadendo a livello inconscio nella relazione analitica. L'uso del linguaggio da parte dello psicoanalista contribuisce in maniera significativa alla possibilità che il paziente riesca a utilizzare ciò che lo psicoanalista ha detto al fine di sognare la propria esperienza, e quindi di sognarsi più pienamente entro l'esistenza.

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