

REVERIE AND INTERPRETATION

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The analyst's reverie experience constitutes an indispensable avenue to the understanding and interpretation of the transference-countertransference and yet is perhaps the dimension of the analyst's experience that feels least worthy of scrutiny. Reverie takes the most mundane, personal, and private of shapes, often involving the minutiae of everyday life. Although the analyst's reveries are personal psychological events, I view them as unconscious intersubjective constructions generated by analyst and analysand. Three analytic sessions are discussed to illustrate the ways in which reveries are experienced as well as the process by which the analyst attempts to make use of this aspect of his or her experience.

Experience is never limited, and it is never complete; it is an immense sensibility, a kind of huge spider-web of the finest silken threads suspended in the chamber of consciousness, and catching every air-borne particle in its tissue. It is the very atmosphere of the mind; and when the mind is imaginative . . . it takes to itself the faintest hints of life . . .

HENRY JAMES (1884)

I believe that we do well in psychoanalysis to allow words and ideas a certain slippage. This is particularly true of the term *reverie* (Bion, 1962a, 1962b). What I shall attempt in this paper is not a definition of reverie, but a discussion of my experience of attempting to use my own states of reverie to further the analytic process. In this way I hope to convey a sense of what I mean by the expe-

rience of reverie in an analytic setting and how I make analytic use of the "overlapping states of reverie" of analyst and analysand.

It is almost impossible not to be dismissive of reverie since it is an experience that takes the most mundane and most personal of shapes. These shapes, especially early on in the process of moving toward verbal symbolization of reverie experience (and we are most of the time early on in the process), are the stuff of ordinary life—the day-to-day concerns that accrue in the process of being alive as a human being. Reveries "are things made out of lives and the world that the lives inhabit . . . [they are about] people: people working, thinking about things, falling in love, taking naps . . . [about] the habit of the world, its strange ordinariness, its ordinary strangeness . . ." (Randall Jarrell [1955, p. 68] speaking about Frost's poetry). They are our ruminations, daydreams, fantasies, bodily sensations, fleeting perceptions, images emerging from states of half-sleep (Frayn, 1987), tunes (Boyer, 1992) and phrases (Flannery, 1979) that run through our minds, and so on.

I view reverie as simultaneously a personal/private event and an intersubjective one. As is the case with our other highly personal emotional experiences, we do not often speak with the analysand directly about these experiences but attempt to speak to the analysand *from* what we are thinking and feeling. That is, we attempt to inform what we say by our awareness of and groundedness in our emotional experience with the patient.

It is no small thing that we ask of ourselves as analysts in attempting to make use of our reverie experience in the analytic setting. Reverie is an exquisitely private dimension of experience involving the most embarrassingly quotidian (and yet all-important) aspects of our lives. The thoughts and feelings constituting reverie are rarely discussed with our colleagues. To attempt to hold such thoughts, feelings, and sensations in consciousness is to forgo a type of privacy that we ordinarily unconsciously rely on as a barrier separating inside from outside, public from private. In our efforts to make analytic use of our reveries, "I" as unself-conscious subject is transformed into "me" as object of analytic scrutiny.

Paradoxically, as personal and private as our reveries feel to us, it is misleading to view them as "our" personal creations, since reverie is at the same time an aspect of a jointly (but asymmetrically) created unconscious intersubjective construction that I have termed "the intersubjective analytic third" (Ogden, 1994a, b, c, d, 1995, 1996a, b). In conceptualizing reverie as both an individual psychic event and a part of an unconscious intersubjective construction, I am relying on a dialectical conception of the analytic interaction. Analyst and analysand together contribute to and participate in an unconscious intersubjectivity. To paraphrase and extend Winnicott (1960), there is no such thing as an analysand apart from the analyst; at the same time the analyst and analysand are separate individuals, each with his or her own mind, body, history, and so on. The paradox is "to be accepted and tolerated and respected . . . for it is not to be resolved" (Winnicott, 1971, p. xii).

The analyst's reveries are more difficult to make use of analytically than the dreams of either analyst or analysand because reveries are "unframed" by sleep and wakefulness. We can usually differentiate a dream from other psychic events because the experience occurs between the time we fall asleep and the time we wake up. Reverie, on the other hand, seamlessly melts into other psychic states. It does not have a clearly delineated point of departure or point of termination separating it, for example, from more focused secondary process thought that may precede or follow it.

The experience of reverie is rarely, if ever, "translatable" in a one-to-one fashion into an understanding of what is going on in the analytic relationship. The attempt to make immediate interpretive use of the affective or ideational content of our reveries usually leads to superficial interpretations in which manifest content is treated as interchangeable with latent content.

Our use of our reveries requires tolerance of the experience of being adrift. The fact that the "current" of reverie is carrying us anywhere that is of any value at all to the analytic process is usually a retrospective discovery and is almost always unanticipated. The state of being adrift cannot be rushed to closure. We must be able

to end a session with a sense that the analysis is at a pause, at best, a comma in a sentence. Analytic movement is better described as a "slouching towards" (Coltart [1986], borrowing from Yeats) rather than an "arriving at." This sort of movement is particularly important to be able to bear in one's handling of reverie. No single reverie or group of reveries should be overvalued by viewing the experience as a "royal road" to the leading unconscious transference-countertransference anxiety. Reveries must be allowed to accrue meaning without analyst or analysand feeling pressured to make immediate use of them. However urgent the situation may feel, it is important that the analytic pair (at least to some degree) maintain a sense that they have "time to waste," that there is no need to account for the "value" of each session, each week, or each month that they spend together. Symbolization (in part verbal) usually develops over time if one is patient and does not force it (cf., Green [1987] and Lebovici [1987] for discussions of the relationship between reverie and verbal symbolization). Forced symbolization is almost always easily recognizable by its intellectualized, formulaic, contrived quality.

Neither should we dismiss any reverie as simply our "own stuff," i.e., as a reflection of our own unresolved conflicts, our distress regarding events in our current life (however real and important those events might be), our state of fatigue, our tendency to be self-absorbed. An important event in the analyst's life, such as the chronic illness of a child, is differently contextualized by the analyst's experience with each patient, and as a result becomes a different "analytic object" (Bion, 1962a; Green, 1975) in each analysis. For example, while sitting with one patient, the analyst may be consumed by feelings of intense helplessness regarding the inability to relieve the pain that his or her child is experiencing. While with another patient (or at a different moment in the hour with the same patient), the analyst may be almost entirely preoccupied with feelings of envy of friends whose children are healthy. While with still another patient, the analyst might be filled with terrible sadness in imagining what it would feel like to attempt to live without one's child.

The emotional fallout of reverie is usually unobtrusive and inarticulate, carrying for the analyst more the quality of an elusive sense of being unsettled than a sense of having arrived at an understanding. I believe that the emotional disequilibrium generated by reverie is one of the most important elements of the analyst's experience with which to get a sense of what is happening at an unconscious level in the analytic relationship. Reverie is an emotional compass that I rely on heavily (but cannot clearly read) to gain my bearings in the analytic situation. Paradoxically, while reverie is for me critical to my ability to be an analyst, it is at the same time the dimension of the analytic experience that feels in the moment least worthy of analytic scrutiny. The emotional tumult associated with reverie usually feels as if it is primarily, if not entirely, a reflection of the way in which one is *not* being an analyst at that moment. It is the dimension of our experience that most feels like a manifestation of our failure to be receptive, understanding, compassionate, observant, attentive, diligent, intelligent, and so on. Instead, emotional disturbances associated with reverie feel like a product of our own interfering current preoccupations, excessive narcissistic self-absorption, immaturity, inexperience, fatigue, inadequate training, unresolved emotional conflicts, etc. Our difficulty in making use of our reveries in the service of analysis is easily understandable since such experience is usually so close, so immediate, that it is difficult to see; it is "too present to imagine" (Frost, 1942, p. 305).

Since I view the use of overlapping states of reverie of analyst and analysand as a fundamental part of analytic technique, a close examination of any analytic session will serve to illustrate significant aspects of the use of reverie (or the difficulty faced by the analytic pair in attempting it). By the same token, a close examination of any experience in the analytic use of reverie is specific to a particular moment in a particular analysis. An exploration of that moment will involve problems of technique and potentialities for emotional growth that are unique to that moment in the psychological-interpersonal movement of analyst and analysand. Consequently, the clinical example that I will present is necessarily

a clinical example of a "special problem" in the analytic use of reverie. (There are no "run-of-the-mill" problems in the effort to make use of reverie.)

CLINICAL ILLUSTRATION: THE WOMAN WHO COULDN'T CONSIDER

The following is a fragment of an analysis that focuses on a series of three consecutive sessions that occurred at the beginning of the sixth year of an analysis conducted five times per week.

My stomach muscles tensed and I experienced a faint sense of nausea as I heard the rapid footfalls of Ms. B racing up the stairs leading to my office. It seemed to me that she was desperate not to miss a second of her session. I had felt for some time that the quantity of minutes she spent with me had to substitute for all of the ways in which she felt unable to be present while with me. Seconds later, I imagined the patient waiting in a state of chafing urgency to get to me. As she led the way from the waiting room into the consulting room, I could feel in my body the patient's drinking in of every detail of the hallway. I noticed several small flecks of paper from my writing pad on the carpet. I *knew* that the patient was taking them in and hoarding them "inside" of her to silently dissect mentally during and after the session. I felt in a very concrete way that those bits of paper were parts of me that were being taken hostage. (The "fantasies" that I am describing were at this point almost entirely physical sensations as opposed to verbal narratives.)

As Ms. B, a forty-one-year-old divorced architect, lay down on the couch, she arched her back, indicating in an unspoken way that the couch made her back ache. (In the course of the previous months she had complained on several occasions that my couch caused discomfort to her back.) I said that she seemed to be beginning the hour by registering a protest about her feeling that I did not care enough about her to provide a comfortable place

for her here. (Even as I was speaking these words, I could hear both the chilliness in my voice and the reflexive, canned nature of the interpretation. This was an accusation disguised as an interpretation—I was unintentionally telling Ms. B about my growing frustration, anger, and feelings of inadequacy in relation to our work together.) Ms. B responded to my comment by saying that "that is the way the couch is." (There was a hardness to the fact that the patient said "is" rather than "feels.") ①

The patient's bitter resignation to the fact that things are the way they are brought to mind her conviction (which she treated as a fact) that she had been an unwanted baby, "a mistake," born almost a decade after her older brother and sister. Her mother had been advancing quickly in her career in the federal government when she became pregnant with the patient and grudgingly took a leave of absence for the first few months of the patient's life. Ms. B felt that her mother had hated her all her life and had treated her from the beginning with a mixture of neglect and disgust while at the same time fiercely insisting that the patient be a "miniature version" of herself. The patient's father, a shadowy figure in the analysis, was also part of the unchangeable "given" to which the patient felt resigned. He was described as a benign but ineffectual man who seemed to have emotionally withdrawn from the family by the time the patient was born.

I said to Ms. B in carefully measured tones that she must feel that she perennially accommodates to me—I must seem to her not to have the slightest intention of accommodating to her. Both the patient and I knew that what we were talking about was a major struggle in the transference-countertransference: the patient's intense anger at me for not giving her what she *knew* I could easily give her if I chose to—a magically transformative part of me that would change her life. This was familiar territory and had been acted out in innumerable ways, including, most recently, her performing fellatio on a friend and triumphantly swallowing his semen, consciously fantasied to be his strength and vitality. I suspected that unconsciously Ms. B fantasized the semen to be the magically transformative milk/power stolen from her mother and

from me. The patient's attempts to steal a magically transformative part of me engendered in me a feeling that it was impossible to give her anything in the way of compassion or concern, much less affection or love, without feeling that I had submitted to her and was passively going through the motions of a role scripted by her.

Ms. B then spoke about events that had occurred earlier in the day involving a longstanding dispute with a neighbor about a dog whose barking the patient found "unnerving." I recognized (with only a touch of amusement) that I was identifying with the neighbor's dog; it seemed to me that the dog was being asked to be an imaginary dog (invented by Ms. B), one that did not make the noises dogs do. Despite the fact that I might have interpreted something about the transference displacement onto the neighbor's dog, I decided not to attempt such an intervention. I had learned from my experience with Ms. B that a good deal of the effect being created by her monologue about the dog was the unstated demand that I point out to her something that she was already fully aware of (i.e., that when she was talking about the dog, she was also talking about me). For me to do so, I imagined, would be experienced by the patient as a momentary victory in her effort to get me to "sting" her with an interpretation that reflected my anger at and interest in her. She would in fantasy passively and gleefully swallow the stolen (angry) part of me. My experience with Ms. B had also taught me that my succumbing to the pressure to make the demanded "stinging" interpretation was disappointing to her, in that it reflected my inability to hold on to my own mind (as she had found it almost impossible to do while with her mother). I also conceived of the patient's effort to evoke an angry response from me as an unconscious attempt to bring me (in the paternal transference) out of the shadows and into life. This, too, had many times been interpreted.

On the other hand, I could expect that if I were not to make an interpretation, Ms. B would become increasingly withdrawn and move to another topic that would feel even more devoid of life than the session currently felt. In the past, under such circum-

stances, she had become somnolent in a way that was experienced by both of us as angrily controlling, and at times she had fallen asleep for periods of up to fifteen minutes. When I interpreted her withdrawal into sleep as a way of protecting herself and me from her anger (and mine), my experience had been that the patient would treat my words as precious commodities to be hoarded (like the scraps of paper on the carpet) rather than used to generate her own ideas, feelings, and responses. Similarly, interpretation of the patient's "use" of my interventions in this way had not been productive. Earlier discussions with her concerning this form of analytic stalemate had led her to quip that Oliver Sacks should write a story about her and call it "The Woman Who Couldn't Consider." (2)

As Ms. B was speaking and as I was mulling over the dilemma just discussed, I began thinking about a scene from a film that I had seen the previous weekend. A corrupt official had been ordered by his Mafia boss to kill himself. The corrupt official parked his car on the shoulder of a busy highway and put a pistol to the side of his head. The car was then filmed from a distance across the highway. The driver's side window in an instant became a sheet of solid red, but did not shatter. The sound of the suicide was not the sound of a gunshot, but the sound of uninterrupted traffic. (These thoughts were quite unobtrusive and occupied only a few seconds of time.)

Ms. B went on without a pause or transition to speak about a date that she had had the previous evening. She described the man by means of a collection of disjointed observations that were quite devoid of feeling—he was handsome, well-read, displayed anxious mannerisms, and so on. There was almost no indication of what it had felt like for the patient to have spent an evening with him. I was aware that although Ms. B was talking, she was not talking to me. It may have been that she was not even talking to herself, in that it did not seem to me that she was the least bit interested in what she was saying. I had many times interpreted this sense of the patient's disconnection from me and from herself. I decided not to offer that observation as an interpretation, in (3)

part because I felt that it would have been experienced as another "sting," and I did not feel that I had a different way of talking to her.

As the patient continued, I was feeling that the hour was moving extremely slowly. I had the claustrophobic experience of checking the time on the clock and then some time later looking at the clock to find that the hands seemed not to have moved. Also, I found myself playing a game (which did not feel at all playful) of watching the second hand on the clock across the room make its silent rounds and finding the precise place in its movement that the digital clock on my answering machine next to my chair would transform one digit to the next. The convergence of the two events held my attention in a way that was oddly mesmerizing, although not exciting or fascinating. This was an activity I had not previously engaged in during sessions with Ms. B or with any other patient. I had the thought that this mental game may have reflected the fact that I was experiencing the interaction with Ms. B as mechanical, but this idea seemed rote and wholly inadequate to the disturbing nature of the claustrophobia and other poorly defined feelings that I was experiencing.

(3) I then began (without being fully aware of it) to think about a phone call I had received several hours earlier from a friend who had just had a diagnostic cardiac catheterization. Emergency bypass surgery would have to be performed the next day. My thoughts and feelings moved from anxiety and distress about the friend's illness and imminent surgery to imagining myself being told the news that I required emergency bypass surgery. In my fantasy of being given this news, I initially felt intense fear of never waking up from the surgery. This fear gave way to a sense of psychic numbness, a feeling of detachment that felt something like the onset of emotional dulling after rapidly drinking a glass of wine. That numbness did not hold; it quietly slid into a different feeling that did not yet have words or images associated with it. This feeling preceded any thought or image—the way one sometimes awakes from sleep with intense anxiety or some other feeling, and only several seconds later re-

members the events or the dream with which the feelings are connected.

In the instance I am describing in the session with Ms. B, I realized that the new feeling was one of profound loneliness and loss that was unmistakably connected with the recent death of a close friend, J. I recalled what I had felt while talking with J shortly after she had been diagnosed with a recurrence of breast cancer. During a long walk on a weekend morning, we were both "figuring out" what the next step should be in the treatment of her widely metastasized cancer. There was, during that walk (I think for both of us), a momentary respite from the full intensity of the horror of what was occurring while we weighed alternatives as if the cancer could be cured. As I went over parts of the conversation in my mind, it seemed in retrospect that the more practical we became, the more make-believe the conversation felt—we were creating a world together, a world in which things worked and had cause and effect relationships with one another. It was not an empty sense of make-believe, but a loving one. After all, it is only fair that $3 + 8 = 11$. Embedded in this part of the reverie was not only a wish for fairness, but a wish for someone to enforce the rules. At that point in the flow of reverie, I became aware, in a way that I had not previously experienced, that the make-believe world that J and I had been creating was a world in which there was no such thing as "we": she was dying; I was talking about *her* dying. She had been alone in it in a way and to a degree that I had never dared feel before that moment in the session with Ms. B. I felt a very painful sense of shame about the cowardice that I felt I had displayed in having protected myself the way I had. More important, I felt that I had left J even more isolated than she had to be by not fully recognizing the extent of her isolation.

I then refocused my attention on Ms. B. She was speaking in a rather pressured way (with an exaggerated lilt in her voice) about the great pleasure she was deriving from her work and from the feeling of mutual respect and friendly collaboration she experienced with her colleagues in her architectural firm. It seemed to me that only thinly disguised by the idealized picture being pre-

sented were feelings of loneliness and hopelessness about the prospect of her ever genuinely experiencing such feelings of ease and closeness with her colleagues, her friends, or me.

As I listened to Ms. B's pressured description, I was aware of feeling a combination of anxiety and despondency, the nature of which was quite nonspecific. I was reminded of the grim satisfaction I had felt earlier in tracking the convergence of the precise, repeatable location of the sweep second hand of the clock and the instant of movement of the digital numbers on the answering machine. I thought that perhaps the fact that there was a place and a moment where the second hand and the digital clock "squared" may have represented an unconscious effort on my part to create a feeling that things could be named, known, identified, located, in a way that I knew that they could not. Ms. B began the following session with a dream:

I was watching a man take care of a baby in an outdoor place of some sort that might have been a park. He seemed to be doing a good job of attending to it. He carried the baby over to a steep set of concrete stairs and lifted the baby as if there were a slide to place it on, but there was no slide. He let go of the baby and let it hurtle down the stairs. I could see the baby's neck break as it hit the top step, and I noticed that its head and neck became floppy. When the baby landed at the bottom of the steps, the man picked up its motionless body. I was surprised that the baby was not crying. It looked directly into my eyes and smiled in an eerie way.

Although Ms. B often began her sessions with a dream, this dream was unusual in that it was disturbing to me. This led me to feel a flicker of hopelessness. The patient's dreams in the past had felt flat and did not seem to invite inquiry or discussion. Ms. B made no mention of the dream and immediately began to talk in an elaborately detailed way about a project at work with which she had been involved for some time. I interrupted her after several minutes and said I thought that in telling me the dream, she had attempted to say something that she felt was important for me to

hear and at the same time was afraid to have me hear it. Her burying the dream in the noise of the details of the project made it appear that she had said nothing of significance to me.

Ms. B then said (in an earnest, but somewhat compliant way) that as she was telling me the dream, she at first felt identified with the baby, in that she often feels dropped by me. She quickly (and unexpectedly) went on to say that this interpretation felt to her like a "kind of a lie" since it was like a "tired old refrain, a knee-jerk reaction." She said that there were several very upsetting things in the dream, beginning with the fact that she had felt "immobilized" and unable to prevent what she saw unfolding. (I was reminded of the shame I had felt in the previous session in connection with the thought that I had shielded myself from J's isolation and in a sense had looked on in an immobilized manner.) Ms. B said that even more distressing to her was her sense of herself as both the baby and the man in the dream. She recognized herself in the baby's act of pointedly looking into her eyes and smiling in a detached, mocking way. She said that the baby's smile felt like the invisible smile of triumph that she often inwardly gives me at the end of each meeting (and at various junctures during the meetings), indicating that she is "above" or "immune to" psychological pain and that this makes her much more powerful than I am (despite what I may think).

I was moved by the patient's conscious and unconscious efforts to tell me (albeit indirectly) that she had some sense of what it had felt like for me to have had to endure her defiant claims not to need me and her triumphant demonstrations of her capacity to occupy a place above (outside of) human experience and psychological pain.

Ms. B then told me that she was very frightened by how easy it is for her to become the man and the baby in the dream, that is, how easily she enters into a "robotic" mode in which she is fully capable of destroying the analysis and her life. She was terrified by her capacity to deceive herself in the way that the man seemed to believe that he was placing a baby on a slide. She could easily destroy the analysis in this mindless way. She felt that she could

not at all rely on her ability to distinguish real talk that is aimed at change from "pseudo-talk" that is designed to make me think she is saying something when she isn't. She said that even at that moment she couldn't tell the difference between what she really felt and what she was inventing.

I will only schematically present elements of the subsequent meeting in an effort to convey a sense of the shape of the analytic process that was set in motion by the two sessions just described.

The next meeting began with Ms. B's picking a piece of loose thread from the couch and, in an exaggerated gesture of disdain, holding it in the air between her thumb and forefinger and dropping it on the floor before she lay down. When I asked her what it felt like to begin our meeting as she had, she laughed embarrassedly as if she were surprised by my inquiry. Sidestepping my question, she said that she had been in a compulsive cleaning frenzy from early that morning. She had awakened at 4:00 A.M. in a state of great agitation that seemed to be relieved only by cleaning the house, particularly the bathroom. She said that she felt she had failed in life and in analysis and that there was nothing to do but to control "the ridiculous things" she had it in her power to control. (I could feel her desperation, but her explanation seemed textbookish.) She went on to fill the first half of the session with ruminative thinking. My efforts to interpret the compulsive/ruminative activities as an anxious response to her having said too much (made a "mess") in the previous day's meeting were given only perfunctory notice before she resumed her ruminations.

While the patient was in the throes of her defensive ruminations, I found myself watching the play of sunlight on the glass vases near one of the windows in my office. The curves of the vases were lovely. They seemed very feminine, resembling the curves of a woman's body. A bit later I had an image of a large stainless steel container in what seemed to be a factory, perhaps a food processing plant. My attention in the fantasy was anxiously riveted on the gears at the end of one of the containers. The machinery was clanking loudly. It was not clear what was frightening me, but it

seemed that the gears were not working as they should and that a major malfunction with catastrophic results was about to occur. I was reminded of the extreme difficulty Ms. B's mother had had with breast-feeding. According to her mother, the patient bit the mother's nipples so hard that they became inflamed and breast-feeding was terminated.

I had the thought that I was experiencing a sensuous and sexual aliveness with Ms. B, but had been made anxious by it and had turned her femininity (her breasts in particular) into something inhuman (the stainless steel container and its nipple/gears). It seemed I was feeling that catastrophic breakdown would follow closely on the heels of sexual desire for, and sensual pleasure with Ms. B. These desires and fears came as a surprise to me since, to this point, I had felt no sexual or sensual attraction to Ms. B, and in fact had been aware of the aridity and boredom that had resulted from the stark absence of this dimension of experience. I thought of the way in which Ms. B had arched her back two sessions earlier and for the first time experienced the image of her arching her back on the couch as an obscene caricature of sexual intercourse.

With about twenty minutes remaining in the session, Ms. B said that she had come today wanting to tell me a dream that had awakened her during the night, but that she had forgotten it until that moment:

I've just had a baby and I'm looking at it in the bassinet. I don't see anything of me in its face which is dark, heart-shaped, Mediterranean. I don't recognize it as something that came out of me. I think, "How could I have given birth to such a thing." I pick it up and hold him and hold him and hold him, and he becomes a little boy with wild curly hair.

Ms. B said, "In telling you the dream, I was thinking of the fact that what comes out of me here doesn't feel like me. I don't take any pride in it or feel any connection with it." (I was aware that the patient was leaving me out of the picture, a fact that was particularly striking, given that my hair is curly. I was also struck by

the aliveness of the dream in the hour and the way this seemed to be in part generated by the patient's telling it in the present tense which was unusual for her.)

I said to the patient that it seemed true that she felt disgusted by everything that came out of her here but that in telling me the dream, she was saying something more to me. I said she seemed frightened of feeling or letting me feel the love she felt for the child in the dream. I asked if she had experienced the change of feeling when she shifted from referring to the child as a "thing" or "it" to using the word "him" when she said that she had picked it up and held him and held him and held him. She fell silent for a minute or two, during which time I had the thought that I may have prematurely used the word "love," which was a word I could not at that moment remember either of us ever having used during the entire course of the analysis.

Ms. B then said she had noticed that change in telling me the dream, but she could feel it *as a feeling* only when she listened to me saying her words. She told me that while I was speaking, she felt grateful to me that I had not let that part of things be "thrown away," but at the same time, she felt increasingly tense with each word that I spoke, fearing that I would say something embarrassing to her. She added that it was as if I might undress her, and she would be naked on the couch. After another silence of almost a minute, she said that it was hard to tell me this but the thought had gone through her mind as she was imagining being naked on the couch that I would look at her breasts and find them to be too small.

I thought of the agony surrounding J's surgery for breast cancer and became aware at this point in the hour that I was feeling both a wave of my deep love for J together with the sadness of the enormous void her death had left in my life. This range of feeling had not previously been part of my experience while with Ms. B. Now I found myself listening and responding to Ms. B in quite a different way. It would be an overstatement to say that the feelings of anger and isolation had disappeared, but they were now part of a larger constellation of emotion. No longer was the isolation

simply an encounter with something that felt nonhuman; rather, the isolation felt more like an experience of missing the humanity of Ms. B that I viscerally knew to exist, but was only being allowed to glimpse fleetingly from afar.

I told the patient that I thought her dream and our discussion of it also seemed to involve feelings of sadness that large parts of her life were being unnecessarily wasted, "thrown away." I said that she began telling me the dream by saying "I've just had a baby," but a great deal of what followed was about the ways in which she prevented herself from living the experience of having a baby. (In the course of the analysis, she rarely had fantasies or dreams of having a baby, and only twice had she discussed the question of whether she might ever want to have children.) There were tears on her face, but no sound of crying in her voice as she said that she had not previously put the feeling into words, but a good deal of her shame about her breasts is that they feel like boys' breasts that could never make milk for a baby.

DISCUSSION

I began the presentation of the first of three sessions in the sixth year of Ms. B's analysis with a description of my response to hearing the patient's footsteps on the stairs leading to my office. I find it invaluable to be as fully aware as I can of what it feels like to meet the patient each session (including the feelings, thoughts, fantasies, and bodily sensations experienced in anticipation of that particular meeting). Much of my response to Ms. B that day, both in listening to her approach and in encountering her in the waiting room, was in the form of bodily responses ("phantasies in the body" [Gaddini, 1982]). From the outset I was anticipating (in fantasy) being physically and psychologically invaded by the patient: my stomach muscles tensed as I unconsciously anticipated receiving a blow to the abdomen, and I was experiencing nausea in preparation for evacuating a noxious presence that I expected to experience inside of me. These feelings were elaborated in the

form of fantasies of the patient's chafing to "get to me" (to get into my office/body) and fantasies of her cannibalizing me through her eyes as she took parts of me hostage in "drinking in" the scraps of paper from my notebook that she noticed on the carpet.

Clearly, this reverie, occurring even before the patient entered the consulting room, reflected a set of transference-countertransference feelings that had been growing in intensity and specificity for some time and yet were not available to either the patient or to me for reflective thought or verbal symbolization. This aspect of the analytic relationship was largely experienced by both of us as simply the way things were.

I experienced Ms. B's arching her back only as a complaint and was not at that point able to entertain the possibility that the gesture had other meanings. My initial interpretation addressed the idea that the patient was angrily protesting my unwillingness to provide a comfortable place for her in my office. I could hear the chilliness in my voice that transformed the interpretation into an accusation. I was at that moment feeling unable to be an analyst with the patient and instead was experiencing myself as angry, at sea, and rather helpless to alter the course of events. The "canned" nature of my interpretation alerted me to my own emotional fixity in relation to Ms. B and to my inability at that point to think or to speak freshly or to render myself open to new possibilities for understanding and experiencing what was occurring between us. These realizations were deeply unsettling.

Although aspects of the patient's experience of her parents went through my mind, I was very little able to bring that context to bear on the present situation in a way that felt real. Moreover, the constellation of ideas about the transference-countertransference that had evolved in the course of this period of analysis (for example, the idea that the patient was relentlessly demanding magically transformative milk/semen/power) had lost most of the vitality that it once had held. These ideas had become for both the patient and for me stagnant formulae that largely served as a defense against feelings of confusion and helplessness and against

the experience of a fuller range of feelings (including loving ones).

Perhaps the disturbing awareness of the way my anger was interfering with my ability to offer usable interpretations allowed for the beginnings of a psychological shift to occur in me. This was reflected in my ability to see (and feel) the humor in my identifying with the neighbor's dog which was (I felt) being asked not to be a dog but rather to be the patient's imaginary, invented creature. This led me to be able to refrain from offering still another intervention of the chilly, clenched teeth ("carefully measured") variety and instead to attempt to listen.

It was after this affective shift that reverie of a more verbally symbolic (less exclusively somatic) sort began. The reverie that occurred at this point in the session consisted of images and feelings derived from a film in which a corrupt official commits suicide in such a way that the sound of the suicide is not that of the report of a gun or the shattering of glass, but the uninterrupted sound of traffic oblivious to this solitary human event. Although these images were emotionally powerful, they were so unobtrusive, so barely available to self-reflective consciousness, that they served almost entirely as an invisible emotional background. The experience of this reverie was nonetheless unsettling and contributed to the creation of a specific emotional context for the unconscious framing of what followed. Ms. B's account of her date the previous night was experienced differently than it would have been otherwise. The principal effect on me of her talk was the creation of a painful awareness of the feeling of not being spoken to, a sense of words filling empty space, words not spoken by anyone to anyone (even to herself).

Feeling at a loss to know how to speak to the patient about her not talking either to me or to herself, I continued to keep silent. Again I found my mind wandering, this time to a brief immersion in the mental "game" of observing the precise place and time of the convergence of movement of the digital time of the answering machine and the sweep second hand of the clock across the room. In part, this served to relieve the claustrophobia I was experienc-

ing in feeling trapped *alone* with Ms. B. I hypothesized that both the reverie about the suicide and the "game" involving the workings of two timepieces may have reflected my sense of the mechanical, nonhuman qualities of the experience with Ms. B, but this idea seemed superficial and hackneyed.

The reveries that followed reflected a movement from a rather rigid, repetitive obsessional form to a far more affect-laden "stream of thought" (W. James, 1890). I felt distressed in recalling a phone call from a friend who had been told he needed emergency open-heart surgery. Very quickly I protected myself from the fear of his dying by narcissistically transforming the event in fantasy into a story of my receiving this news. My own fear of dying was expressed as a fear of never waking up. The idea of not waking up was at this juncture unconsciously overdetermined and in retrospect seems to have included a reference to the oppressive "living death" of the analysand as well as to my own anesthetized state in the analysis, from which I unconsciously feared I would never awake.

In all of this there was a rapidly growing sense of being out of control both in relation to my own body (illness/sleep/death) and in relation to people I loved and depended upon. These feelings were momentarily allayed by a defensive withdrawal into emotional detachment, a psychic numbness. My unconscious efforts at emotional detachment did not hold for very long and gave way to a form of reverie in the shape of vivid images of a time spent with a very close friend, J, in the midst of her attempting to wrestle with imminent death. (Only for want of a better word would I refer to the creation of these reverie images as "remembering," because the idea of remembering too strongly connotes something fixed in memory that is "called up to consciousness again" [re-membered]. The experience in the session was not a repetition of anything, not a remembering of something that had already occurred; it was occurring for the first time, an experience being generated freshly in the unconscious intersubjective context of the analysis.)

In the course of the reverie of the conversation with J (in which

make-believe, but desperately real efforts were being made to "figure out" what next to do), an important psychological shift occurred. What began in the reverie as a wishful insistence that things be fair and "make sense" became a painful feeling of shame regarding my sense that I had failed to appreciate the depth of isolation that J was experiencing. The symbolic and affective content of the reverie was barely conscious and did not yet constitute a conscious self-awareness of isolation about which I could speak to myself or from which I could speak to the patient. Nonetheless, despite the fact that a conscious, verbally symbolized understanding of the reverie experience did not take place at this moment, an important *unconscious* psychological movement did occur which, as will be seen, significantly shaped the subsequent events of the hour.¹

In "returning" the focus of my attention to Ms. B, I was not going back to a place I had been in the session, but was going to a new psychological "place" that had not previously existed, a place emotionally generated in part by the reverie experiences that I have just described. Ms. B was speaking in an anxiously pressured, idealizing way about relationships with colleagues. The reverie experiences discussed above (including my experience of defensive psychic numbing) had left me acutely sensitive to the experience of psychological pain disguised by reliance on manic defense, particularly the pain of efforts to live with terrible loneliness and in isolation with one's feelings of powerlessness.

The "clock-game" reverie that had occurred earlier in the hour took on new meaning in the emotional context of what was now taking place. The "earlier" reverie was in an important sense

¹ The unconscious movement brought about by the reverie might be thought of as the outcome of the unconscious "understanding work" (Sandler, 1976) that is an integral part of dreaming (and reverie). Dreaming and reverie always involve an unconscious internal discourse between "the dreamer who dreams the dream and the dreamer who understands the dream" (Grotstein, 1979). If there were no such unconscious discourse (if there were no unconscious "understanding work" in relation to the unconscious "dream work"), we would have to conclude that only the dreams (not the reveries) that we remember have psychological value and contribute to psychological growth. This is a view to which few analysts would subscribe.

occurring for the first time, in that the act of recalling it in the new psychological context made it a different "analytic object." The "mental game" as I experienced it at this point was filled not with boredom, detachment, and claustrophobia, but with desperation that felt like a plea. It was a plea for someone or something to rely on, some anchoring point that could be known and precisely located and would, if only for a moment, stay put. These were feelings that in the hour felt "multivalent," that is, they seemed simultaneously to have bearing on my feelings about J (not "old" feelings but feelings taking shape in the moment) and about the evolving analytic relationship.

The affective movement just described is not accurately conceptualized as the "uncovering" of heretofore "hidden" feelings in relation to my past experience with J. It would be equally misleading to reduce what was occurring to a process in which the patient was helping me to "work through" my previously unresolved unconscious conflicts in relation to J (a process that Searles [1975] referred to as the patient's serving as "therapist to the analyst"). Rather, I conceive of the reverie experiences generated in this hour as reflecting an unconscious intersubjective process in which aspects of my internal object world were elaborated in ways that were uniquely defined by the particular unconscious constructions being generated by the analytic pair. The emotional change that I experienced in relation to my (internal object) relationship with J could have taken place in the way that it did only in the context of the specific unconscious intersubjective relationship with Ms. B that existed at the moment. The internal object relationship with J (or with any other internal object) is not a fixed entity; it is a fluid set of thoughts, feelings, and sensations that is continually in movement and always susceptible to being shaped and restructured as it is *newly* experienced in the context of each new unconscious intersubjective relationship. In every instance it will be a different facet of the complex movement of feeling constituting an internal object relationship that will be most alive in the new unconscious intersubjective context. It is this that makes each unconscious analytic interaction unique for both analyst and

analysand. I do not conceive of the analytic interaction in terms of the analyst's bringing pre-existing sensitivities to the analytic relationship that are "called into play" (like keys on a piano being struck) by the patient's projections or projective identifications. Rather, I conceive of the analytic process as involving the creation of unconscious intersubjective events that have never previously existed in the affective life of either analyst or analysand.

Ms. B's experience of and participation in the unconscious intersubjective movement that I have been describing was reflected in the dream with which she began the second of the three sessions presented. In that dream the patient was watching a man take care of a baby. The man placed the baby on an imaginary slide and allowed it to fall down a concrete staircase breaking its neck in the process. At the end of the dream, as the man picks up the silent, motionless baby, the infant looks directly into the patient's eyes and smiles eerily.

After reporting the dream Ms. B went on as if she had not said anything of significance about her dream life or any other part of her life. I found (without planning it) that the wording of the interpretation I offered drew upon both the imagery of my reverie of the traffic noise covering the solitary suicide as well as the emotional effect on me of the absolute silence that framed the patient's dream (no spoken words, cries, screams, thuds, occurred in her account of the dream). I commented on the way the patient had used words as "noise" to talk over (drown out) something of great importance that she both hoped I would hear and was trying to prevent me from hearing in telling me the dream. The question of where my reveries stopped and the patient's dream began was not possible to determine in any meaningful way at this point. Both my reveries and the patient's dream were created in the same "intersubjective analytic dream space" (Ogden, 1996b).

Ms. B's response to my interpretation was more direct, self-reflective, and affectively colored than had been the case for some time. Despite a note of compliance, it was clear that the analytic relationship was in the process of changing. After beginning by saying that she saw herself as the baby that was being dropped by

me, she was able to observe that the interpretation was a "kind of a lie," in that it felt stale and reflexive. She then spoke of feeling "immobilized" in her inability to prevent what she was observing from happening. My reverie from the previous session involving my sense of shame associated with the feeling of being an immobilized observer of J's isolation led me to wonder whether shame and guilt were important aspects of the patient's distress in relation to the dream as well as in relation to her treatment of me. Ms. B's next comments seemed to bear out this understanding: she told me indirectly that she was frightened of her capacity to isolate herself and me through her claims to be "immune to" psychological pain.

As Ms. B spoke about her use of the "eerie smile" with me, I was not certain whether she was conscious of her efforts to relieve me of my feelings of isolation while with her. This session concluded with the patient's speaking *to me* about her fear of her capacity to become so mechanical that she is capable of destroying the analysis and her life. In her experiencing her inability to distinguish real feeling from deceptive "pseudo-talk," Ms. B, without fully recognizing it, was talking to me about the only things that she could know in any visceral way to be real—her frightening awareness of not knowing what, if anything, is real about her and the feeling of being fully entrapped in herself.

The following meeting began with a theatrical acting-in, in which Ms. B fastidiously removed a piece of loose thread from the couch. It had been a longstanding pattern for the patient to anxiously withdraw after sessions in which it had felt to me that we had spoken to one another in a way that reflected a feeling of human warmth. Nonetheless, the imperious, detached quality of the patient's gesture left me with a distinct feeling of disappointment that the connection I had begun to feel had again been abruptly brought to an end. I felt that I was being dropped with about as much concern as she was feeling toward the piece of thread that was being dropped to the floor.

It seemed that she, too, was experiencing disappointment in herself, feeling herself to be a failure in life and in analysis. She

was also apparently feeling frightened and embarrassed that she had (in fantasy) soiled herself and me and was feverishly engaged in cleaning up the spilled bodily contents/feelings (the dirty bathroom mess). My efforts to talk with her about what I thought I understood of the way her current feelings and behavior represented a response to what she had experienced with me in the previous meeting were systematically ignored.

During the bulk of the session, while the patient was ruminating, my own reveries included a sensuous enjoyment of the feminine lines created by the play of sunlight on the vases in my office. This was followed by an anxiety-filled set of reverie images of malfunctioning gears on containers in a factory that may have been a food-processing plant. There was a strong sense of impending disaster. These images and feelings were connected in my mind with the patient's description of the very early termination of breast-feeding that had resulted from her "excessive" desire (her biting her mother's nipples so hard that they became inflamed).

It felt to me that despite the fact that I had not previously experienced any hint of sexual or sensual aliveness while with Ms. B, I was now beginning to have these feelings and was experiencing anxiety about the catastrophe that such feelings would in fantasy bring on. I was reminded of Ms. B's arching her back at the beginning of the session earlier in the week and recalled how the gesture had held no sexual force for me at the time. That bodily movement now seemed to me to be a denigrating caricature of sexual intercourse, i.e., both an expression of sexual desire toward me and the simultaneous denigration of that desire.

These thoughts as well as the reverie feelings and images served as the emotional context for my listening and responding to the dream that the patient presented in the second half of the hour. In that dream, Ms. B had just given birth to a baby that felt alien to her. On holding him and holding him and holding him, he turned into a little boy with wild curly hair. Ms. B quite uncharacteristically offered her own interpretation of the dream, saying that she felt it reflected the way in which she feels no connection

with what comes out of her in the analysis. I acknowledged that this did seem to capture something she had felt for a long time, but (influenced by the feeling residue of my reveries) I told her I thought that she was telling me more than that in telling me the dream. I said that I thought it was frightening to her to openly experience affection for her child. (I chose to defer until a later session interpreting the idea/wish that the curly haired baby was "ours" because it seemed necessary that the patient first be able to genuinely experience her own connection with him [me/herself/the analysis].) I then asked if she had felt the way in which, almost despite herself, she had allowed the baby to become human (and loved) as she moved midsentence from referring to the infant as "it" to using the word "him."

After a silence that felt both thoughtful and anxious, she told me that she had felt grateful that I had not "thrown away that part of things." I was aware that she was using vague language ("that part of things") instead of using the word "love" (as I had done), or introducing a word of her own to name the feeling that was "not thrown away." She went on to tell me that she had been afraid that I would embarrass her with my words (in fantasy, undress her) and that her breasts would be revealed and that I would find them too small.

I then experienced, in a way that I had not been able to feel in the course of the analysis, the intensity of the love that I felt for J as well as the depth of my feelings of sadness and loss. It was only at that juncture that I began to suspect that the feelings of shame I had felt during the reverie about J in the earlier session had served to protect me from experiencing the pain of that love and the feeling of loss. I suspected that Ms. B's shame regarding the fantasy of my finding her breasts too small similarly served a defensive function in relation to the more frightening wishes to be able to love me and to feel loved by me (as well as the accompanying fears of my contempt for her and her contempt for herself for having such wishes). This fearful, defensive contempt had been expressed in her imperious gesture at the start of the meeting.

The reveries and thoughts that I have just described (e.g., the reveries involving an anonymous suicide, the effort to control the passage of time, the inability to fully grieve the early death of a friend, the anxiety associated with foreclosed sexual and sensual aliveness and relatedness) strongly contributed to my saying to Ms. B that I felt there was a sadness in what we were talking about which had to do with the feeling that important aspects of her life were not being lived (were being "thrown away"). In referring to the sadness of a thrown-away life, a life un-lived, I was thinking not only of the way she had not allowed herself to have the experience of being the mother of her (our) baby in the dream, but also of the way in which (to varying degrees) she had not allowed herself to live the experience of being in analysis with me and had not allowed herself to live the experience of being a daughter to her mother or of having a mother.

Ms. B responded to what I said by crying in a way that felt to me that she was experiencing sadness with me as opposed to dramatizing for me an invented feeling. She elaborated on the idea that much of her life had not been lived by telling me that she had, to a large extent, not experienced her life as a girl and as a woman since she had not had a sense of herself as having had a female body. As a result she felt she would never be able to "make milk for a baby." Implicit in this final statement of the hour was the patient's fear that she would never be able to fully experience being alive as a sexual woman with me and experience (in imagination) being the mother of our baby.

CONCLUDING COMMENT

There are, of course, innumerable lines of thought and feeling and levels of meaning in these three sessions which I have either ignored altogether or only briefly and incompletely alluded to in my discussion. Such is the nature of analytic work, especially analytic work in which one attempts to attend to the infinite complexity of the interplay of the unconscious life of the analysand

and that of the analyst and to the ever-changing unconscious constructions generated in the "overlap" of the two. My intent has not been to be exhaustive in the explication of unconscious meanings, but to provide something of a sense of the rhythm of the to-and-fro of experiencing and reflecting, of listening and introspection, of reverie and interpretation, in analytic work that views the use of the analyst's reveries as a fundamental component of analytic technique.

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