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Associative dreaming: reverie and active imagination

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Abstract: The idea of countertransference has expanded beyond its original meaning of a neurotic reaction to include all reactions of the therapist: affective, bodily, and imaginal. Additionally, Jung's fundamental insight in 'The psychology of the transference' was that a 'third thing' is created in the analysis, but he failed to demonstrate how this third is experienced and utilized in analysis. This 'analytic third', as Ogden names it, is co-created by analyst and analysand in depth work and becomes the object of analysis. Reverie, as developed by Bion and clinically utilized by Ogden, provides a means of access to the unconscious nature of this third. Reverie will be placed on a continuum of contents of mind, ranging from indirect to direct associative forms described as associative dreaming. Active imagination, as developed by Jung, provides the paradigm for a mode of interaction with these contents within the analytic encounter itself. Whether the analyst speaks *from* or *about* these contents depends on the capacity of the patient to dream. Classical amplification can be understood as an instance of speaking *about* inner contents. As the ego of the analyst, the conscious component, relates to unconscious contents emerging from the analytic third, micro-activations of the transcendent function constellate creating an analytic compass.

Key words: ability to dream, active imagination, amplification, analytic compass, analytic third, associative dreaming, countertransference, reverie, transcendent function

The third in analysis

Gertrude Stein (1970) is quoted as saying, 'One of the pleasantest things for those of us who write or paint is to have the daily miracle'. For analysts and depth psychotherapists[1] one of our most 'pleasantest things' is to be able to monitor the analytic interaction in such a way as to be able to understand and/or say something to the patient which deeply conveys that we grasp what is happening in the interaction. This is our 'daily miracle' which we search for and hope to attain.

In order to gain such understanding theorists have looked to the nature of the interactive field. Much has been written on the dynamics of this field (Jacoby 1984; Schwartz-Salant 1998; Sedgwick 2001; Spiegelman 1996). Earlier in the

[1] Analyst and therapist will be used synonymously. Here the therapist is considered to be working in a depth analytical modality.

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history of psychoanalysis countertransference was considered to be a neurotic reaction on the part of the analyst. Today, it has come to be understood as the totality of the mental, emotional and bodily reactions of the analyst (Wiener 2009). Countertransference reactions can be considered as arising from the combined unconscious reactions of the analytic couple. The underlying premise is that of Jung's fundamental insight of the creation of a 'third' thing in the analytic situation. The creation of this third is outlined in Jung's (1946) 'The psychology of the transference', through a series of alchemical plates, '*The Rosarium Philosophorum*'. Although Jung consciously chooses not to include actual clinical material in this essay, he suggests that all countertransference reactions emerge from and are determined by this analytic third. The nature of the unconscious interconnection of the two participants is clearly identified in his statement:

> As soon as the dialogue between two people touches on something fundamental, essential, and numinous, and a certain rapport is felt, it gives rise to a phenomenon which Lévy-Bruhl fittingly called *participation mystique*. It is an unconscious identity in which two individual psychic spheres interpenetrate to such a degree that it is impossible to say what belongs to whom.
>
> (Jung 1958, para. 852)

Ogden describes a similar phenomenon from the perspective of the intersubjective school:

> I use the term *analytic third* to refer to a third subject, unconsciously co-created by analyst and analysand, which seems to take on a life of its own in the interpersonal field between analyst and patient. This third subject stands in dialectical tension with the separate, individual subjectivities of analyst and analysand in such a way that the individual subjectivities and the third create, negate, and preserve one another. In an analytic relationship, the notion of individual subjectivity and the idea of a co-created third subject are devoid of meaning except in relation to one another, just as the idea of the conscious mind is meaningless except in relation to the unconscious.
>
> (1999a, p. 1; italics in original).

It should be noted that Ogden's insights are purely clinical in nature. He provides no underlying theory exactly as to why or how this third is created. Using the plates of the Rosarium, Jung suggests that the non-ego psyche provides the therapist with purposely generated correspondent images and dynamics of the patient, i.e., awareness of sudden memories, inspirations, fantasy images, musings, dreams (Morris 2007).

In 'The psychology of the transference' Jung (1946) uses the notion of the third in several differing ways:

> The elusive, deceptive, ever-changing content that possesses the patient like a demon flits about from patient to doctor and, as the *third party* in the alliance, continues its game... alchemists aptly personified it as the wily god of revelation, Hermes or Mercurius.
>
> (para. 384; italics added)

Here the third is that mercurial entity in a session that is difficult to catch and allocate to whom it belongs. Following Bion, Ogden (1997a, 1997b) names

the state in which one has access to these most mercurial elements of analysis–reverie. Reverie includes the most commonplace and unobtrusive thoughts, feelings, fantasies, ruminations, daydreams and bodily sensations. He notes that they usually feel 'utterly disconnected from what the patient is saying and doing at the moment' (1997a, p. 720). Cartier-Bresson (1952), the famous photographer, once published a book of photographs entitled, *L'image à la Sauvette*. A literal translation means 'an image taken on the run'. The non-literal translation of the process he is describing is to capture 'the decisive moment'. For the analyst, the decisive moment in the work arises in and through these capricious experiences of thoughts, images and feelings coming into one's mind and body. These are 'now moments' as described by the Boston Change Process Study Group in which something affectively new has entered the field. 'These moments are pregnant with an unknown future that can feel like an impasse or an opportunity. The present becomes very dense subjectively as in a "moment of truth"' (Stern et al. 1998, p. 911).

It should be noted that there are many other things going on in the mind and body of the analyst, i.e., more direct associative material linked to previous sessions, amplificatory material to themes in the work, and theoretical reflections on what is happening. These will be discussed later under the general heading of associative dreaming.

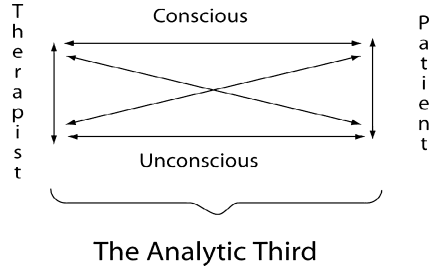
Jung also describes the third in another way.

> Psychological induction inevitably causes the two parties to get involved in the *transformation of the third* and to be themselves transformed in the process, and all the time the doctor's knowledge, like a flickering lamp, is the one dim light in the darkness.
>
> (1946, para. 399; italics added)

Here Jung emphasizes the mutuality of the process—both parties necessarily are changed through the engagement. I would add that the analyst's knowledge is precisely that awareness that the analytic dyad creates 'a third thing', which provides content for interventions and the direction they are to take in any given moment. Addressing this imaginal material arising from the third provides the 'compass' for analytic work.

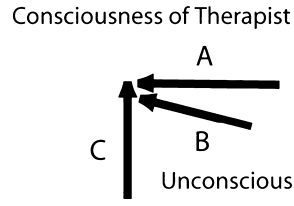
Areas of countertransference

Diagram 1



In the 'The psychology of the transference', Jung (1946) envisions a diagram which conveys all of the possible conscious and unconscious connections between the analyst and patient (although, it should be noted that his original diagram shows the adept in relationship to his unconscious *anima* and the other side of the diagram shows the soror in relationship to her *animus*). Jacoby's (1984, p. 25) variation, here expanded to include the analytic third, is a beautiful diagrammatic imagining of the complicated processes happening in the analytic encounter. The unconscious-to-unconscious connection between the two participants is the creation of some unknown third thing affecting the dyad. Precisely because of its unconscious nature one can never know how much of one's own material is in the mix. As the interpersonalists suggest, transference is always a countercountertransference. This analytic third affects all of the other interactions and communications of the two people involved. As Ogden (1999b) points out, even the dreams of the patient are no longer simply intrapsychic events, but possible manifestations of the analytic third. This allows the analyst greater freedom to explore his/her own associations to the dream and bring them into the analytic space.

Diagram 2



The upper left hand corner of the diagram describes the area of conscious awareness of the analyst (Cwik 2006a). It is only here that the material of the interaction enters into his/her mind and body in some identifiable way. It is like the old 'cloud chamber' of the physicists. When particles collided the traces of what was created in the collision could be observed in an apparatus called the 'cloud chamber'. The actual collision itself could not be observed, but the trace particles generated in that collision allowed the physicist to deduce the nature of the interaction. In the interpersonal meeting of analysis, previously unconscious material begins to appear through indirect means, as will be described later. In the asymmetry of therapy, the therapist tracks the 'fallout' of the interaction in his/her mind and body. It should be acknowledged that while there may be an 'illusion' of clarity of what is coming from where, Jung states, 'in certain cases they can merge into each other, and this naturally leads to the greatest possible confusion' (1946, para. 423). When we allow for the influence of the analytic third, all material arising in the analytic encounter is more or less co-created. This awareness is a constant reminder that certainty about the meaning

of the contents arising is not to be had. The therapist's acknowledgement of this analytic reality creates a system in which blame for failures is never just located in the patient but also mutually shared (Benjamin 2004). With that in mind let us look at the various areas of awareness in the mind and body of the analyst with particular focus on the areas of countertransference.

'A' Arrow entering into consciousness of therapist

This is the purely conscious area that is related to the manifest content of what the patient/analysand actually says. Awareness here is of direct emotional and cognitive expression uncontaminated by conflicting unconscious contents. The patient is expressing precisely what he/she wants to communicate. As Jung notes in his description of the diagram, it reflects an 'uncomplicated personal relationship' (1946, para. 423). This type of communication very often generates a thinking response in the therapist. It comes direct, without much unconscious complication and the therapist is unaware of any undertow related to the communication. Of course, affectively, simple forms of empathy or mirroring are also generated and the 'Rogerian' response of simply playing back what was heard and perceived can be effective. But with a deeper analytic sensibility, true empathy should reflect unconscious experience and not just surface emotions. It should name what is pre-conscious and trying to come into the field of awareness.

'B' Arrow entering into consciousness of therapist

In this area the therapist becomes aware of material emanating from the unconscious of the patient. It is the traditional area of the classical transference; the patient is projecting either onto or into, as projective identification, the person of the therapist. The therapist may listen for and decipher derivative communications (Langs 1979). Here the patient may be talking about someone or some situation, but he or she is unconsciously communicating about some dynamic of the transferential relationship that has not yet come to consciousness. The therapist holds in his/her mind an 'adaptive context' or trigger that may have generated such unconscious reactions, i.e., a break in the frame, a previous intervention. The therapist then waits for a 'bridge', some link to the therapeutic situation, to comment on what the patient unconsciously might have experienced.

Similarly, the patient may be using metaphors or similes to extend what is consciously known or understood. Metaphorical language, although not quite full-fledged symbols in the Jungian sense, can be understood as an attempt to communicate additional information about the intrapsychic state of the patient and/or the interpersonal situation of the analytic couple (Ogden 1997a).

At the sensate or body level, the therapist's awareness may be focused outwardly on the body language of the patient, i.e., how the patient is

holding him- or herself. Other unconscious body indicators might include tics, changes in heart rate, anomalous body movements, or the commonly found 'psychoactive' leg that begins swinging, indicating that some underlying emotional content has been activated. The patient's body and what can be gleaned from careful observation of it becomes a living association test.

Traditionally, the recognition and exploration of slips, other parapraxes, dreams, and other imaginal products, i.e., active imaginations, from the patient belong in this area. These phenomena emanate directly from the patient, but carry unconscious communicative value. Also, projective identifications, considered as unconscious emotional transmission, are 'put into' the analyst. In this model, these should not be considered solely as a pathological defensive manoeuvre, but for their communication value again arising in relation to the analytic third (Tansey & Burke 1989; Gordon, 1984). As Bion (1962b) poignantly states, 'projective identification is an early form of that which later is called a capacity for thinking' (p. 36).

'C' Arrow entering into consciousness of therapist

The 'C' arrow denotes the area of countertransference where the analyst becomes aware of what is coming into consciousness directly from his/her own unconscious and body during the analytic encounter. It is here that reverie occurs with its mundane ruminations, unobtrusive thoughts, fantasies, feelings and daydreams. It is also in this area where the analyst experiences 'proprioception': his/her own bodily sensations such as pains, discomfort, tics and involuntary movements that may be intimately connected with the patient's inner world.

But many of the contents described above may not always be accessible to the therapist without creating a particular state of consciousness that can allow them into awareness, observe and note them, and engage them in a kind of dialogue that yields some sort of understanding. The best state of mind for 'harvesting' these contents is described in the following section.

Active imagination as a paradigm for utilizing the countertransference

Davidson (1966) was the first to consider that the transference situation itself could be considered a form of active imagination. She states that the analyst has a role in analytic therapy similar to that of the ego in active imagination. The analyst provides a space that allows the patient the freedom to say whatever comes to mind. The analyst then engages this material with the patient. In this manner analysis becomes a 'lived through form of active imagination'.

In 'formal' active imagination, as described by Jung (1916), various steps need to take place. The first, and foremost, is that an altered state of consciousness, an *abaissement du niveau mental* as Jung calls it, must occur. This can be considered a form of 'ego receptivity' as described in the hypnosis literature

(Cwik 1995). Here the ego is not in a purely active state that remains in a direct, cognitive thinking mode, a secondary processing mode as Freud would say. Nor is it in a purely passive state being invaded by unconscious contents as in sleep or hallucinations. It is 'receptive' to more subtle material arising from the unconscious and the body in various forms; it is more sensitive to primary process. Compare this to Bion's statement about the optimal state of the analyst's mind in session. Bion writes of the need for the analyst to regress to a state where he is nearly unconscious: 'the nearer the analyst comes to achieving suppression of desire, memory and understanding, the more likely he is to slip into a near sleep akin to stupor. Though different the difference is hard to define' (1970, p. 47). This is the state of reverie.

Obviously, the use of the couch allows the analyst greater freedom to enter a reverie state. In face-to-face interactions one can imagine the great difficulty to be in this state under the watchful eye of the patient. I am suggesting that this state can be reached even in the face-to-face situation with training and conditioning, particularly if the therapist is familiar with doing active imagination in his/her own inner work. One can develop ego receptivity.

In regular active imagination the inner image is then focused on and followed. Then it is concretized in some form, i.e., a written dialogue, or drawn and painted. Obviously this step is not actualized in countertransference reverie unless the therapist takes process notes after the session. Some supervisors now ask their supervisees to draw or give physical shape to their countertransference reactions (Dougherty 2009). This can often be a quite insightful endeavour as previously unconscious material regarding the analytic third comes forward while engaging the image.

In active imagination proper there is an ethical confrontation of the ego with the material arising from the unconscious. In the analytical situation, the analyst must make clinical decisions if he/she should comment on the material at all, and what exactly to say regarding the material that is arising. This is the 'decisive moment' totally dependent on the analyst's clinical judgement. Ogden states, 'I speak to the patient *from*, but infrequently *about* my reverie experience (or about other forms of countertransference experience)' (1999a, p. 3; italics added). It is this *from* or *about* that is of the greatest significance and is addressed later in the paper.

Schaverien (2007) describes how the countertransference can be seen as a form of active imagination. She describes the imaginal activity of the analyst in three different situations: an auditory active imagination in which a song is related to the field; a visual active imagination in which there is communication of an unsymbolized state by the patient; and an active imagination within the transference itself in which an image or metaphor arises from the patient and both patient and therapist engage in a dialogue about it.

What is being described here is expanding the idea of active imagination into a broader sense of the therapist's own discourse with his/her imaginal

contents during the analytic session. Active imagination becomes the paradigm for approaching countertransference contents (Cwik 2006a, pp. 215–17). The therapist enters into a receptive or altered-state to elicit imaginal material assumed to be arising from the analytic third. The therapist then engages these images/reveries while staying consciously attuned to the patient. The therapist speaks from what is extracted from the active imaginal engagement or shares the actual content of the material. Active imagination becomes no longer just a Jungian technique, but a way of 'being with' material emerging from the unconscious in therapeutic sessions.

Associative dreaming: reverie and other associative material

Reverie

To understand the importance of reverie one must understand its invaluable role in infancy. Some of this material may be familiar to many readers, but it is worth reviewing to understand the significance of this revisioning of countertransference and reverie in the interactive field. Bion (1962b) theorizes that beta-elements are raw sense impressions. By themselves they cannot be linked to create meaning. They must somehow be digested, metabolized, or transformed in such a manner that the infant can make sense out of what is happening. Alpha function, on the other hand, is a set of as yet unknown mental functions that transform these raw sense impressions into alpha-elements. These elements are capable of being stored as unconscious memory in a form that makes them accessible for creating linkages, ultimately allowing the creation of meaning.

Bion states that

> The mother's capacity for reverie is the receptor organ for the infant's *harvest of self sensation* gained by its consciousness.
>
> (Bion 1962a, p. 116; Italics added)

> The term reverie may be applied to almost any content. I wish to reserve it only for such content as is suffused with love or hate. Using it in this restricted sense reverie is that state of mind which is open to the reception of any 'objects' from the loved object and is therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad. In short, reverie is a factor of the mother's alpha-function.
>
> (Bion 1962b, p. 35)

Bion describes the state of mind of a receptive mother as a state of reverie which allows her to contain the infant's projective identification. He postulates that the baby's projective identification 'enlists' his sympathetic mother to experience for him and later feed him metabolized material. She then 'metabolizes' these contents, understands or grasps their emotional significance, and 'feeds' them back to the infant. If she is unable to do this successfully, these contents are

'evacuated' by the infant and left in the mother to 'haunt' her or evoke her retaliation (Boyer 1988).

In analysis and depth psychotherapy a capacity for reverie harvests and metabolizes the patient's projections and returns them through timely interpretive activity and/or comments that demonstrate that the therapist has understood deeply the current state of the analytic third. The capacity for reverie in the analytic session is similar to a mother's psychic nourishing of the infant's mind. It plays as important a function in Bion's psychoanalytic world as actual physical nurturance (Bollas 1978).

The Boston Change Process Study Group is doing significant work around the impact of even non-interpretive connections in the analytic encounter. The dyadic consciousness hypothesis of Tronick (1998, p. 292) states that:

> each individual, in this case the infant and mother or the patient and the therapist, is a self-organizing system that creates his or her own states of consciousness (states of brain organization), which can be expanded into more coherent and complex states in collaboration with another self-organizing system.

I believe these states in which the therapist accesses the analytic third by way of reverie is such a state. Dowd (2009) presents interesting case material with a borderline patient in which her 'dreaming for the patient' in session, as described below, provided a symbol for the analyst herself to work on and amplify behind the scene of analysis. This work provided containment and self-organization for the analyst and impacted the analysand even though the patient was never directly informed.

Associative continuum and the nature of the patient

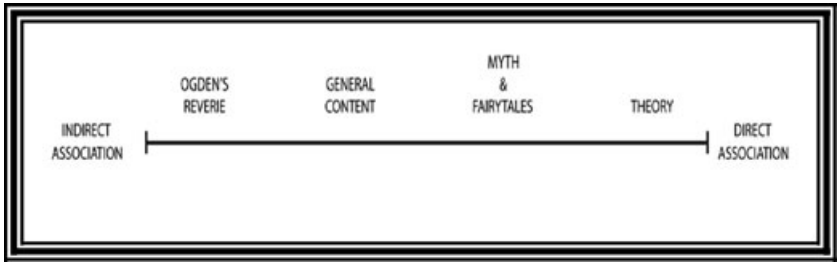
While Bion notes that 'the term reverie may be applied to almost any content', Ogden (1997a) prefers the more mundane and random thoughts, the 'quotidian' as he calls them, as providing the best material to discern the dynamics of the analytic third. He describes clinical examples such as reflections on picking up his son at the airport, or noticing a return address on an envelope sitting on his desk. From such random fare he is able to, in an amazingly creative manner, extract dynamics pertinent to the analytic third. One way of understanding his almost fanatical focus on reveries of the mundane is alchemically: 'from the least valued laden content come the highest or most important insights' (Cambray 2009). But Ogden never seems to have 'mythological reveries', reveries concerning myths or fairytales.

When the contents of mind are closely observed during an analytic session one will notice that many more organized forms are also available: well-formed images, scenes from movies or books, music, memories of work with other patients, whole or parts of myths and fairytales etc. This may be particularly true for analysts trained in the archetypal or classical Jungian modalities. Schwartz-Salant (1982, 1989, 1998, 2007) describes a type of aperspectival 'seeing' of

the analytic couple which allows the analyst an imaginal view of the field that is occurring in the session. Samuels (1985), arguing that the analytic situation activates the *mundus imaginalis*, states that one can speak of 'analytic visions'; imaginative consciousness is the organ that perceives the countertransference in the here-and-now aspects of the field.

Surely theory also enters the analyst's mind as he/she tries to organize the material arising in the session, but exactly what aspects of what theory would seem to be determined by the unique nature of the analytic third being created? We may think of a continuum of contents ranging from the inchoate reveries described by Ogden extending to well-formed cognitive theoretical formulations as illustrated by diagram 3:

Diagram 3



Under general content I would include better formed images and identifiable feeling states than Ogden's quotidian content. This continuum moves from an indirect associative process to a more direct associative process. In indirect association no clear link as to why one is thinking what one is thinking can be made. In direct association the connection can be quite obvious, i.e., the patient describes an image or scene which was formerly discussed, an archetypal motif, say descent, 'reminds' the analyst of a Persephone-type story. (It should also be noted that a fairytale or myth could come into an analyst's mind without understanding just why this particular story entered his/her mind at that time.) I am naming this continuum 'associative dreaming'. It usually occurs during 'reverie-like' states in the analytic hour and is expressive of the analytic third co-created by the analyst/patient dyad. As Ferro (2006, p. 1054) dramatically states, 'The field is held to immediately assume an oneiric form of functioning. There is no communication that cannot be seen as having to do with and belonging to the field itself'.

Since the unconscious tends to make itself known through indirect means and *primary process* contents, i.e., slips, parapraxes, dreams and dream-like material, the left end of the chart would seem to denote more direct access to what might be happening in the unconscious. Automatic thoughts, feelings and sensations predominate with a sense that they are having us rather than we are

having them. We experience a *not knowing* of just what is coming into our mind and body at a given moment. As we move to the right end of the scale *secondary process* takes over with thinking and understanding predominating. These contents usually have the feeling that we are having them rather than the opposite.

One hypothesis is that in moving along the continuum towards the right end of the scale in session the therapist actually becomes more defensive to the deeper affectivity being constellated in the relationship and the analytic third. We would rather think *about* the patient in theoretical terms than *into* the patient's unique, individual experience. This can be seen in colloquium or case presentation when the group, here understood as the group unconscious, responds by categorizing, defining or giving suggestions about the patient rather than allowing themselves to become deeply affected by the patient's material (Cwik 2010a). Although it may be necessary at times to think theoretically about the patient, it could sometimes be understood as a defensive gesture moving out of reverie and into a *knowing* position.

Similarly, the analyst's own dreams of the patient and the patient's dreams of the analyst in the manifest content can be thought of as information about the true unconscious nature of the relationship. As Ogden notes above, the dynamics of the analytic third are such that 'individual subjectivities and the third create, negate, and preserve one another'. These dreams can be understood as self-correcting operations emanating from the analytic third in a relationship that has become unbalanced. The 'healer', those unconscious elements of the patient that are not in complex, help to correct the 'wounded' aspects in the therapist (Groesbeck 1975). In this situation as Searles (1979) poignantly states: the patient becomes therapist to the analyst. They may be considered valid unconscious perceptions of what is happening in the analysis. From a classical Jungian perspective they could also be considered a more objective view of the couple from the non-ego, objective psyche. As such these dreams might be called 'supervision by the Self' (Cwik 2006a). And if Ogden is correct in assuming that all of the patient's dreams are co-created once analysis begins, then any of the analyst's dreams may be speaking to the various analytic thirds in which he/she participates.

But when should the analyst amplify, that is speak *about* and share the contents of his/her mind, and when might it be more appropriate to just speak *from* the inner content in a more personal manner from what he/she extracts during the active imaginal process? Ogden (2004) may give some guidelines by describing two types or classes of patients (Cwik 2010b). One must first understand how he uses the word 'dreaming' as first elaborated by Bion. He states that 'Dreaming involves a form of psychological work in which there takes place a generative conversation between preconscious aspects of the mind and disturbing thoughts, feelings and fantasies that are precluded from, yet pressing toward conscious awareness (the dynamic unconscious)' (Ogden 2005, pp. 99–100). Like reverie, dreaming is considered a capacity

to do unconscious psychological work—to transform raw sense impressions into linkable material useable for thinking and memory. Ogden uses two known categories of sleep disturbance in a metaphorical, non-literal, manner: night terrors and nightmares. In the class identified with night terrors, as in the actual disturbance, the individual cannot sleep, hence cannot dream. In other words he/she cannot use basic sense impressions to link thought and feeling. The individual can be thought of as suffering from 'undreamt dreams', unmetabolized and unintegratable material. Since they cannot do psychological work, the work of the analyst is to 'dream the undreamt dreams' in order to 'harvest' the disturbing raw sensations, for and with the patient. 'The capacity of another to intuit and imagine one's state of mind gives life to the mind and restores life to minds gone dead' (Bollas 1978, pp. 165–66). This happens when the analyst can create conditions whereby the intersubjective analytic third is experienced through reverie and spoken *from* with the patient. Individuals in the category of those who suffer from 'nightmares' are capable of doing psychological work, but can be overwhelmed by the pain of their emotional experience. It exceeds their capacity for continued dreaming. Ogden poetically refers to this situation as 'interrupted cries'. Working with patients in this category the analyst provides an auxiliary ego in the work of containing overwhelming affect that prevents the patient from being able to continue to dream.

These two general classes of patients compare well to Ferro's (2006) categorization of types of trauma. Patients with the most severe traumas never internalized an adequate capacity for alpha functioning.

> The highest degree of trauma results, in childhood, from a defect in the function governing the development of the caregiver-object's capacity to transform protoemotions and protosensorality into images (the α-function), likely resulting in an inadequate development of the child's α-function. It is in this context that the seeds are sown of extremely severe pathologies involving failure to introject the instruments necessary for the basic management of psychic life and for the very development of the capacity to dream.
>
> (p. 1045)

Here we can understand Ogden's patients who have undreamt and undreamable dreams. They suffer from damaged psychic equipment and are unable to use reverie, dream or even metaphor. These patients must always be approached by speaking *from* the associative dreaming experience. Talking to them directly about what is going on inside the analyst—such as using amplification—confuses, alienates and even angers them. They feel disconnected and treated like a clinical object. Developmentally they cannot yet grasp metaphor or symbol.

Ferro (2006) goes on to elaborate that in lesser levels of trauma alpha function has been established, but there has been a lack of the ability of caregivers to contain certain emotional states. Here the deficit is one of containment and holding. And since anyone is capable of being overwhelmed by life events, he notes that 'an appropriate capacity for containment encounters a situation of

acute or chronic stress with an excess of stimuli (β-elements) that accumulate as "undigested facts" awaiting transformation' (p. 1046). Here are Ogden's patients who suffer from 'nightmares'. I would suggest that with these patients the therapist is free to move about the associative dreaming continuum and speak either *from* or *about* his/her reverie contents. Although it should be noted that speaking *from* always tends to be preferred in highly emotional states. Speaking *about* inner contents and/or amplifications in these situations tends to be distancing. It can be a way for the therapist to dissociate from the deeper states that are resonating within. As Ogden (1997b) states, 'Forced symbolization is almost always easily recognizable by its intellectualized, formulaic, contrived quality' (p. 569).

> 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 that moment.
>
> (Ogden 2004, p. 864)

What the therapist says must be able to be used by the patient for his/her own dreaming process, 'thereby dreaming himself [herself] into existence' (p. 858).

Clinical vignettes

The following examples are just glimpses into the workings of associative dreaming. Since it happens rather continuously, or as long as the therapist is able to maintain a reverie state, the movement through an entire session might be of particular value. Looking at interactions with the different types of patients may help the reader grasp the affective differences in the *from* and *about* approach. A future paper will expand this notion of the *from* or *about* of reverie experiences.

Though not discussed but implied above, one should note that the analyst's reverie experience is changed in and by the experience of the patient. This relates to Ogden's comment that 'the individual subjectivities and the third create, negate, and preserve one another', quoted at the beginning of the article. Not only is something remembered or imagined by the therapist that can be helpful to the patient, but the therapist also gains some new understanding by imaginally relating to it in session. This is the 'mutuality' suggested by Jung in the second notion of the third noted above where the therapist is 'themselves transformed in the process'.

It should be noted that the 'validity' of the intervention is judged by its capacity to allow the patient to access previously unconscious material, connect with previously unavailable feelings, or further the dialogue in new and unexpected ways.

Speaking *from*

Early in her analytic work an overweight, middle-aged woman presented in a hypomanic fashion. She was referred by her priest and felt lost in her search for God and out of control in relation to her body. Her speech was pressured as she ran from topic to topic in a jovial manner. She talked incessantly about the new self-help books she read, sometimes culling something of value from them, but very often disagreeing with the bulk of what they had to say. She insisted on being told what therapy was about and how it worked before she could participate in it. Of course any attempt to do this only confused her more. She often struck me as a 'big kid' as she tumbled into the room. She literally could not remember dreams and what she did remember was a hodge-podge of disconnected images. This was a patient incapable of 'dreaming' as described above.

Very early in the analysis a recurring image came into my mind. It was of seeing her across a deep abyss. She was a tiny figure on the other side and took the shape of the figure in Edvard Munch's 'The Scream'. As I recently had seen the Munch picture at the Art Institute of Chicago, I opened more to the paradox of a silent, screaming figure that originally I did not grasp. I also thought about how the gaping distance seemed so foreign to the intensity of the woman in the consulting room. As the image kept reappearing I decided to speak from the image, the 'decisive moment', and said, 'It seems to me that there is some kind of gulf between us that feels unbridgeable. And that you are on the other side trying to express something unspeakable'.

This frenetic and chaotic woman immediately slowed down and began to cry. She moved into talking about how distant she felt from her Germanic mother who did not seem to understand her in the least bit throughout childhood. I seemed to be able to dream some aspect of her experience into existence, allowing her a different form of communication and way of being in her body, at least temporarily.

Another patient, a male with anger problems and prone to self injury revealed several months into the analysis that he was having a sexual relationship with his former therapist. He felt reluctant to tell me of the relationship as I might make or encourage him to end it and report her to the authorities. He had left his marriage in the hopes of being with her. Of course the woman, being his former therapist, knew of his propensity to anger outbursts, but none had occurred during the early period of their relationship. This man was unable to link his inner states to any kind of understanding either when he was in the throes of his rage outbursts or when he was caught in his compulsive self injurious behaviour.

On the eve of moving in together the couple had a horrendous fight, ostensibly when he came home tired from work and felt he could not fulfil their plans for the evening. While discussing the fight which was rather violent, I kept hearing a song by Pete Townshend, 'Let My Love Open the Door'. As I imaginally

engaged with the song while the patient continued to talk, my first reaction was that it provided a rather strange soundtrack for what I was hearing. I know Townshend to be a rather angry man, but this particular song is rather light and even fluffy. Never having thought much about the song before, although liking it, I began to grasp that hope in love would be able to change things. Speaking *from* this active imagination regarding the song I decided to say, 'Perhaps you both made some kind of unconscious bargain that this relationship was somehow going to heal both of you; and, that night of the fight you both rudely found out that was not going to be the case'. I was struck by my use of the word 'rudely'. It surprised even me when I heard myself saying it. But it also may have been the 'rudeness' of the emotions that surprised the couple themselves.

This man who had been escalating in his angry emotional intensity suddenly stopped, and cried intensely. He had never cried during a session before, anger seemed the only accessible emotion. It seemed that my comment named something just below the surface. I think that the song also may have conveyed an aspect of the transference relationship by expressing the hope that my acceptance of the relationship, and somehow the fight itself, would make everything all right. I chose to relate to the aspects going on in their relationship as it felt the more immediate concern and most alive in the moment.

Speaking *about*

A very intellectual man with a degree in philosophy was describing his relationship to an uncle when he was young. The uncle was very successful as a businessman and routinely brought the family together for barbecues at a huge family compound in Texas. All was fun and games until the uncle 'diabolically' used the occasion to ridicule and demean the various participants. Everybody tolerated it because of his power and wealth and, of course, nobody wanted to be left out of the will. The patient described this as his first experience of evil and feared that somehow he would become like his uncle. The patient did have a tendency to be cynical and could be very demeaning to his employees. Yet at the same time he would deny that any such early encounter could be so determining in his life; that this is the stuff of therapy and we would latch onto it to make more of the experience than it really does.

As the patient was telling the story my mind drifted to the scene in *Pan's Labyrinth* where the young girl journeys down into the underworld. There she has to face a very Saturnian figure that devours little children, as evidenced in photographs and the children's shoes collected in that dark place. I could see the direct connection with the patient's coming into contact with something dark and dangerous, but I was struck that the story of the film was that of a young girl who was, in reality, struggling with terrifying life circumstances. This 'little girl' element felt so alien from this highly intellectual man who could be rather

unfeeling. In this circumstance I decided to share with him my thoughts of the movie scene. Trying to give words to the scene actually felt more difficult than sharing the recollection. The image was rather terrifying in and of itself. This is closer to classical amplification as I was relating mythological material through a scene in a movie. The risk was that we would then talk about the movie avoiding his own—and by the nature of the analytic third, my own—terrifying childhood experience. As it turns out, he had seen the movie and remembered the scene quite well. He found it quite disturbing and it struck him particularly because of the strange figure whose eyes were in his hands. As we engaged the image it also became apparent that the movie raises the question of whether this other world encountered by the young girl was 'nothing but' a fantasy world, a flight from the horrors of her outer life. He began to see how this echoed his own struggles with the reality of his own inner life and emotions. The primacy of his rational cognitive abilities became relativized by some awareness of the depth of the terrifying affect. This man could 'dream'. What he could not do was trust and allow validity to those dreams. He gradually became more open to his feeling life and allowing feeling values to impact his decisions. He became more capable of 'dreaming himself into existence'.

A warning

A female patient was seeing a man who had a propensity for disappearing from the relationship periodically in what we imaginatively named his 'Greta Garbo complex': 'I *vant* to be alone'. She was struggling with why she stayed with him. We had analysed the pain of the abandonment feelings reenacting father's abandonment of her large family in youth. Yet she struggled with why she stayed. She even tried working on not having it affect her. During this period my closest friend had been diagnosed with a brain tumor. Thoughts and feelings of the situation often flooded the consulting room. There was no need to induce an altered-state because I was living in one, which could be described as an affect-ego (Cwik 1995). I knew that this material was 'mine'. It permeated my analytic day and certainly was not particular to any patient. Ogden (1994) suggests that it is often difficult to believe that even this type of highly personal material can be affected by the analytic third.

So believing that even these potent reflections still could be affected by the analytic third, I was attempting to pay particular attention to just what aspects of my friend's illness came into my mind with each patient. As this patient was describing her difficulties with her partner I ended up reflecting on the day before when I was driving my friend to chemo. I remember we were approaching the toll gate and I was thinking how complicated our relationship really was and how frustrating he could be. Often he would leave a party or a dinner engagement without concern for any others who were present. Within this reverie I remembered a story I had once heard about a black aide in a hospital overhearing a dying mother and her daughter bickering. The mother

and daughter were going at it when the aide said to them how she missed 'the mother /daughter talk' because her mother died so long ago.

As I tried imaginally to engage this material as the patient was discussing her difficulties, I began to realize just how much I did love my friend; and, how much I would really miss him. Speaking *from* the depth of this awareness I said to the patient that 'Perhaps what you are afraid to acknowledge is that you really love (X) and that you are really terrified of losing him when he goes away'. Not an extraordinarily insightful comment, but it felt true to the situation. She had not admitted her love for her partner before. She was taken aback, but said that she felt something shifting inside. She also felt relieved. I remember feeling particularly satisfied with the session and with how I worked with the reverie material. That should have been a dead giveaway. I have noted that feeling prideful or particularly content after any work generally does not bode well for the future.

In the next session, she said how helpful the last session was and proceeded to report a dream. In the dream she is in session with me and everything is as the way it actually is except that in my seat is Gollum from *Lord of the Rings*. Gollum! I was actually quite shaken to say the least. She seemed unaffected. Now in my mind Gollum is a great guide and will take you where you want to go, but he has been distorted by the power of the ring. He only guides because he wants/needs the ring for himself. Not a flattering unconscious perception. Exploring the dream with the patient did not reveal any additional insights into her feelings about the last session. She insisted that she felt quite helped by the work and experienced some ease around the relationship. She was not that familiar with the *Lord of the Rings*. I amplified some of my thoughts about the figure. Still, she could not quite grasp why I would be portrayed by such a figure as Gollum. I take the dream as a self-correction from the analytic third formed between us or as 'supervision by the Self' warning about the need to be cautious in my use of reverie material. Although the patient's conscious mind received the intervention positively, her unconscious suggests that I was using my very intense reverie experience as an 'overvalued idea'. Britton and Steiner (1994) suggest that a therapist can often use 'selected facts', such as the content of my reverie experience, in a defensive way to reduce confusion and uncertainty. I think that, particularly at that time in my life, I was in such need to be the good analyst while facing the death of my friend, that I, not so unconsciously, 'used' deep and sensitive material for my own inner gratification. I overvalued the idea that all reverie could necessarily be related to the patient's dynamics. It should be noted that the patient later married her friend and that he eventually stopped 'going away'.

The analytic compass

As we look to discovering the 'daily miracle' in our analytic sessions, we orient ourselves to the analytic third by summoning and engaging our associative

dreaming to guide the way. Ogden states that 'the use of my reverie experience is the **emotional compass** upon which I most heavily rely (but cannot clearly read) in my efforts to orient myself to what is happening in the analytic relationship in general, and in the workings of the analytic third in particular' (1999a, p. 3; emphasis added). Winnicott (1971) states that psychotherapy has to do with two people playing together. In the type of analysis described in this paper there is an attempt to create an 'imaginal play-space' (Cwik 1991) where the analytic engagement includes and is centred on information arising from the analytic third. In discussing the value of reverie, Bachelard (1960, p. 8) states, 'one can also understand the great value in establishing a phenomenology of the imaginary where the imagination is restored to its proper, all-important place as the principle of direct stimulation of psychic becoming'.

In Jungian terms we could understand that what is happening in the moment is the activation of the transcendent function. This is the name given by Jung (1916) to describe a natural function of the psyche that mediates opposites. It functions to transition from one attitude to another. Here the opposites could be understood as the ego consciousness of the analyst as he/she engages the products of the unconscious generated by the analytic third in an active imaginal manner. The result, in session, is not so much a grand uniting symbol of the opposites, but a small and gentle opening of awareness that guides the way for the analytic couple. Ogden describes analytic movement as a 'slouching towards' rather than an 'arriving at' (1997b, p. 569).

We could think of these as micro-activations of the transcendent function resulting in new images, thoughts and feelings that appear to the analyst *from* and *about* which he/she can speak, or even just be with the patient. This is the transcendent function of everyday analytic life rather than the 'big' creation of a new and grand uniting symbol as can happen in formal active imaginations (Cwik 1995). Recent research by the Boston Change Process Study Group (Stern et al. 1998) finds that patients are not only affected by key interpretations, but also powerfully by 'moments of meeting'. By this they mean that the patient experiences a felt sense of an authentic person-to-person connection. I believe that moments of meeting are more likely to occur through adequate deciphering of the analytic third. As Ogden (2004) states

> Feeling known in the analytic situation is not so 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.
>
> (pp. 866–67)

This is a valuable reminder that repeating tried and true interpretations, suggesting to supervisees exactly what to say, and amplifying patterns of behaviour with favourite myths and fairytales can lead to stalled analyses.

In the end it may be that the patient internalizes the analyst's relationship with the unconscious by repeatedly being in the 'reverie bath' of analysis, referencing

plate 4 of the *Rosarium* where the analytic third could be thought of as being formed (Cwik 2006b). The symbolic function and the capacity for reverie in the analyst contribute to the mediation of emergent consciousness in the patient (Schaverien 2007). Or as Ferro states

> I believe that the receptivity of the analyst, together with the reverie and the affective transformations that it realizes within a stable setting, are the basis of any further development of the patient's α-function. This development takes place through a silent operation of introjection of the mental functioning of the analyst and of the couple at work—similar to the way a Renaissance painter-in-training might have begun by attending the atelier of the master.
>
> (2006, p. 1055)

Finally, can we truly believe that everything that enters the mind and body of the analyst during a session is countertransference and belongs to the analytic third? Given the quotidian crawl that is the human mind it is hard to imagine that anything and everything is emerging from the third. Insisting that it is, as Ferro's statement made earlier that 'There is no communication that cannot be seen as having to do with and belonging to the field', can be a dangerous situation. The method of associative dreaming is extremely intuitive. It too can become an 'overvalued idea' and be used in an overly defensive manner (Britton & Steiner 1994). One can then have the illusion of certainty about what is happening in the interaction. All interventions should be tentative and thoroughly explored by the individuals involved, especially since they are all considered 'joint creations'. Bion makes a remarkable statement that may help guide through the crawl. He states, 'When the mother loves the infant what does she do it with? Leaving aside the physical channels of communication my impression is that her love is expressed by *reverie*' (1962b, pp. 34–35; emphasis added). It is only those fantasies, images, memories, random thoughts that carry a certain aliveness through love, caring and connectedness related to the patient that conceal the analytic gold leading to the creation of the analytic compass.

Translations of Abstract

L'idée de contretransfert dépasse largement son acceptation d'origine comme réaction névrotique, elle s'étend désormais à l'ensemble des réactions du thérapeute; affectives, corporelles, imaginales. La création d'une instance « tierce » au cœur du processus analytique constitue l'*insight* fondamental de Jung dans 'La psychologie du transfert', bien qu'il n'ait pas réussi à montrer comment ce tiers est expérimenté et utilisé au cours de l'analyse. Ce « tiers analytique », ainsi que le dénomme Odgen, est co-créé par l'analyste et l'analysant au cours du travail des profondeurs et il devient l'objet de l'analyse. La rêverie, telle qu'elle est développée par Bion et cliniquement mise en œuvre par Odgen, fournit une voie d'accès à la nature inconsciente de ce tiers. Elle se situe dans un continuum de contenus psychiques, allant de formes associatives indirectes à des formes directes, décrites comme rêverie associative. L'imagination active telle

qu'elle fut développée par Jung, fournit le paradigme d'un mode d'interaction avec de tels contenus au sein de la rencontre analytique. Que l'analyste parle *à partir de* ces contenus ou qu'il s'exprime *à leur sujet,* cela dépendra de la capacité de rêver du patient. L'amplification classique peut être comprise comme une façon de parler des contenus internes. Tandis que le moi de l'analyste—la composante consciente—se relie aux contenus inconscients émergeant du tiers analytique, des micro-activations de la fonction transcendante contribuent à la création d'une « boussole » analytique, permettant de s'orienter dans le processus.

Die Idee der Gegenübertragung hat sich über ihre originäre Bedeutung als eine neurotische Reaktion hinausentwickelt und schließt nun alle Reakrionen des Therapeuten ein: affektive, körperliche und imaginative. Zusätzlich ist anzumerken, daß zwar Jungs fundamentale Erkenntnis in 'Psychologie der Übertragung' darin bestand, daß eine 'dritte Sache' in der Analyse erschaffen wird, daß er aber verpaßte darzustellen, wie diese erfahren und analytisch nutzbar gemacht wird. Dieses 'analytische Dritte', wie Ogden es nennt, wird vom Analytiker und vom Analysanden in der Tiefenarbeit gemeinsam geschaffen und wird zum Objekt der Analyse. Reverie, wie von Bion entwickelt und klinisch von Ogden umgesetzt, stellt ein Verfahren der Zugangsgewinnung zur Natur dieses Dritten dar. Reverie wird angesiedelt auf einem Kontinuum des Geistes, welches von indirekten bis zu direkten assoziativen Formen reicht und als assoziatives Träumen bezeichnet wird. Aktive Imagination, wie sie von Jung entwickelt wurde, bildet das Paradigma für die Art und Weise des Umgangs mit diesen Inhalten innerhalb der analytischen Erfahrung selbst. Ob der Analytiker *von* oder *über* diese Inhalte spricht hängt von den Fähigkeiten des Patienten zu träumen ab. Klassische Amplifikation kann verstanden werden als ein Beispiel für das Reden *über* persönliche Inhalte. So wie das Ego des Analytikers, die bewußte Komponente, sich auf unbewußte Inhalte bezieht, die aus dem analytischen Dritten auftauchen, konstellieren Mikroaktivierungen der transzendenten Funktion die Erschaffung einen analytischen Kompasses.

L'idea di controtransfert si è ampliata oltre il suo significato originale di una reazione nevrotica fino ad includere tutte le reazioni del terapeuta: affettive, corporee e immaginali. Inoltre, la fondamentale intuizione di Jung nella 'Psicologia della translazione' che 'una terza cosa' viene creata in analisi mancò di una dimostrazione del come si possa fare esperienza e del come possa essere utilizzato in analisi. Questo 'terzo analitico', come Ogden lo chiama, è co-creato dall'analista e dall'analizzando durante il lavoro nel profondo e diviene l'oggetto dell'analisi. La reverie, come sviluppata da Bion e clinicamente utilizzata da Ogden, fornisce uno strumento di accesso alla natura inconscia di questo terzo. La reverie viene collocata in un continuum di contenuti della mente, che vanno da forme associative indirette a dirette, che vengono descritte come il sognare associativo. L'immaginazione attiva, come descritta da Jung, fornisce il paradigma per una modalità di interazione con tali contenuti all'interno dell'incontro analitico stesso. Dipende dalla capacità del paziente di sognare se l'analista parla *da* o *di* tali contenuti. L'amplificazione classica può essere intesa come una spinta per

parlare *di* contenuti interiori. Così l'io dell'analista, la componente conscia, si relaziona ai contenuti inconsci che emergono dal terzo analitico, le micro-attivazioni della funzione trascendente costellano la creazione di una direzione analitica.

Представление о контрпереносе переросло свое первоначальное значение невротической реакции, включив в себя все реакции психотерапевта: аффективные, телесные и фантазийные. Изначальный инсайт Юнга, изложенный в «Психологии переноса», заключался в том, что в анализе создаеця нечто «третье», однако он не смог показать, как именно это «третье» переживаеця и используется в анализе. «Аналитический третий», как называет его Огден, есть продукт со-творчества аналитика и анализируемого в глубинной работе, и этот «аналитический третий» становится объектом анализа. Грезы, как это показал Бион и клинически использовал Огден, предоставляют нам средства доступа к бессознательной природе этого третьего. Грезы помещаются в континуум душевных содержаний – от косвенных до прямых ассоциативных форм, описанных как ассоциативные сновидения. Активное воображение, как продемонстрировал Юнг, обеспечивает парадигму для способа взаимодействия с этими содержаниями внутри аналитической встречи. Ґоворит ли аналитик *из* или *об* этих содержаниях, зависит от способностей пациента сновидеть. Классические амплификации могут быть поняты как примеры речи о внутренних содержаниях. Поскольку эго аналитика, сознательный компонент, связывается с бессознательными содержаниями, поступающими из аналитического третьего, микро-активации констеллированной трансцендентной функции создают аналитический компас.

La idea de la contratransferencia se ha expandido más allá de su significado original como reacción neurótica y ahora se incluyen en ella todas las reacciones del terapeuta: afectivas, corporales, e imaginales. Además, el concepto fundamental de Jung incluido en la 'Psicología del transferencia' era que una 'tercera cosa' se creaba en el análisis, sin embargo no logró demostrar cómo se experimentaba este tercero y como podría ser utilizado en el análisis. Este 'tercero analítico', como lo denomina Ogden, es co-creado por el analista y el sujeto analizado en el trabajo profundo y llega a ser el objeto del análisis. El concepto de Reverie, desarrollado por Bion y utilizado clínicamente por Ogden, proporciona una vía de acceso a la naturaleza inconsciente de este tercero. El Reverie será colocado en un continuo de contenidos de la mente, moviéndose de lo indirecto a las formas asociativas directas descritas como el soñar asociativo. La imaginación activa, tal como fue desarrollada por Jung, proporciona el paradigma para un modo de interacción con estos contenidos dentro del encuentro analítico mismo. Si el analista habla *de* o *acerca* de estos contenido dependerá de la capacidad del paciente para soñar. La amplificación clásica puede ser comprendida como un caso de hablar *acerca* del contenido interior. Como el ego del analista, el componente consciente, relaciona al contenido inconsciente que surge del tercero analítico, las micro-activaciones de la función trascendente se constelizan creando una guía analítica.

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