
On talking-as-dreaming

‘Auntie, speak to me! I’m frightened because it’s so dark.’ His aunt answered him: ‘What good would that do? You can’t see me.’ ‘That doesn’t matter,’ replied the child, ‘if anyone speaks, it gets light.’

(Freud, 1905, p. 224, n.1)

I take as fundamental to an understanding of psychoanalysis the idea that the analyst must invent psychoanalysis anew with each patient. This is achieved in no small measure by means of an ongoing experiment, within the terms of the psychoanalytic situation, in which patient and analyst create ways of talking to one another that are unique to each analytic pair at a given moment in the analysis.

In this chapter, I will focus primarily on forms of talking generated by patient and analyst that may at first seem “unanalytic” because the patient and analyst are talking about such things as books, poems, films, rules of grammar, etymology, the speed of light, the taste of chocolate, and so on. Despite appearances, it has been my experience that such “unanalytic” talk often allows a patient and analyst who have been unable to dream together to begin to be able to do so. I will refer to talking of this sort as “talking-as-dreaming.” Like free association (and unlike ordinary conversation), talking-as-dreaming tends to include considerable primary process thinking and what appear to be non sequiturs (from the perspective of secondary process thinking).

When an analysis is a “going concern” (Winnicott, 1964, p. 27), the patient and analyst are able to engage both individually and with one another in a process of dreaming. The area of “overlap” of the patient’s dreaming and the analyst’s dreaming is the place where analysis occurs (Winnicott, 1971, p. 38). The patient’s dreaming, under such

circumstances, manifests itself in the form of free associations (or, in child analysis, in the form of playing); the analyst's waking-dreaming often takes the form of reverie experience. When a patient is unable to dream, this difficulty becomes the most pressing aspect of the analysis. It is these situations that are the focus of this chapter.

I view dreaming as the most important psychoanalytic function of the mind: where there is unconscious "dream-work," there is also unconscious "understanding-work" (Sandler, 1976, p. 40); where there is an unconscious "dreamer who dreams the dream" (Grotstein, 2000, p. 5), there is also an unconscious "dreamer who understands the dream" (p. 9). If this were not the case, only dreams that are remembered and interpreted in the analytic setting or in self-analysis would accomplish psychological work. Few analysts today would support the idea that only remembered and interpreted dreams facilitate psychological growth.

The analyst's participation in the patient's talking-as-dreaming entails a distinctively analytic way of being with a patient. It is at all times directed by the analytic task of helping the patient to become more fully alive to his experience, more fully human. Moreover, the experience of talking-as-dreaming is different from other conversations that bear a superficial resemblance to it (such as talk that goes nowhere or even a substantive conversation between a husband and wife, a parent and child, or a brother and sister). What makes talking-as-dreaming different is that the analyst engaged in this form of conversation is continually observing and talking with himself about two inextricably interwoven levels of this emotional experience: (1) talking-as-dreaming as an experience of the patient coming into being in the process of dreaming his lived emotional experience; and (2) the analyst and patient thinking about and, at times, talking about the experience of understanding (getting to know) something of the meanings of the emotional situation being faced in the process of dreaming.

In what follows, I will offer two clinical illustrations of talking-as-dreaming. The first involves a patient and analyst talking together in a way that represents a form of dreaming an aspect of the patient's (and, in a sense, her father's) experience that the patient previously had been almost entirely unable to dream. In the second clinical example, patient and analyst engage in a form of talking-as-dreaming in which the analyst participates in the patient's early efforts to "dream himself up," to "dream himself into existence."

A theoretical context

The theoretical context for the present contribution is grounded in Bion's (1962a, b, 1992) radical transformation of the psychoanalytic conception of dreaming and of not being able to dream. Just as Winnicott shifted the focus of analytic theory and practice from play (as a symbolic representation of the child's internal world) to the experience of playing, Bion shifted the focus from the symbolic content of thoughts to the process of thinking, and from the symbolic meaning of dreams to the process of dreaming.

For Bion (1962a), "alpha-function" (an as-yet-unknown, and perhaps unknowable, set of mental functions) transforms raw "sense impressions related to emotional experience" (p. 17) into "alpha-elements" that can be linked to form affect-laden dream-thoughts. A dream-thought presents an emotional problem with which the individual must struggle (Bion, 1962a, b; Meltzer, 1983), thus supplying the impetus for the development of the capacity for dreaming (which is synonymous with unconscious thinking). "[Dream-]thoughts require an apparatus to cope with them . . . Thinking [dreaming] has to be called into existence to cope with [dream-]thoughts" (Bion, 1962b, pp. 110–111). In the absence of alpha-function (either one's own or that provided by another person), one cannot dream and therefore cannot make use of (do unconscious psychological work with) one's lived emotional experience, past and present. Consequently, a person unable to dream is trapped in an endless, unchanging world of what is.

Undreamable experience may have its origins in trauma – unbearably painful emotional experience, such as the early death of a parent, the death of a child, military combat, rape or imprisonment in a death camp. But undreamable experience may also arise from "intrapsychic trauma" – that is, experiences of being overwhelmed by conscious and unconscious fantasy. The latter form of trauma may stem from the failure of the mother to adequately hold the infant and contain his primitive anxieties or from a constitutional psychic fragility that renders the individual in infancy and childhood unable to dream his emotional experience, even with the help of a good-enough mother. Undreamable experience – whether it be the consequence of predominantly external or intrapsychic forces – remains with the individual as "undreamt dreams" in such forms as psychosomatic illness, split-off psychosis, "dis-affected" states (McDougall, 1984), pockets of

autism (Tustin, 1981), severe perversions (de M'Uzan, 2003), and addictions.

It is this conception of dreaming and of not being able to dream that underlies my own thinking regarding psychoanalysis as a therapeutic process. As I have previously discussed (Ogden, 2004a, 2005a), I view psychoanalysis as an experience in which patient and analyst engage in an experiment within the analytic frame that is designed to create conditions in which the analysand (with the analyst's participation) may be able to dream formerly undreamable emotional experience (his "undreamt dreams"). I view talking-as-dreaming as an improvisation in the form of a loosely structured conversation (concerning virtually any subject) in which the analyst participates in the patient's dreaming previously undreamt dreams. In so doing, the analyst facilitates the patient's dreaming himself more fully into existence.

Fragments of two analyses

I will now present clinical accounts of analytic work with two patients who were severely limited in their ability to dream their emotional experience in the form of free associations or in other types of dreaming. In both of these analyses, the patient was eventually able, with the analyst's participation, to begin to engage in genuine dreaming in the form of talking-as-dreaming.

Talking-as-dreaming formerly undreamt dreams

Ms L, a highly intelligent and accomplished woman, began analysis because she was tormented by intense fears that her seven-year-old son, Aaron, would fall ill and die. She also suffered from an almost unbearable fear of dying that for periods of weeks at a time had rendered her unable to function. These fears were compounded by her feeling that her husband was so self-centered as to be unable to care for their son if anything were to happen to her. Ms L was so preoccupied with her fears concerning her son's life and her own that she could speak of practically nothing else in the first years of analysis. Other aspects of her life seemed to be of no emotional significance to her. The idea that the patient was coming to see me to think about

her life held virtually no meaning – she came to each of her daily sessions with the hope that I would be able to free her of her fears. Ms L’s dream-life consisted almost entirely of “dreams” that were not dreams (Bion, 1962a; Ogden, 2003a); that is, she was unchanged by the experience of the repetitive dreams and nightmares in which she was helpless to prevent one catastrophe after another. My own reverie experience was sparse and unusable for purposes of psychological work (see Ogden, 1997a, b for detailed discussions of the analytic use of reverie experience).

From the beginning of the analysis, the patient’s way of speaking was distinctive. She spoke spasmodically, blurting out clumps of words, as if trying to get as many words as she could into each breath of air. It seemed to me that Ms L was afraid that at any moment she would lose her breath or would be cut off by my telling her that I had heard enough and could not stand to hear another word.

By the beginning of the second year of analysis, the patient appeared to have lost all hope that I could be of any help to her. She barely paused after I spoke before continuing the line of thought that I had momentarily interrupted. She seemed hardly at all interested in what I had to say – perhaps because she could hear almost immediately in my tone of voice and rhythm of speech that what I was about to say would not contain the relief that she sought. The patient responded to the combination of fear and despair that she was feeling by flooding the sessions with clump after clump of words that had the effect of drowning out (both for herself and me) any opportunity for genuine dreaming and thinking. In a session that took place during this period of the analysis, I said to Ms L that I thought that she felt that there was so little of her that she did not have sufficient substance to achieve change through thinking and talking. (I had in mind her inability to speak without chopping her sentences and paragraphs into bits. The relief that she hoped I would supply was the only means by which she could imagine her life changing.) After I made this observation, the patient paused slightly longer than usual before continuing with what she was saying. I commented that what I had just said must have felt useless to her.

In the months preceding the session that I will present, the patient’s speech had become somewhat less pressured. She was able for the first time to talk with feeling about her childhood experience. Up to that point, it was as if the patient felt that there was not “time” (i.e. psychological room) for thinking and talking about anything other than her

efforts “to cope,” to keep herself from losing her mind. The patient’s fear of dying and her worries about Aaron diminished to the point that she was able to read again for the first time since Aaron was born. Reading and the study of literature had been a passion of the patient’s in college and in graduate school. Aaron was born only a few months after she completed her doctoral thesis.

The session that I will discuss was a Monday session that the patient began by telling me that over the weekend she had re-read J. M. Coetzee’s novel, *Disgrace* (1999). (Ms L and I had briefly spoken about Coetzee’s work in the course of the previous year of analysis. Like Ms L, I greatly admire Coetzee as a writer and no doubt this had come through in the brief exchanges we had had about him.) Ms L said, “There is something about that book [which is set in post-apartheid South Africa] that draws me back to it. The narrator [a college professor] tries to bring himself back to life – if he ever was alive – by having sex with one of his students. It seems inevitable that the girl will turn him in, and when she does, he refuses to defend himself. He won’t even go through the motions of saying the repentant words to the academic council that his friends and colleagues are urging him to say. And so he gets fired. It is as if he has felt like a disgrace his whole life and that this incident is only the latest evidence of this state, evidence he cannot and will not attempt to refute.”

Although the patient was speaking in her characteristic way (blurt-ing out words in clumps), it was unmistakable that a change was occurring: Ms L was speaking with genuine vitality in her voice about something that did not relate directly to her fears about Aaron’s safety or her own health. (It must be borne in mind that this change did not arise *de novo* in the session being described. Rather, it developed over the course of years, beginning with a note of humour here, an unintended, but appreciated, pun there, an occasional dream that had a small measure of aliveness, and a reverie of mine that had unexpected vitality. Very slowly such scattered events became elements of an unselfconscious way of being that came alive in the form that I am in the process of describing.)

I did not tell the patient my thought that she, in speaking about the narrator, may also have been speaking to herself and to me about a psychological conflict of her own – that is, that one aspect of herself (identified with the narrator’s refusal to lie) seemed to be at odds with another aspect of herself (for whom fears of death crowded out the possibility for genuine thinking, feeling, and talking). To have said any

of this to Ms L would have been equivalent to waking the patient from what may have been one of her first experiences of dreaming in the analysis in order to tell her my understanding of the dream. It was nonetheless important that I make this interpretation to myself silently because, as will be seen, I was at the time engaging in something very similar to what Ms L was doing in that I, too, was evading thinking and feeling.

I said to Ms L, “Coetzee’s voice in *Disgrace* is one of the most unsentimental voices I have ever read. He makes it clear in every sentence that he deplors rounding the edges of any human experience. An experience is what it is, no more and no less.” In saying this, I felt as if I was entering into a form of thinking and talking with the patient that was different from any exchange that had previously occurred in the analysis.

Ms L, somewhat to my surprise, continued the conversation by saying, “There’s something about what’s happening *between* the characters and *in* the characters – no matter how awful it is – that is oddly right.”

I then said something that even at the time felt like a non sequitur: “You can hear in Coetzee’s early books a writer who did not yet know who he was as a writer or even as a person. He’s awkward, trying this and trying that. I sometimes feel embarrassed with him.” (I felt that the words “with him” said more of what I was feeling in the session with Ms L than would have been conveyed by the words “for him.” I was putting the emphasis on my own, and what I sensed to be the patient’s, feelings of self-consciousness in response to the awkwardness of our efforts at talking/thinking/dreaming in this new way.)

Ms L then said, in another of our apparent non sequiturs, “Even after the rape of the narrator’s daughter and the shooting of the dogs that the daughter loved so much, the narrator found ways to hang onto the fragments of his humanity that remained alive for him. After helping the veterinarian euthanize dogs that had no one and no place on this earth to which they belonged, he tried to spare the corpses the indignity of being treated like garbage. He made it his business to be there very early in the morning to put the corpses into the cremation machine himself instead of giving the bodies to the workmen who ran the machine. He couldn’t bear to see the workers use shovels to smash the dogs’ legs which were stiffened and outstretched with rigor mortis. The outstretched legs made it harder to get the corpses to fit

into the door of the machine.” There was sadness and warmth in Ms L’s voice as she talked. As the patient was speaking, I was reminded of talking with a close friend soon after he had come home from a hospitalization during which it had seemed all but certain that he would die. He told me that he had learned one thing from the experience: “Dying doesn’t take courage. It’s like being on a conveyor belt taking you to the end.” He added, “Dying is easy. You don’t have to do anything.” I remembered feeling humbled, as he and I talked, by the dignity with which he had faced death in the hospital and by the way he used his capacity for irony and wit, even while emotionally and physically exhausted, to keep from being crushed by the experience.

As I re-focused on Ms L, I responded to what she had been saying about the handling of the dogs’ corpses (and the compassionate way in which she had been saying it) by commenting, “The narrator kept making that small gesture [in connection with the cremation of the dogs] even though he knew that what he was doing was so insignificant as to be imperceptible to anybody or anything else in the universe.” As I was saying this, I began to think (in a way that was new for me in this analysis) about the effect of the terrible deaths in Ms L’s life. The patient had told me early on in the analysis, and then again in a session a few months prior to the one being discussed, that her father’s first wife and their three-year-old daughter had been killed in a car accident. (The patient deeply loved her father and felt loved by him.) On the two occasions that Ms L had mentioned the death of her father’s first wife and daughter, she did so as if presenting a piece of information that I should know about because analysts (with their stereotypic ways of thinking) tend to make a big deal about such things. I was able at this point to make use of the silent interpretation that I had made earlier to myself regarding the way the patient (and I) were evading thinking/dreaming/speaking/remembering what was true to the emotional experience that was occurring. In my work with Ms L, I had, for more than a year, been unable and perhaps unwilling to think/dream/remember and keep alive in myself the enormous (unimaginable) pain that the patient’s father and the patient had experienced in relation to the death of his first wife and their daughter. I was astounded by my inability to have kept alive in me the emotional impact of those deaths.

At that point in the session I was able to begin to dream (to do conscious and unconscious psychological work with) what I now

perceived to be the patient's feelings of "disgrace" for being alive "in place of" her father's wife and daughter and in place of the parts of her father that had died with them. Ms L responded to what I said about the narrator's "insignificant," but important, gestures by saying, "In Coetzee's books dying is not the worst thing that can happen to a person. For some reason, I find that idea comforting. I don't know why, but I'm reminded of a line I love from Coetzee's memoir. He says near the end something like: 'All we can do is to persist stupidly, doggedly in our repeated failures.'" Ms L laughed deeply in a way I had never heard her laugh before as she said, "Dogs are everywhere today. I am very fond of dogs. They're the innocents of the animal kingdom." She then became more pensive and said, "There's nothing glamorous about repeated failures while they're happening. I feel like such a failure as a mother. I can't lie to myself and pretend that my obsession with Aaron's dying isn't felt by him and doesn't scare the life out of him. I didn't intend to put it that way – 'scare the life out of him' – but that is what I feel I'm doing to him. I'm terrified that I'm killing him with my fear – that I'm scaring the life out of him, and I can't stop doing it. That's my 'disgrace.'" Ms L cried as she spoke. It seemed clear to me at this moment that Ms L's father's response to his "unthinkable" losses had scared the life out of her.

I said, "I think that you've felt like a disgrace your whole life. Your father's pain was unbearable not only to him, but to you. You couldn't help your father with his unimaginable pain. His pain was such a complicated thing for you – you're still in the grip of it with him – pain beyond what anyone can take in." This was the first time in the analysis that I addressed the patient's inability not only to help her father, but also to dream her experience of her response to his pain. I thought, but did not say, that it felt shameful to her that she felt angry at her father for not having been able to be the father she wished he were. Moreover, she took that anger out on her husband in the form of demeaning him for what she perceived to be his inadequacy as a father to their son.

Ms L did not respond directly to what I said, and instead said, "I think that it's odd that I think of the characters in Coetzee's book as courageous. They don't think of themselves that way. But they do feel that way to me. In *Life & Times of Michael K* [Coetzee, 1983], Michael K [a black man in apartheid South Africa] builds a cart out of scraps of wood and metal. He wheels his dying mother toward the town where she was born so she can die there – it is the closest thing to a home

that she has ever had. I don't think Michael K felt courageous as he was doing it. He just knew that that was what he had to do. It was a doomed effort. I think he knew that from the beginning – I think I did, too. But it had to be done. It was the right thing to do. I like the fact that Coetzee's narrators are often women. In *The Age of Iron* [Coetzee, 1990], the woman narrator [a white woman living in apartheid South Africa] took in the homeless black man and felt guilty and pitied him and grew to admire him and became angry with him and even loved him in her own odd way. She never once pulled a punch in the way she talked to herself and to him. You and I can sometimes be like that. We've done some of that today – not entirely, but enough so I feel stronger now, which is not to say happier. But being stronger is what I need more than feeling happier." I could hear in the sound of Ms L's voice that she felt, but could not yet say (even to herself), that she felt admiration and anger and her own odd brand of love for me and that she hoped that I, one day, might feel all of this for her.

The actual course of the session had a far more meandering quality than the account I have been able to give. The patient and I drifted from topic to topic, book to book, feeling to feeling, without experiencing the need to tie one to the next, or to think in a logical way, or to respond directly to what the other had said. We spoke of Coetzee's choice to live in Adelaide, Australia, John Berger's scathingly anti-capitalist Booker Prize acceptance speech, our disappointment in Coetzee's two most recent novels, and so on. It is impossible for me to say which of these subjects were spoken about in the session under discussion and which were spoken about in subsequent sessions. Neither can I say with any certainty which parts of the dialogue that I have presented from the session were spoken by Ms L and which parts by me.

As the emotional experience of this session evolved in subsequent weeks and months, the patient told me that her father had had bouts of severe depression as she was growing up and that she had felt responsible for helping him to recover from them. She said that she had often sat with him for long periods of time as "he sobbed uncontrollably, choking on his tears." As Ms L described these experiences with her father, it occurred to me that her talking in clumps of words, cramming as many words as she could into a breath of air, may have been related to her experience of her father choking on his tears while sobbing uncontrollably. Perhaps, unable to dream her

experience with her father, she had somatized her undreamt dreams (and his) in her pattern of speaking and breathing.

In sum, in the session I have discussed, the way Ms L and I talked about books served as a form of talking-as-dreaming. It was an experience in dreaming that was neither exclusively the patient's dream nor mine. Ms L had only rarely been able to achieve a state of waking-dreaming to that point in the analysis. Consequently, she had been trapped in a timeless world of split-off undreamable experience that she feared had not only robbed her father and herself of a good deal of their lives, but also was killing her child. Ms L had developed psychosomatic symptoms (her manner of speech and breathing) and intense fears of death at the psychological point at which she was no longer able to dream *her* experience of her father's depression or her anger at him. As the session under discussion progressed, the patient was able to dream (in the form of talking-as-dreaming) formerly undreamable experience of and with her father. This talking-as-dreaming moved unobtrusively into and out of talking about dreaming. I view such movement between talking-as-dreaming and talking-about-dreaming as a hallmark of psychoanalysis when it is "a going concern."

Talking-as-dreaming oneself into existence

I shall now describe a clinical experience in which talking-as-dreaming served as a primary means through which a patient was able to begin to develop his own rudimentary capacity "to dream himself into being."

Mr B grew up under circumstances of extreme neglect. He was the youngest of five children born to an Irish Catholic family living in a working-class suburb of Boston. The patient, as a child, was tormented by his three older brothers who humiliated and frightened him at every opportunity. Mr B did what he could to "become invisible." He would spend as little time as possible at home and, while at home, would draw as little attention to himself as he could. He learned early on that bringing his problems to his parents' attention only made matters worse in that it would lead to his brothers' redoubling their brutalizing of him. Nonetheless, he tenaciously clung to the hope that his parents, particularly his mother, would see what was happening without his having to tell them.

Beginning at age seven or eight, Mr B immersed himself in reading.

He would literally read shelf after shelf of books at the public library. He told me that I should not mistake reading with either intelligence or the acquisition of knowledge: “My reading was pure escapism. I lost myself in the stories, and, a week after reading a book, I couldn’t tell you a thing about it.” (In a previous contribution [Ogden, 1989a], I have discussed the use of reading as a sensation-dominated experience that may serve as an autistic defense.)

Despite the fact that I liked Mr B, I found the first four years of the analysis to be rather lifeless. Mr B spoke slowly, deliberately, as if considering every word that he said before saying it. Over time, he and I came to view this as a reflection of his fear that I would either use what he said as a way of humiliating him (in the fraternal transference) or somehow fail to recognize what was most important, and yet unstated, in what he said (in the maternal transference).

It was not until the fifth year of this five-session-per-week analysis that the patient began to be able to remember and tell me his dreams. Among these early dreams was one in which there was a single horrifying image of a shabby wax figure of a Madonna and infant in a wax museum. What was most disturbing about the image was the vacant stare that each was giving the other.

The session that I will describe occurred shortly after the Madonna-and-infant dream. It was a period of analysis in which the patient and I were beginning to be able to talk to one another in a way that held some vitality, and yet this way of talking was still so new as to feel brittle and, at times, a bit awkward.

Mr B began the session by saying that at work he had overheard a woman saying to a colleague that she could not bear to watch the Coen brothers’ film *Raising Arizona* because she could not see the humor in the kidnapping of a baby.¹ Mr B then asked me, “Have you seen that movie?” This was only the second or third time in the entire analysis that Mr B had asked me a direct question of this sort. The analytic relationship to that point was one in which the focus was almost entirely on the patient’s experience and state of mind, with virtually no explicit allusion to – much less questioning or discussing – my experience. It did not feel entirely natural to simply answer his question, but I

¹ In *Raising Arizona*, a couple (played by Nicolas Cage and Holly Hunter), unable to conceive a baby of their own, steal one of the quintuplets recently born to Nathan Arizona and his wife. Cage and Hunter convince themselves that a family with so many babies would hardly notice that one of them was missing.

could not imagine responding by reflexively returning the question to the patient by, for instance, asking why he had asked the question or suggesting that he had been afraid that I would not understand the significance of what he was about to say. I told Mr B that I had seen the film a number of times. I was aware only as I was saying these words that in responding in this way I was saying to the patient more than he had asked of me. I experienced this not as a slip but as a line that I was adding to a squiggle game. Nonetheless, I was a bit worried that what I had added would be experienced by the patient as intrusive and would precipitate the equivalent of a play disruption.

Mr B moved his head on the pillow of the analytic couch in a way that conveyed a sense of surprise that I had responded as I had. It seemed clear to both of us that we were in uncharted waters. As this emotional shift was occurring, I had in mind a number of thoughts about the transference-countertransference. Mr B, in asking me a direct question, had dared to make himself less “invisible,” and I had, without conscious intention, responded in kind. Moreover, he was inviting me to join him in talking about the work of two brothers, the Coen brothers, who made extraordinary things together. Making something (becoming someone) with one’s brother was an experience that the patient had missed out on with his own brothers. Perhaps his introducing the Coen brothers into the analysis reflected a wish to have such an experience with me. I decided not to say any of this to the patient because I believed that it would have distracted from and undermined the tentative movement toward emotional intimacy that the patient and I were making.

With an intensity of feeling in his voice that was unusual for him, Mr B said that he thought that the woman whom he had overheard talking about *Raising Arizona* was treating the film as if it were a documentary: “It seems crazy for me to get worked up about this, but that film is one of my favorites. I have seen it so many times that I know the dialogue by heart, so I hate to hear the film disparaged in a mindless way.”²

I said, “There’s irony in every frame of that film. Sometimes irony can be frightening. You never know when it’ll be turned on you.” (Even though the patient had unconsciously commented on what

² I am again and again impressed by the way in which film images and narratives seem to share some of the evocative power of dream images and narratives (see Gabbard, 1997a, b; Gabbard and Gabbard, 1999).

was going on between us – our being less mindless and rigid with one another than had been our pattern – it seemed to me that to have responded at that level would have disrupted what I sensed was becoming talking-as-dreaming.)

Mr B said, “The movie is not a documentary, it’s a dream. It opens with Nicolas Cage being photographed for mug shots after being arrested for one bungled petty crime after the next. It’s as if right from the start two levels of reality are being introduced: the person and the photograph. I’ve never thought of the opening of the film in that way before. And the huge guy on the motorcycle – more an archetype than a person – lives in the film in a parallel reality that is disconnected from the reality of the other parts of the film. I’m sorry for getting so carried away.” The patient’s voice was full of the excitement of a child.

I asked, “Why not get carried away?” (This was not a rhetorical question. I was saying in a highly condensed way that there had been very good reasons for the patient as a child to feel that it was dangerous to talk with excitement in his voice, but that those reasons were true to another reality, the reality of the past, which for him often eclipsed the reality of the present.)

Mr B went on without a pause to say, “My favorite part of the film is the voice-over at the end [which takes place after Nicolas Cage and Holly Hunter have returned the baby that they took and Holly Hunter has told Nicolas Cage that she is leaving him]. As he lies awake in bed next to her, he speaks in a way that is somewhere between thinking while falling asleep and dreaming. In his voice, there is a feeling that he’d do anything to have a second chance to get it right, but he knows himself well enough to realize that odds are he’ll screw it up again. Now that I think of it, the end is a repetition, in a much richer form, of the opening scene in which the mug shots are being taken after each of his arrests. He can never get it right. But by the end, you know him and it hurts to see him never getting it right. He has a good heart. In the voice-over monologue at the end, he imagines the life of the baby, Nathan, Jr. [the baby they took and then returned to his family]. Cage can make out vaguely in the future his own invisible presence in the life of the child as he grows up. The child can feel someone lovingly watching him, feeling proud of him, but the child can’t quite connect the feeling with a particular person.” (Of course, I heard this as the patient’s unconscious way of telling me that he felt lovingly watched over by me. In addition, the beloved

baby that Mr B and I were dreaming/conceiving seemed to “embody” the analytic experience itself that, in this session, was being freshly “brought to life” in the process of the patient and me dreaming together.)

I said to Mr B, “In the last scene Nicolas Cage also imagines a couple – maybe it’s himself and Holly Hunter – with their own children and grandchildren.”

Mr B excitedly interrupted me to say, “Yes, his dream at the end has it both ways. I want to believe he’s looking into the future. No, it’s a softer feeling than that. It is a feeling of *maybe*. Even for such a screw-up as Cage, if he can imagine something, it might happen. No, that sounds so trite. I can’t find the right way of putting it. It’s so frustrating. If he can dream it, it has happened in the dream. No, I can’t say it the way I mean it.”

I chose not to focus directly on the meaning of the patient’s difficulty in finding the right words – which may have derived from his anxiety about the love that he was feeling for me and his hope that it was reciprocated. Instead, I made my comments within the terms of the talking-as-dreaming that I sensed was occurring. I said, “See if this way of putting it squares with what you have in mind. For me, the sound of Cage’s voice as he tells his dream at the end is different from the way his voice has sounded at any point earlier in the film. He’s not faking a change in himself in order to get Holly Hunter to stay with him. There’s a genuine change in who he is. You can hear it in his voice.” It was only in the act of saying these words that I recognized that not only was I addressing the imagery of the patient’s talking-as-dreaming, but also I was implicitly saying that I could hear and did appreciate the difference in the patient’s voice and my own voice, as well as in Cage’s voice.

Mr B, with relief in his voice, said, “That’s it.”

While at that moment in the analysis neither Mr B nor I was inclined to talk more directly about what was happening in the analytic relationship, it was clear to both of us that something new and significant was taking place between us. Some weeks later, Mr B spoke about his experience of that session in which we had talked about *Raising Arizona*. He compared his experience during that session with his experience of reading as a child: “The way I spoke about *Raising Arizona* couldn’t have been more different from the way I read as a kid. In reading I became a part of another person’s imaginary world. In talking about that film in the way we did, I found that I was

not losing myself, I was becoming more myself. I wasn't just talking about what Nicolas Cage and the Coen brothers had done, I was talking about myself and what I thought of those films."

Still later in the analysis, Mr B spoke about that session: "I think that it doesn't matter what we talk about – movies or books or cars or baseball. I used to think that there were things that we should be talking about like sex and dreams and my childhood. But it now seems to me that the important thing is *the way* we talk, not *what* we talk about."

It may be that the film, *Raising Arizona*, caught the patient's imagination because it is a story of two people who, unable to create (dream) a life of their own, attempt in vain to steal a part of someone else's life. But I believe that the emotional significance of the session did not lie primarily in the symbolic meaning of the film; rather, what was most important to the patient and me was our experience of talking/dreaming together. It was an experience in which Mr B was "dreaming himself up" in the sense that he was creating a voice that felt like his own. I think that he was right when, on looking back on the session, he said that it did not matter what we talked about. What was significant was the experience of his coming into being in the very act of dreaming and talking in a voice that felt like his own.

In reading my version of the dialogue that occurred in the session, I am struck by how difficult it is to capture in words the analytic experience of talking-as-dreaming. The dialogue here and throughout this chapter too often manages only to "play the notes" while failing to "make the music" of the intimate, multi-layered exchange that constitutes talking-as-dreaming. That "music" lies in tone of voice, rhythm of speech, "oversounds" (Frost, 1942, p. 308) of words and phrases, and so on. The nature of the music of talking-as-dreaming differs widely from patient to patient and from transference experience to transference experience. In one session, the music of talking-as-dreaming may be the music of an adolescent girl talking to her father at the dinner table after the rest of the family has left. The sound is the sound that the father hears in the voice of his daughter (who is beautiful in his eyes) as she speaks her thoughts on anything in the world she cares to talk about. In another transference-countertransference experience, the sound of talking-as-dreaming is the sound of a three-year-old boy babbling as his mother does the dishes. He speaks in a sing-song way – almost a lullaby – in semi-coherent sentences about the fact that his brother is a jerk and that he

loves it when Deputy Dawg flies and that he hopes they will be having corn on the cob again tomorrow, and on and on. And in still another experience in the transference-countertransference, talking-as-dreaming has the heart-wrenching sound of a 12-year-old girl, who after having awoken in tears in the middle of the night, is telling her mother how ugly and stupid she feels and that no boy will ever like her and that she will never get married. It is these sorts of sounds that are so difficult to capture in writing.

Concluding comments

I will conclude with three observations about talking-as-dreaming. First, in the experience of talking-as-dreaming, even when the analyst is participating in the patient's dreaming, the dream is, in the end, the patient's dream. Unless this fundamental principle is borne in mind, the analysis may become a process in which the analyst "dreams up the patient," instead of the patient dreaming himself up.

Second, when I engage in talking-as-dreaming, it always feels to me as if more, not less, attention to the analytic frame is required. It seems to me that a good deal of analytic experience is required before an analyst can responsibly engage in talking with patients in the ways I have described. In participating in talking-as-dreaming, it is essential that the difference between the roles of analyst and patient remain a solidly felt presence throughout. Otherwise, the patient is deprived of an analyst and of the analytic relationship that he needs.

Finally, in introducing the idea of talking-as-dreaming, I am not making a case for "breaking the rules" of psychoanalysis or for making new rules. Rather, I think of the clinical work that I have described as improvisations which took form in the context of my analytic work with particular patients under particular circumstances. In saying this, I find myself returning to what I believe to be so fundamental to the practice of psychoanalysis: our efforts as analysts to invent psychoanalysis freshly with each of our patients.