end of life. Winnicott wrote in his personal diary (not read by anyone until after his death), "Oh God! May I be alive when I die" (Winnicott, 2016, p. 298). Here Winnicott was expressing his wish to become more fully himself in his experience of dying.

References

Bion, W. R. (1962). *Learning from Experience*. London: Tavistock.

Loewald, H. (1979). The waning of the Oedipus complex. In *Papers on Psychoanalysis*. New Haven, CT: Yale University Press, 1980, pp. 384–404.

Ogden, T. H. (2004). This art of psychoanalysis: Dreaming undreamt dreams and interrupted cries. *The International Journal of Psychoanalysis*, 85:857–877.

Ogden, T. H. (2010). On three types of thinking: Magical thinking, dream thinking, and transformative thinking. *The Psychoanalytic Quarterly*, 79: 314–347.

Ogden, T. H. & Gabbard, G. O. (2010). The lure of the symptom. *Journal of the American Psychoanalytic Association*, 58:533–544.

Poland, W. (2000). The analyst's witnessing and otherness. *Journal of the American Psychoanalytic Association*, 78:17–34.

Winnicott, C. (2016). D. W. W.: A reflection. In *The Collected Works of Donald Winnicott, Vol. 12, Appendices and Bibliographies*. Oxford, UK: Oxford University Press, p. 298.

Winnicott, D. W. (1963). Communicating and not communicating leading to a study of certain opposites. In *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 179–192.

1

ONTOLOGICAL PSYCHOANALYSIS OR "WHAT DO YOU WANT TO BE WHEN YOU GROW UP?"

A friend who was stationed in London as a U.S. Army psychiatrist during the Second World War regularly attended Winnicott's rounds on the Adolescent Unit of Paddington Green Hospital. He told me that Winnicott asked every adolescent he saw the question "What do you want to be when you grow up?" and placed great weight on his or her response (Ira Carson, personal communication, 1983). This question is perhaps the most important question any of us asks ourselves from very early in life until the moment just before we die. Who would we like to become? What kind of person do we want to be? In what ways are we not ourselves? What is it that prevents us from being more the person we would like to be? How do we become more of the person we feel we have the potential to be and the responsibility to be? These are the questions that bring most patients to therapy or analysis, though they are rarely aware that this is the case, being more focused on finding symptomatic relief. At times, the goal of treatment is to bring a patient from a state of not being able to form such questions to a state in which he is.

Having begun by focusing on the second half of the title of this chapter, I will now turn to the first half—"ontological psychoanalysis"—while trying all the while to hold in mind the question, "What do you want to be when you grow up?"

DOI: 10.4324/9781003228462-1

Epistemological and ontological psychoanalysis

A radical change has occurred, rather unobtrusively, in the theory and practice of psychoanalysis in the course of the past 70 years, a change for which, until recently, I have not had a name. That transformation involves a shift in emphasis from *epistemological* (pertaining to knowing and understanding) psychoanalysis to *ontological* (pertaining to being and becoming) psychoanalysis. I view Freud and Klein as the founders of a form of psychoanalysis that is epistemological in nature, and I consider Winnicott and Bion as the principal contributors to the development of ontological psychoanalysis. Finding words to describe this movement in psychoanalysis holds a good deal of personal significance for me. This chapter is, in a sense, an account of the movement in my own thinking from a focus on unconscious internal object relationships to a focus on the struggle in which each of us is engaged to more fully come into being as a person whose experience feels real and alive to himself or herself.

Though it is beyond the scope of this chapter to review the work of the many analytic thinkers who have contributed to the development of the ontological aspect of psychoanalysis, I will refer the reader to the work of a few of those authors: Balint (1992), Berman (2001), Civitarese (2010, 2016), Eshel (2004), Ferro (2011), Gabbard (2009), Greenberg (2016), Grinberg (1980), Grotstein (2000), Laing (1960), Levine (2016), Milner (1950), Searles (1986), Semrad (Semrad and Day, 1966), Stern et al. (1998), Sullivan (1962), Will (1968), and Williams (2019).

It is important for the reader to bear in mind throughout this chapter that *there is no such thing as ontological psychoanalysis or epistemological psychoanalysis in pure form*. They coexist in mutually enriching relationship with one another. They are ways of thinking and being—sensibilities, not "schools" of analytic thought or sets of analytic principles or analytic techniques. So there is much in the work of Freud and Klein that is ontological in nature, and much in the work of Winnicott and Bion that is epistemological.

Epistemological psychoanalysis, as I am using the term, refers to a process of gaining knowledge, arriving at understandings of the patient, particularly understandings of the patient's unconscious inner world and its relation to the external world. These understandings serve to organize one's experience in a way that is of value in addressing one's emotional problems and achieving psychic change.

The analyst's interpretations are meant to convey understandings of the patient's unconscious fantasies, wishes, fears, impulses, conflicts, aspirations, and so on. As Laplanche and Pontalis (1973) put it,

> Interpretation is at the heart of the Freudian doctrine and technique. Psychoanalysis itself might be defined in terms of it, as the bringing out of the latent meaning.
>
> (p. 227)

They continue:

> Interpretation reveals the modes of the defensive conflict and its ultimate aim is to identify the wish that is expressed by every product of the unconscious.
>
> (p. 227)

From a similar perspective, Klein (1955) describes her work with a child in analysis:

> The child expressed his phantasies and anxiety mainly in play, and I consistently interpreted its meaning to him … I was also guided throughout by two other tenets of psycho-analysis established by Freud, which I have from the beginning regarded as fundamental: that the exploration of the unconscious is the main task of psycho-analytic procedure and that the analysis of the transference is the means of achieving this aim.
>
> (p. 123)

The most important clinical intervention, from an *epistemological* vantage point, is the interpretation of the transference: the analyst conveys in words to the patient his or her understanding of the ways in which the patient is experiencing the analyst as if he or she were a real or imagined figure from the patient's infancy or childhood. "In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy" (Laplanche and Pontalis, 1973, p. 445). Experiencing the present as if it were the past blocks psychic change: it constitutes a closed loop that repeats itself endlessly, allowing little or no room for new possibilities to develop.

By contrast, I am using the term *ontological psychoanalysis* to refer to a dimension of psychoanalysis in which the analyst's primary focus

is on facilitating the patient's efforts to become more fully himself. Winnicott (1971a) concisely describes the difference in perspective between ontological and epistemological psychoanalysis:

> I suggest that in her writings Klein (1932), in so far as she was concerned with play, was concerned almost entirely with the use of play [as a form of symbolization of the child's inner world] ... This is not a criticism of Melanie Klein or of others who have described the use of the child's play in the psychoanalysis of children. It is simply a comment on the possibility that ... the psychoanalyst has been too busy using play content to look at the playing child, and to write about playing as a thing in itself. It is obvious that I am making a significant distinction between the meanings of the noun "play" and the verbal noun "playing."
>
> (pp. 39–40)

Winnicott is making a distinction here between the *symbolic meaning* of "play" and the *state of being* involved in "playing." Arriving at understandings of the symbolic meaning of play is the domain of epistemological psychoanalysis; working in and with the state of being involved in playing is the domain of ontological psychoanalysis.

From an ontological perspective,

> *Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. The corollary to this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play.*
>
> (Winnicott, 1971a, p. 38, original emphasis)

The analyst's role, as described in this passage (and in Winnicott's work as a whole) is quite different from the role of the analyst in the analysis of a predominantly epistemological sort. While in epistemological psychoanalysis the analyst's role centrally involves conveying in the form of interpretation the analyst's understanding of the leading edge of anxiety in the present moment of the analysis, in a predominantly ontological psychoanalysis the analyst had better

"wait" (Winnicott, 1969, p. 86) before conveying his or her understandings to the patient:

> It appalls me to think how much deep change I have prevented or delayed ... by my personal need to interpret. If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever.
>
> (Winnicott, 1969, p. 86)

From the perspective of ontological psychoanalysis, it is not the knowledge arrived at by patient and analyst that is the central point; rather, it is the patient's experience of "arriv[ing] at understanding creatively and with immense joy," an experience in which the patient is engaged not predominantly in searching for self-understanding, but in *experiencing* the process of becoming more fully himself.

Winnicott (1971b), in one of his late papers, "Dreaming, fantasying, and living," reaches a conclusion that lies at the heart of his opus and differentiates his approach from Klein's, in particular, and epistemological psychoanalysis in general. For Winnicott, unconscious fantasy is a vicious cycle that entraps one in one's inner world. In describing a portion of an analysis, he writes,

> For me the work of this session had produced an important result. It had taught me that fantasying interferes with action and with life in the real or external world, but much more so it interferes with dream[ing] and with the personal or inner psychic reality, the living core of the individual personality.
>
> (1971b, p. 31)

Winnicott (1971c), almost in passing, in his "transitional object" paper, uses a phrase that I view as the process underlying successful psychoanalysis and every other form of psychic growth: we "weave other-than-me objects into the personal pattern" (p. 3). In other words, we take something that is not yet part of us (for example, an experience with a spouse or a friend or in reading a poem or listening to a piece of music) and weave it into who we are in a way that makes us more than who we were before we had that experience, before weaving the experience into our personal pattern.

Winnicott, here, in developing the ontological aspect of psychoanalysis, is inventing language as he goes—"to weave other-than-me objects into the personal pattern"—a way of speaking about psychic growth that I have never come across anywhere else.

When the patient or analyst is unable to engage in playing, the analyst's attention must be directed to this problem, for it precludes the patient and analyst from *experiencing* "the overlap of two areas of playing." If the analyst is unable to engage in playing, he must determine whether his inability to engage in this state of being (playing is not simply a state of mind, it is a state of being) is a reflection of what is occurring between him and the patient (possibly a profound identification with the patient's lifelessness) or a reflection of his own inability to genuinely engage in playing, which would likely require that he return to analysis.

It might be argued that what I am calling epistemological psychoanalysis and ontological psychoanalysis are merely different ways of looking at a single analytic endeavor. There are, indeed, vast areas of overlap of the two. For instance, the analyst may offer a sensitively worded, and well-timed, interpretation of the patient's fear that only one of the two of them—the patient or the analyst—can be a man at any given time because if both are men at the same time, they will inevitably enter into a battle to the death of one of them. The outcome of such an understanding may not simply be enhanced self-knowledge on the part of the patient, but as importantly, a greater sense of freedom to be himself as a grown man.

It is not difficult to find ontological thinking in the work of Freud and Klein. Take, for instance, Freud's (1923) idea that the analyst attempts

> to avoid so far as possible reflection and the construction of conscious expectations, [and attempts] not to try to fix anything he heard particularly in his memory, and by these means to catch the drift of the patient's unconscious with his own unconscious.
>
> (p. 239)

"He [the analyst] should simply listen, and not bother about whether he is keeping anything in mind" (Freud, 1912, p. 112). "Simply listen[ing]" is a state of being, a way of being with the patient.

Also representative of Freud's ontological thinking is his famous statement, "*Wo Es war, soll Ich werden*": "Where id [it] was, there ego [I] shall be" (Freud, 1933, p. 80). What had been experienced as other to oneself ("the it") is incorporated into one's being (who I am, who I "shall *be*," who I am becoming). (Freud [1926] was explicit in his instructions "to keep [psychoanalytic concepts] in contact with the popular mode of thinking" [p. 195]. Thus, *Das Ich* is better translated as "the I" and *Das Es* as "the it.")

Notwithstanding the overlap and interplay of the epistemological and ontological dimensions of psychoanalysis, and the fact that neither ever exists in pure form, it seems to me that there are a great many experiences that occur in the course of an analysis that are predominantly epistemological or predominantly ontological in nature. To my mind, these two aspects of psychoanalysis involve quite different modes of therapeutic action. Therapeutic action characterizing the epistemological dimension of psychoanalysis involves arriving at understandings of previously unconscious thoughts, feelings, and bodily experience, which help the patient achieve psychic change. By contrast, therapeutic action characterizing ontological psychoanalysis involves providing an interpersonal context in which forms of experiencing, states of being, come to life in the analytic relationship that were previously unimaginable by the patient (for instance, the states of being involved in *experiencing* transitional objects and phenomena (Winnicott, 1971c) and in *experiencing* the silent communication at the core of the self (Winnicott, 1963).

It is beyond the scope of this chapter to compare what I am calling the ontological dimension of psychoanalysis and the rather diverse set of ideas grouped under the general heading "existential psychoanalysis." Much of existential psychoanalysis is concerned with conscious awareness, intentionality, freedom, and responsibility, which are seen as inextricably linked (which undercuts the Freudian concepts of unconscious pressures and limitations of freedom). Major contributors to existential psychoanalysis include Ludwig Binswanger, Victor Frankl, Rollo May, Otto Rank, Jean-Paul Sartre. Neither will I take up the philosophical underpinnings of ontology and epistemology. I am restricting myself to a general linkage of the former with being and becoming, and the latter with gaining knowledge and understanding.

Being alive, feeling all the sense of real

I will now attempt to state in more detail what I have in mind when I refer to the practice of ontological psychoanalysis. I will focus first on the work of Winnicott, and later on that of Bion.

Winnicott, in almost every paper he wrote, introduces and describes states of being not previously recognized in the analytic literature, for instance, the state of "going on being" (Winnicott, 1949, p. 245), a phrase that is all verb (verbal noun) and devoid of a subject, thus capturing something of a very early subjectless state of being; the state of being involved in the mother surviving while being destroyed by the infant (Winnicott, 1969); and the state of being involved in "primary maternal preoccupation" (Winnicott, 1956).

Perhaps Winnicott's most significant contribution to ontological psychoanalysis is his concept of "transitional objects and phenomena" (1971c), which he describes as

> an intermediate state of *experiencing*, to which inner reality and external life both contribute. It is an area that is not challenged, because no claim is made on its behalf except that it shall exist as a resting-place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet interrelated.
>
> (p. 2, original emphasis)

The infant or child's capacity to develop a "state of being" (Winnicott, 1971c, p. 14) bound up with experiencing transitional objects and phenomena requires a corresponding state of being on the part of the mother (or the analyst) in which

> *it is a matter of agreement between us and the baby that we will never ask the question: "Did you conceive of this* [object] *or was it presented to you from without?" The important point is that no decision on this point is expected. The question is not to be formulated.*
>
> (Winnicott, 1971c, p. 12, original emphasis)

The state of being underlying transitional phenomena is paradoxical in nature:

> In health the infant creates what is in fact lying around waiting to be found. But in health *the object is created, not found* … This has to be accepted as a paradox, and not solved by a restatement that, by its cleverness, seems to eliminate the paradox.
>
> (Winnicott, 1963, p. 181, original emphasis)

This state of being underlies "the intense experiencing that belongs to the arts and to religion and to imaginative living" (Winnicott, 1971c, p. 14). (When Winnicott speaks of the mother–infant relationship, he is using this as a metaphor that includes not only the mother–infant relationship, but also the analyst–patient relationship, as well as every other significant relationship experienced by infants, children, and adults.)

Also prominent among Winnicott's contributions to ontological psychoanalysis is his conception of the state of being that resides at the core of the self:

> the non-communicating central self, for ever immune from the reality principle [immune to the need to respond to anything external to the self], and for ever silent. Here communication is not non-verbal; it is, like the music of the spheres, absolutely personal. It belongs to being alive. And in health, it is out of this that communication naturally arises.
>
> (1963, p. 192)

This state of being that lies at the core of the self constitutes an impenetrable (utterly unknowable) mystery that is the source both of lively communicating and absolute silence. The silence at the core of the self is not verbal in nature, but what makes the state of being at our core unimaginable is the fact that it is also "not non-verbal." Silence that is neither verbal nor non-verbal is beyond human comprehension. "It is, like the music of the spheres, absolutely personal." The metaphor of the music of the spheres is derived from Pythagoras's fifth-century BC conception of the music produced by the movement of celestial bodies, a music of perfect harmony, but inaudible to humankind. How better to describe the inconceivable secret that each of us keeps at the core of our being, a secret that is "absolutely personal. It belongs to being alive."

Bion's contributions to ontological psychoanalysis

As I read Bion, throughout his opus, he is principally an ontological thinker. Just as Winnicott shifted the focus of analysis from play to playing, Bion shifted the analytic focus from (the understanding of) dreams to (the experience of) dreaming (which, for Bion, is synonymous with doing unconscious psychological work [cf. Ogden, 2007a]).

Bion insists that, as psychoanalysts, we must shed the desire to understand, and instead engage as fully as possible in the *experience of being* with the patient. We must "cultivate a watchful avoidance of memory" (Bion, 1967, p. 137) because memory is what we think we know based on what no longer exists, and is no longer knowable. And we must renounce "desires for results, 'cure,' or even understanding" (p. 137). Both memory of what we think we know and desire for understanding of what has not yet occurred (and consequently is unknowable) are a "hindrance to the psychoanalyst's intuition of the reality [of what is occurring *in the present moment* of a session] with which he must be at one" (1967, p. 136). This is Bion's brand of ontological thinking: being has supplanted understanding; the analyst does not come to know or understand or comprehend or apprehend the reality of what is happening in the session, he "intuits" it, he *becomes* "at one" with it, he *is* fully present in *experiencing* the present moment.

Bion's (1962a, b) conception of "reverie" also reflects his ontological bent. Reverie (waking-dreaming) is *a state of being* that entails making oneself unconsciously receptive to experiencing what is so disturbing to the patient (or infant) that he is unable to "dream" (to do unconscious psychological work with) the experience. The analyst's (or mother's) reveries—waking-dreaming, which often takes the form of his most mundane, quotidian thoughts (Ogden, 1997a, b)—constitute a way in which the analyst (or mother) unconsciously experiences something like the patient's (or infant's) unthinkable, undreamable experience. In the analytic setting, the analyst makes available to the patient the transformed (dreamt) version of the patient's "undreamt" or partially dreamt experience by speaking (or relating in other forms) *from*, not *about*, reverie experience (Ogden, 1994).

Bion speaks in terms of states of being when he describes psychic health and psychopathology, for example, psychosis is a state of being in which the individual "cannot go to sleep and cannot wake up" (Bion, 1962a, p. 7).

I view Bion's (1962a) theory of alpha-function as a metaphor for the transformation of beta-elements (raw sense impressions that are bodily responses to experience, but which do not yet constitute meaning, much less *being* oneself) into alpha-elements, which comprise components of subjectless being, much like Winnicott's "going on being." Alpha-elements are linked with one another in the process of producing "dream-thoughts," which in turn are used in the process of dreaming. Dreaming is the psychic event in which the individual becomes a subject experiencing his own being. When, in severe forms of psychopathology (which I will describe in the clinical portion of this chapter), alpha-function ceases to process sense impressions, not only does the individual lose the capacity to create meaning, he also loses the capacity to experience himself as alive and real.

For me, Bion's ontological thinking comes alive in a particularly vivid way in his "Clinical Seminars" (1987). I will offer a few examples that hold particular importance to me. To a presenter who is worried by the "mistakes" he made with a patient, Bion comments that only "*after* you have become qualified and have finished your own analysis—then you have a chance to find out who you really are [as an analyst]" (1987, p. 34; see also Gabbard and Ogden, 2009, on becoming an analyst). Here, Bion is differentiating between learning how to "do analysis" and the experience of *being and becoming* "who you really are" as an analyst.

I would add that becoming an analyst involves developing an "analytic style" (Ogden, 2007b) that is uniquely one's own, as opposed to adopting "a technique" handed down from previous generations of analysts. In so doing, we "invent psychoanalysis" (see Chapter 3) for each patient and develop the capacity to respond spontaneously in the moment, sometimes in words, at other times non-verbally. There are times when spontaneous response takes the form of action. Such actions are unique to a particular moment of the analysis of a particular patient; they are not generalizable to work with other patients. When asked, for example, if I would go to a patient's home for a session, or take a severely ill patient in my car to a hospital, or meet with the patient's family, or accept a patient's gift, I say, "It all depends."

One of Bion's (1987) comments to a presenter entails a particularly vivid example of his ontological thinking. The presenter says that his psychotic patient told him he had a dream. Bion asks, "Why does he say they are dreams?" (p. 142). The presenter, nonplussed, replies, "He simply tells me so" (p. 142).

A bit later, Bion describes the way in which he might have spoken to the patient, a manner that addresses the patient's state of being:

> So why does the patient come to see a psycho-analyst and say he had a dream? I can imagine myself saying to a patient, "Where were you last night? What did you see?" If the patient told me he didn't see anything—he just went to bed—I would say, "Well, I still want to know where you went and what you saw." (p. 142)

Here, Bion is imagining talking with a patient in a way that focuses not on the content of what the patient is calling a dream, but on the state of being of the patient—Where did you go? "Where were you?" Who were you? Who did you become when you got into bed? This response strikes me as a remarkably adept way of talking with a psychotic patient about his state of being while asleep.

Ontological psychoanalysis and object-relations theory

For object-relations theorists (for example, Freud in some of his writings [cf. Ogden, 2002], Klein, Fairbairn, and Guntrip), alterations of unconscious internal object relationships (and the resultant change in relationships with external objects) constitute the medium through which psychic change occurs.

For Freud (1917), Klein (1946), Fairbairn (1940, 1944, 1958), and Guntrip (1961, 1969), to name only a few "object-relations theorists," internal object relationships take the form of relationships among split-off and repressed parts of the ego. For Fairbairn, the relationships among the repressed, split-off parts of the ego are internalizations of the unsatisfactory aspects of the real relationship with the mother. The internal object world is a closed system of addictive relationships with tantalizing and rejecting internal objects (Fairbairn, 1944). A driving force for the individual, from infancy onward, is the wish to transform the internalized unsatisfactory object-relationships with the mother into satisfactory relationships

characterized by feelings of love for and from the mother, and the feeling that she recognizes and accepts one's love (cf. Ogden, 2010). It is the patient's release from the closed system of internal object relationships and entry into the world of real external objects that is the aim of psychoanalysis (Fairbairn, 1958).

For Klein (1961, 1975), who is an object-relations theorist of a sort different from Fairbairn, the patient's anxieties are derived from the dangers emanating from phantasied internal object relationships. Unconscious phantasies (the psychic manifestations of life and death instincts) are often concerned with what is occurring inside the body of the mother/analyst, for instance, attacks on the babies or the father's penis inside the mother. These primitive anxieties are manifested in the transference and interpreted in such a way that they ring true to the patient and help diminish the patient's persecutory and depressive anxieties which are impeding psychic growth.

Klein's object-relations theory differs from Fairbairn's in many ways. Their primary difference lies in the way Fairbairn views internal object relationships as internalizations of actual unsatisfactory experience in the mother–infant relationship, while Klein views internal object relationships as unconscious phantasies derived from the infant's experience of envy (the principal psychic manifestation of the death instinct).

I do not view Winnicott and Bion as object-relations theorists. (Reference to internal object relationships is rare in the work of both of these authors.) They are not primarily concerned with understanding and interpreting the pathological internal object relationships in which the patient is ensnared. Their focus is primarily on the range of states of being experienced by the patient (and the analyst) and the states of being the patient (or analyst) is unable to experience. For object-relations theorists, psychic growth involves freeing oneself from the persecutory and depressive anxieties generated in his internal object world (Klein) or freeing oneself from the addictive ties between internal objects, so one can engage in relationships with real external objects (Fairbairn and Guntrip). As I have discussed, for Winnicott and Bion, the most fundamental human need is that of *being and becoming more fully oneself, which to my mind, involves becoming more fully present and alive to one's thoughts, feelings, and bodily states; becoming better able to sense one's own unique creative potentials and finding forms in which to develop them; feeling that one is speaking one's own ideas with a voice of one's own; becoming a larger*

person (perhaps more generous, more compassionate, more loving, more open) in one's relationships with others; developing more fully a humane and just value system and set of ethical standards; and so on.

Not only are unconscious internal object relationships rarely mentioned by Winnicott and Bion, Winnicott in his late work (for example, *Playing and Reality* [1971d]) makes little explicit mention of the unconscious, and Bion creates a new conception of the nature of the unconscious. *States of being infuse every aspect of oneself; they transcend the divide between conscious and unconscious aspects of mind, between being asleep and being awake, between dream-life and waking life, between the psychotic and non-psychotic parts of the personality.*

Clinical illustrations of ontological psychoanalysis

"Ontological psychoanalysis" is a conception of psychoanalysis which, like every other understanding of psychoanalysis, can be hardened into a mindless ideology. "Ontological psychoanalysis" is a dimension of analytic theory and practice that coexists with many other dimensions (ways of thinking), including, but not limited to, an epistemological dimension. But as I have said earlier, it is also true that, for me, there are large sectors of analytic thinking and practice that are predominantly ontological or epistemological in nature.

I will now briefly illustrate clinically what I have in mind when I refer to the ontological dimension of psychoanalysis. It must be kept in mind in the clinical portion of this chapter that my interventions are meant as illustrations that pertain only to a given patient at a particular moment in his or her analytic experience, and *do not represent an analytic technique*. I believe that an analyst's rigid adherence to any set of rules of clinical practice (for instance, a technique associated with a school of psychoanalysis) not only feels impersonal to the patient, but also limits the analyst's capacity to be creative in working with his or her patients. I speak with each patient in a way that is different from the way I speak to any other patient (see Chapter 3).

Haven't you had enough of that by now?

The patient, a 30-year-old man, several years into the analysis, had a falling out with his father and had not spoken to him for a year. We had discussed this situation in many forms over the years. Just

before the end of a session, I said, "Haven't you had enough of that by now?"

In this fragment of an analytic session, I told the patient in a highly condensed way that continuing to not talk to his father was a *way of being* that no longer reflected who the patient had become in the course of the previous years of analysis. Not talking with his father may have suited the person who the patient once was, but not the person he is now.

The patient called his father that evening. His father, too, had changed and welcomed hearing from his son. The patient told me in the closing months of the analysis that he would never forget my saying to him, "Haven't you had enough of that by now?" That moment in the analysis to which he was referring was less an experience of arriving at an understanding, and more an experience that altered something fundamental to who the patient was.

Of course you are

Ms. L, at the beginning of our initial analytic meeting, sat in her chair, her face drained of color. She burst into tears and said, "I'm terrified by being here." I replied, without planning to do so, "Of course you are."

Spontaneously responding in the way I did (saying something I had never said to any other patient) felt to me in the moment to be a way of being fully accepting of the patient's terrified state. Had I asked, "What's frightening you?" or "Tell me more," I think that the patient very likely would have felt that I was backing away from the intensity of her feeling by asking her to engage in secondary process thinking aimed at finding reasons and explanations, as opposed to *experiencing* the patient's way of introducing herself to me (telling me who she was at that moment). (See also Chapter 3 for further exploration of this experience.)

Do you watch TV?

I met with Jim on a long-term adolescent inpatient ward five times a week. He did not come to the sessions on his own and had to be brought by one of the nurses. Jim did not object to seeing me, but when the two of us were seated in the small room on the ward used for psychotherapy, he seemed not to know why the two of us were

sitting there. He was silent most of the time. I learned that asking him questions led only to perfunctory one-word replies.

As time went on, he began to talk with me about events on the ward—new patients arriving, others leaving—but the words he used sounded imitative of things he had heard other people say at ward group meetings and community meetings. I said to him, "It's hard to know if you're coming or going." He looked bewildered.

I found the sessions trying and had the feeling that I did not know the first thing about how to work with this patient, or with any other patient, for that matter.

About five months into the analysis, Jim was brought to his session walking in a listless way. His face was utterly expressionless; his eyes were like the eyes of a dead bird. He said to no one in particular, "Jim is lost and gone forever."

I felt something of relief that the thin charade covering an immense psychic catastrophe was over, but I also felt that a psychic death had occurred which could easily become actual suicide. A patient on the ward, a year earlier, had committed suicide, and the memory of this event had become part of the (usually unspoken) culture of the ward.

I said, "Jim has been lost and gone for a very long time, and only now is the word out."

He looked into the glare of the reflected sunlight in the Plexiglas window, his eyes unfocused.

I was silent for some time feeling the immense emptiness of what was happening. As this was occurring, I began to feel strongly that the danger of suicide on the ward was grossly underestimated and the ward should become a locked ward which the patients could only leave with the permission of the staff, and usually accompanied by a staff member. I became aware of the distance that I was creating between the patient and me. He was now a "dangerous" patient who frightened me. I was now "managing" him, a person who had become a thing.

After some time had passed in the session, I noticed that the usual background noise of my mind—the thoughts that came and went, the "peripheral vision" of reverie, even the bodily feelings of my heart pumping, my breath moving, were absent. I felt frightened that not only had Jim disappeared, I too was disappearing. Everything was becoming unreal—the small room in which we were seated ceased being a room; it had become a collection of shapes, colors, and

textures; everything seemed arbitrary. I felt the terror of drowning, but at the same time, I was an indifferent observer, simply watching myself drowning.

As the session continued, I was reminded of a frightening experience I had had as an adolescent when, alone in the kitchen after dinner, I repeated the word *napkin*, out loud, over and over again until it became a mere sound, no longer having any tie to the thing it once named. I was at first intrigued by this phenomenon when I began the "experiment," but quickly became frightened that if I were to do with other words what I was doing with the word *napkin*, I would lose the ability to speak or think or have any connection with anyone or any thing. For many years after that event, the sound *nap* followed by the sound *kin* did not name anything, they were simply sounds that caused me to doubt the stability of my connection to anyone, even to myself. In the session with Jim, I felt momentarily relieved to have a mind that could remember a past that was continuous with the present, but this relief was only a momentary respite from my fear that if I stayed in the room with Jim, I would lose myself.

I dreaded the daily meetings with Jim. For several weeks, we sat together, mostly in empty silence. I did not ask him questions. I, now and again, tried to describe what I was experiencing. I said to him, "Sitting here feels like being nowhere and being no one." He made no response, not even the slightest change of facial expression.

For the six weeks following Jim's telling me he was lost and gone forever, I felt adrift and directionless with him. To my great surprise, in the middle of a session, Jim said with an expressionless voice, as if to nobody, "Do you watch TV?"

I took his question not as a symbolic comment on feeling like a machine that displayed images of people talking to one another, but as his way of asking me, "Who are you?"

I said, "Yes, I do. I watch quite a lot of TV."

Jim made no response.

After a while, I said, "Have you ever seen someone strike a match in a place that's completely dark, maybe a cave, and everything lights up, so you can see everything—or at least a lot—and then, a moment later, everything gets dark again, but not as dark as it had been."

Jim did not reply, but it did not feel to me that the silence we returned to was as empty as it had been.

I looked at my watch and found that we had gone half an hour past the end of the 50-minute session. I said, "It's time to stop." He looked at me and said, "Is it?" It seemed to me that he was correcting me: the experience we had had was not one that could be measured in, or dictated by, "clock time."

In the first of the sessions I have described, I was for quite a long time completely immersed in a state of losing my sense of being someone. Jim and I were "lost and gone forever," and initially we were each absolutely alone in that state—we did not exist for one another, any more than we existed for ourselves. I refrained from asking the patient questions about what was happening or what might have led him to feel as he did. I simply experienced a terrifying sense of losing myself, which was essential if I was to ever be of any use to him. In not being anyone, I was experiencing something akin to what he was feeling in the session, and probably for the entirety of his life.

My reverie about my own experience as an adolescent helped me, at least for a moment, to be both in the situation with the patient and to bring to it some of my own sense of living at the very edge, *but not over the edge*, of losing myself.

The patient's asking me, about six weeks into this period of the analysis, "Do you watch TV?" felt to me as if I was hearing a dog speak. His addressing me, acknowledging me, was astounding. I was not the least bit inclined to take up possible symbolic meanings of watching TV, for to do so would have decimated the living experience that was occurring, an event having everything to do with being, and little to do with understanding.

I told the patient, in response to his question, that I watched quite a lot of TV. But the more important part of my response to his question took the form of my *describing* (not explaining) by means of a metaphor something of the state of being I felt was occurring: the sensory experience of the striking of a match and illuminating for a moment what had been invisible (the two of us as separate people), followed by a feeling that the darkness was not quite as absolute as it had been.

How to begin?

I have for most of my career been fascinated by the initial analytic meeting, by which I mean the very first time I meet the patient

(Ogden, 1992). Many of the clinical examples I have provided in this chapter and in other analytic papers have been taken from initial sessions. In writing this chapter, I have come to appreciate an aspect of the initial meeting that I have not been able to name until now. I now suspect that the depth and intimacy and suspense I feel in the first meeting derives in part from the fact that in that meeting, for the patient, one question is of more importance than any other: "*Who is this person* who I hope will help me." And I am asking, "*Who is this person* who is coming to me for help?" These are fundamental ontological questions. Responses to these questions arise in the experience with one another that unfolds. I hope that at the end of the meeting, if the patient asks how I practice psychoanalysis, I can say, "Just as you've seen today."

I will describe an initial meeting that illustrates a way a patient in effect asked me, "Who are you?" and the way I replied.

Mr. D told me in his first session that he would never begin a session. He had seen six previous analysts all of whom had unilaterally terminated the analysis. In these aborted analyses, the analyst had refused to begin sessions, as the patient had asked them to do, and instead used "hackneyed analytic tricks" such as beginning the session by asking him what it feels like not to be able to begin the session. If we were to begin a therapy, it would be up to me, Mr. D told me, to begin each of the sessions. I said that that would be fine with me, but it might take me some time to begin the sessions because I would begin each meeting by telling him what it felt like being with him on that particular day. He said that that would be okay with him, but there was thick skepticism in his voice regarding my willingness to carry through with what I was promising.

In this exchange, the patient and I were introducing ourselves to one another, showing more than telling who we were at that moment, and who we were in the process of *becoming with one another*. The patient was asking me to respect his way of being, his way of allaying his terrors, and I was showing him that I honored his request that I be the analyst he needed me to be.

In the course of the analysis, I began the sessions. The patient was gradually able to reclaim parts of himself, parts of his unlived life as a child, which had been too brutal, too frightening to experience at the time they occurred. (See Ogden, 1995, for a detailed discussion of this case.)

Because she was dead

A clinical experience in a group setting conveys a good deal of what I mean by the ontological dimension of psychoanalysis. The experience occurred in a "Balint Group" in which I participated for a year at the Tavistock Clinic. The group of seven GPs (General Practitioners) met weekly with the psychoanalyst who led the group for two years to discuss their clinical work. In the group in which I participated, each meeting began with the analyst asking, "Who's got a case?" In one of these meetings, a GP in his mid-40s said that he had received a call from a patient saying that her elderly mother had died in her sleep at home. Both the woman who called and her mother had been patients in his practice for many years. He told his patient that he would come by that afternoon. When he arrived, the daughter took him to her mother's room where he examined her.

The GP said he then called the mortuary. The analyst asked, "Why did you do that?" The GP, puzzled by the question, said, "Because she was dead."

The analyst said, "Why not have a cup of tea with the daughter?"

Those words—"Why not have a cup of tea with the daughter?"—have stayed with me for the 44 years since I heard them. Such a simple statement captures the essence of what I mean by the practice of ontological psychoanalysis. The group leader was pointing out that the GP took haste in getting the body of the mother out of the apartment, and in that way, foreclosed the opportunity to *live the experience with the daughter* by simply being with her in that apartment where her mother lay dead in the bedroom. (For further discussion of this experience, see Ogden 2006.)

What do you want to be when you grow up?

I will close this chapter by describing an experience with a patient that holds great importance to me.

Mr. C, a patient with cerebral palsy, had begun work with me in a twice-weekly psychotherapy because he was in great distress, with intense suicidal thoughts, in response to unreciprocated love of a woman, Ms. Z (who suffered from no physical disabilities). He described how, as a child, his mother had thrown shoes from her closet at him to keep the "slobbering monster" away from her. Mr. C walked in awkward, lumbering strides and spoke in poorly articulated

speech. He was a college graduate who worked well at a demanding technical job. In the course of working together for some time, I became very fond of Mr. C and when he bellowed in pain, with mucus dripping from his nose and tears streaming down his face, I felt a form of love for him that I would later feel for my infant sons.

Several years into our work, after considerable change had occurred regarding his desperate longing for the love of Ms. Z, Mr. C told me a dream: "Not much happened in the dream. I was myself with my cerebral palsy washing my car and enjoying listening to music on the car radio that I had turned up loud."

The dream was remarkable in that it was the first time Mr. C, in telling me a dream, not only mentioned the fact that he had cerebral palsy, he seemed to fully accept it as a part of who he was: "I was myself with cerebral palsy." How better to recognize and accept himself for who he was in a loving way? No longer the monster he had once felt himself to be, he was, in the dream, a baby being joyfully bathed and sung to by a mother who took delight in him just as he was. The dream was not a manic picture of succeeding in winning the love of an unreachable mother, it was a part of ordinary life: "Not much happened in the dream."

I had not the slightest inclination to talk with Mr. C about my understanding of the dream. I said to him, "What a wonderful dream that was." (For a detailed discussion of this clinical work, see Ogden, 2010.)

Being able to recognize and tenderly accept himself, just as he was, might be thought of as Mr. C's response (at that moment) to the question, "What do you want to be when you grow up?" Himself.

References

Balint, M. (1992). *The Basic Fault: Therapeutic Aspects of Regression*. London: Routledge.

Berman, E. (2001). Psychoanalysis and life. *The Psychoanalytic Quarterly*, 70:35–65.

Bion, W. R. (1962a). *Learning from Experience*. London: Tavistock.

Bion, W. R. (1962b). A theory of thinking. In *Second Thoughts*. New York: Aronson, 1967, pp. 110–119.

Bion, W. R. (1967). Notes on memory and desire. In *Wilfred Bion: Los Angeles Seminars and Supervision*, edited by J. Aguayo & B. Malin. London: Karnac, 2013, pp. 136–138.