On Three Forms of Thinking: Magical Thinking, Dream Thinking, and Transformative Thinking

Thomas H. Ogden

The author believes that contemporary psychoanalysis has shifted its emphasis from the understanding of the symbolic meaning of dreams, play, and associations to the exploration of the processes of thinking, dreaming, and playing. In this paper, he discusses his understanding of three forms of thinking—magical thinking, dream thinking, and transformative thinking—and provides clinical illustrations in which each of these forms of thinking figures prominently. The author views magical thinking as a form of thinking that subverts genuine thinking and psychological growth by substituting invented psychic reality for disturbing external reality. By contrast, dream thinking—our most profound form of thinking—involves viewing an emotional experience from multiple perspectives simultaneously: for example, the perspectives of primary process and secondary process thinking. In transformative thinking, one creates a new way of ordering experience that allows one to generate types of feeling, forms of object relatedness, and qualities of aliveness that had previously been unimaginable.

In broad strokes, the current era of psychoanalysis might be thought of as the era of thinking about thinking. It seems to me that many of
the most interesting and generative questions with which analysts are currently working have less to do with the symbolic content of dreams, associations, play, and other behavior, and more to do with what work we do psychically with our lived experience. In other words, our attention as analytic clinicians and analytic theorists has been increasingly focused on the way a person thinks, as opposed to what he thinks. To my mind, the two most important contributors to this movement in psychoanalysis are Winnicott, who attended more to the capacity for playing than to the symbolic content of play; and Bion, who explored in his writing the process of dreaming/thinking far more extensively than he discussed the symbolic meanings of dreams and associations.

In this paper, I will demonstrate some of the ways in which this shift in emphasis from symbolic content to thought process has altered the ways I approach my analytic work.

I conceive of the three forms of thinking that I will be discussing—magical thinking, dream thinking, and transformative thinking—as coexisting, mutually creating, preserving, and negating aspects of every experience of thinking. None of these forms of thinking is ever encountered in pure form.¹ Neither is there a linear relationship among these forms of thinking, such as a “progression” from magical thinking to dream thinking. Rather, I see these forms of thinking as standing in dialectical tension with one another, just as I view the relationship between the conscious and unconscious mind; the paranoid-schizoid, the depressive, and the autistic-contiguous positions (Klein 1946; Ogden 1989); the psychotic and the nonpsychotic parts of the personality (Bion 1957); the basic assumption groups and the work group (Bion 1959); the container and the contained (Bion 1970); primary and secondary process thinking (Freud 1911); and so on. Moreover, none of these forms of thinking is a single, unitary way of thinking; rather, each “form of thinking” represents a rather wide spectrum of ways of thinking. The particular variation of the form of thinking that an individual may employ is always in flux and depends upon his level of psychological maturity, the intrapsychic and interpersonal emotional context of the moment, cultural factors, and so forth.

¹ Of the inseparability of forms of thinking, Freud (1900) wrote: “It is true that, so far as we know, no psychical apparatus exists which possesses a primary process only [i.e., without secondary process] and that such an apparatus is to that extent a theoretical fiction” (p. 603).
The forms of thinking upon which I will focus by no means encompass the entire spectrum of ways of thinking. For example, I will not address operational thinking (de M'Uzan 1984, 2003), autistic thinking (Tustin 1981), psychic foreclosure (McDougall 1984), or “phantasy in the body” (Gaddini 1969), to name only a few.

In order to provide a sense of the trajectory of this paper, I will briefly introduce the three forms of thinking before delving into each clinically and theoretically. (In the tradition of Bion, when I speak of thinking, I am always referring to thinking and feeling.) I use the term magical thinking to refer to thinking that relies on omnipotent fantasy to create a psychic reality that the individual experiences as “more real” than external reality—for example, as seen in the use of the manic defense. Such thinking substitutes invented reality for actual external reality, thereby maintaining the existing structure of the internal world. Moreover, magical thinking subverts the opportunity to learn from one's lived experience with real external objects. The psychological cost paid by the individual for his reliance on magical thinking is a practical one: magical thinking does not work in the sense that nothing can be built on it except for additional layers of magical constructions.

I use the term dream thinking to refer to the thinking we do in the process of dreaming. It is our most profound form of thinking, which continues both while we are asleep and in waking life. Though it is primarily an unconscious mental activity, it acts in concert with preconscious and conscious thinking. In dream thinking, one views and attributes meaning to experience simultaneously from multiple vantage points, for example, from the perspectives of primary and of secondary process thinking, of the container and of the contained, of the infantile self and of the mature self, and so on (Bion 1962a; Grotstein 2009). Dream thinking generates genuine psychological growth. Such thinking may be done on one's own, but a point is inevitably reached beyond which one needs another person with whom to think/dream one's most deeply troubling emotional experience.

The third of the forms of thinking that I will discuss, transformative thinking, is a form of dream thinking that involves a radical alteration of the terms by which one orders one's experience: one transcends the categories of meaning that have previously been felt to be the only possible
categories with which to organize one's experience. In transformative thinking, one creates new ways of ordering experience in which not only new meanings, but new types of feeling, forms of object relatedness, and qualities of emotional and bodily aliveness are generated. Such a fundamental change in one's way of thinking and experiencing is more striking in work with severely disturbed patients, but occurs in work with the full spectrum of patients.

In the course of the discussion that follows, I will present clinical examples that illustrate some of the ways in which conceptualizing forms of thinking in the ways I have described are of value to me in talking with myself—and, at times, with the patient—about what I think is occurring in the analytic relationship and in other sectors of the patient's internal life and life in the world.

Magical Thinking

Beginning with Freud (1909, 1913), omnipotent thought has been a well-established concept in psychoanalytic theory. Freud (1913) credits the Rat Man with coining the term omnipotence of thought (p. 85). I will make a few observations that capture something of my sense of the differences between magical thinking and the other two forms of thinking that I explore in this paper.

Magical thinking has one purpose and one purpose only: to evade facing the truth of one's internal and external experience. The method employed to achieve this end is the creation of a state of mind in which the individual believes that he creates the reality in which he and others live. Under such circumstances, psychic reality eclipses external reality: reality is "the reality not of experience but of thought" (Freud 1913, p. 86). Consequently, emotional surprise and encounters with the unexpected are, as much as possible, foreclosed. In the extreme, when the individual fears that the integrity of the self is in danger, he may defend himself by means of virtually all-encompassing omnipotent fantasies that so disconnect him from external reality that his thinking becomes delusional and/or hallucinatory. In this psychological state, the individual is unable to learn from experience and incapable of distinguishing between being awake and being asleep (Bion 1962a)—i.e., he is psychotic.
To the degree that psychic reality eclipses external reality, there is a progressive deterioration of the individual's capacity to differentiate dreaming and perceiving, symbol and symbolized. As a result, consciousness itself (self-awareness) is compromised or lost. This leads to a state of affairs in the analytic setting in which the patient treats his thoughts and feelings not as subjective experiences, but as facts.

Magical thinking underlies a great many psychological defenses, feeling states, and forms of object relatedness. I will briefly discuss only three. Mania and hypomania reflect the hegemony of a set of omnipotent fantasies: the individual relying on the manic defense feels that he has absolute control over the missing object and therefore he has not lost the object, he has rejected it; he celebrates, not grieves, the loss of the object because he is better off without it; and the loss is not a loss because the object is valueless and contemptible. The feeling states associated with these omnipotent fantasies are concisely summed up by Klein (1935) as feelings of control, contempt, and triumph.

Projective identification is also based upon omnipotent fantasy: the unconscious belief that one can split off dangerous and endangered aspects of oneself and put them into another person in such a way that that aspect of oneself takes control of the other person from within. (The act of “containing” 
[88 Bion 1970; Ogden 2004a] a projective identification involves the “recipient's” transforming the “projector's” magical thinking into dream thinking, which the projector may be able to utilize in dreaming/thinking his own experience.)

Similarly, envy (which protects the individual from disturbing feelings such as abject emptiness and desolation) involves the omnipotent fantasy that one is able to steal what one lacks from another person and spoil what remains of what is envied in that person.

The qualities of magical thinking just discussed all reflect the use of omnipotent fantasy in the service of creating the illusion (and, at times, delusion) that one is not subject to the laws that apply to others, including the laws of nature, the inescapability of time, the role of chance, the irreversibility of death, and so on. One may speak cruelly to another person and then believe that one can literally “take back” the comment (re-create reality)—for instance, by renaming it a joke. Saying something makes it so. One's words are felt to have the power to substitute a newly
created reality for a reality that is no longer convenient. More broadly, history can be rewritten at will.

Magical thinking is very convenient—simply saying something obviates the need to face the truth of what has occurred, much less do anything about it. But as convenient as magical thinking is, it has one overriding drawback: it does not “work”—nothing can be built on it or with it except additional layers of magical constructions. Such “thinking” has no traction in the real world that exists outside of one's mind. Rather than constituting a form of genuine thought, it is an attack both on the recognition of reality and on thinking itself (i.e., it is a form of anti-thinking). It substitutes invented reality for actual reality, thus collapsing the difference between internal and external reality. The belief, for example, that one can use an indiscriminate “forgive-and-forget” approach to interpersonal experience serves not only to further blind the individual to the reality of the nature of the emotional connection that exists between himself and others, but also further blinds him to who he himself is. He increasingly becomes a fiction—a magical invention of his own mind, a construction divorced from external reality.

Nothing (and no one) can be built on or with magical thinking because omnipotently created “reality” lacks the sheer immovable alterity of actual external reality. The experience of the otherness of external reality is necessary for the creation of genuine self-experience. If there is no not-I, there can be no I. Without a differentiated other, one is everyone and no one.

One implication of this understanding of the central role of the recognition of otherness in the development of the self is the idea that, as important as it is for the analyst to understand the patient, it is equally important for the analyst to be a person who is different from the patient. The last thing in the world any patient needs is a second version of himself. The solipsistic aspects of a patient's thinking—the self-reinforcing nature of his ties to his unconscious beliefs—leads to a limitation of the patient's ability to think and to grow psychologically. What the patient (unconsciously) is asking of the analyst—even when the patient is explicitly or implicitly claiming that he has no need of the analyst—is a conversation with a person other than himself, a person who

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is grounded in a reality that the patient has not created (see Fairbairn 1944; Ogden 2010).

**A Patient Who Was Reduced to Omnipotence**

Ms. Q told me in the initial interview that she had come to me for analysis because “I am unusually talented in wrecking everything in my life—my marriage, the way I treat my children, and the way I do my work.” Despite the intended irony of this statement, it felt to me to be more a boast than an admission of failure or a request for help. It seemed to me that Ms. Q was putting me on notice that she was no ordinary person (“I am unusually talented”).

In the first week of Ms. Q's five-session-per-week analysis, something quite striking occurred. Ms. Q left a phone message saying that, due to a change in her work schedule, she was unable to attend the meeting we had scheduled for the following day, but she would be able to attend the session just after the one we had scheduled, i.e., she could meet an hour later. She ended the message by saying, “I'll assume that's all right with you unless I hear from you.” I had no choice but to return her phone call. In my phone message, I said that I expected her at the time we had agreed upon. Had I not returned her call, she would have arrived at the same time as the patient to whom that later session belonged, which would have created an intrusive situation for the other patient and me when the three of us met in the waiting room.

The patient arrived twenty minutes late for the session she had asked to change. She offered facile apologies and explanations. I said to her, “It seems to me that you don't believe I've genuinely made a place for you here and so you feel you have to steal one. But I don't think that such things can be stolen.” I strongly suspected that the fear of not having a place of her own had been a lifelong anxiety for the patient, but I did not say this to her.

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2 Bion once said to his analysand James Grotstein, “What a shame it was that you were reduced to omnipotence” (Grotstein 2001). The connection between shame and omnipotent thinking that Bion subtly makes in this comment is a highly significant one: unconscious, irrational shame is a powerful force impelling one to give up on the real world, and instead to create a world that is fully under one's control.
Ms. Q said that she did not think it was so complicated as that, and went on to tell me more about events at work. I said to her, “I guess I’m not to have a place here with you unless I fight for it.” The patient behaved as if I had said nothing.

Ms. Q spoke in a rather flippant way about her life. In talking about her “formative years,” she said that she had had a “perfectly normal childhood” and had “perfectly reasonable parents” who were highly successful academics. “I can't blame it all on them.” I imagined that what the patient said was true in a way that she was not at all aware of. That is, she had been a “perfectly” behaved child (compliant, and fearful of her emotions), and her parents were “perfectly reasonable” in the sense that they were little able to be receptive to, or expressive of, feeling. This inference was borne out over time, both in the transference-countertransference and in the patient's accounts of her childhood.

Closely linked with Ms. Q’s efforts to control me and steal from me and from my other patients was her belief that I had the answers to her problems —her inability to be a mother, a wife, a friend, or a productive member of her profession. My “stubbornness” in not giving her solutions to her problems puzzled and enraged her.

I gradually became aware of a way in which the patient had been relating to me from the very beginning of the analysis, but which had become less disguised and more provocative as time went on. The patient would regularly misrepresent feelings, behaviors, and events that had occurred either within or outside of the consulting room. This was most striking when Ms. Q distorted something that she or I had said in the current session or in a recent one. After almost two years of feeling controlled in this way, I said, “I think that by presenting yourself and me with story after story that you know to be untrue or misleadingly incomplete, you ensure that everything I say or think is of no interest or value to you. Reality is only a story that you create and re-create as you choose. There is no real me or real you that lies outside of your control. Since you can create any reality that suits you, there's no need to actually do anything to make the changes in your life that you say you want to make.”

As I said this to Ms. Q, I was aware that I was angry at her for the ways she undermined me and the analytic work. I was also aware that
my pointing out that she was failing to conduct herself in a way that I
approved of would likely force her into an even more highly defended state.
(That is, in fact, what ensued.) But it was not my anger that was most
disturbing to me at this point. I was speaking in a chastising way that felt quite
foreign to me.

A few sessions later, I closed my eyes for a few minutes while sitting in
my chair behind the couch (as I often do while working with patients in
analysis). After a while, I suddenly became very anxious. I opened my eyes,
but for a few moments did not know where I was, what I was doing, or whom,
if anyone, I was with. My disorientation did not lift even after I saw a person
lying on the couch. It took me a few seconds more to deduce where I was,
who the person on the couch was, and what I was doing there (i.e., who I
was). It took several more moments before this deductive thinking was
succeeded by a more solid sense of myself as a person and as Ms. Q's analyst.
This was a disquieting experience that led me, over time, to become aware of
my own fears of losing myself in the psychological-interpersonal experience
in which Ms. Q continuously reinvented reality and reinvented herself and me.
It seemed to me that Ms. Q was showing me what she could not tell me (or
herself), i.e., what it felt like to invent and reinvent herself, and to be invented
and reinvented by another person. I was reminded of Ms. Q's parents' demand
on her, and her own efforts to be “a perfect child,” a child who makes no
emotional demands on her parents, a child who is not a child.

I said to Ms. Q “I think that your distortions of reality, and particularly
your inventions of yourself and me, are efforts to show me what you don't feel
able to convey to me in words. It seems to me that when you were a child, you
felt you were the invention of someone else's mind, and you continue to feel
that way. I think that you've been afraid to tell me or to tell yourself the truth
because that would endanger what little you have of yourself that feels real.
To tell me the truth would be to leave yourself open to my taking from you
what feels most real about you, and replacing it with my own version of you.”
Ms. Q did not reflexively dismiss what I said with a sardonic quip or other
form of contemptuous dismissal, as was her wont. Instead, she was quiet for
the few minutes that remained of the hour.

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In the following day's session, Ms. Q told me a dream: “I was playing tennis—in reality I don't know how to play tennis—and the ball rolled to a far corner of the series of courts on which we were playing. There was a kind of trough at the edge of the far court that was filled with brand-new tennis balls, but I didn't know how to take more than one or two with me. I can't remember what happened after that. I woke up in the morning feeling all right—not great, not terrible.”

I said, “In telling the dream, you told me and yourself right away that in the dream you are playing tennis, but in reality you can't play tennis. It seems that it felt important to you that we both know what is real and what isn't. The ball rolled to a far corner where there's a trough. You find a great many new tennis balls in it—it seems like an exciting treasure, but you can only take one or two with you. On the other hand, the tennis balls that you already have are enough. When you woke up, you didn't feel cheated of a treasure, nor did you feel like a thief, as you have felt so often in the past. You felt all right.”

Ms. Q said, “That's right, I didn't really care that I couldn't take all the tennis balls. I didn't want them or need them. Finding the tennis balls in the trough didn't feel like discovering a treasure, it just seemed strange. When I was a kid ... actually I was in high school ... I shoplifted things I didn't want and threw them away as soon as I got outside the store. It makes me feel queasy remembering that. I knew I didn't want the stuff, but I couldn't stop myself.”

In the course of the succeeding year of analysis, Ms. Q's creation of her own reality greatly diminished. At times, when she was engaged in distorting reality, she would interrupt herself, saying, “If I continue talking in this way, it will be pointless because I'm leaving out an important part of what happened that I'm embarrassed to tell you.”

In the portions of the analysis that I have discussed, the patient relied heavily on magical thinking in an effort to create (and destroy) reality, including herself and me. The alternative to creating reality, for her, was not simply an experience of helplessness, but a sense of losing herself, a feeling of having herself stolen by someone else. Moreover, she felt ashamed of not being able to hold onto a sense of herself that felt real and true to her.
The patient's distortions of reality (her magical creation of her own reality) angered me because of the way in which they contributed to what felt like a theft of meaning from the analytic dialogue and a theft of my sense of self. What I initially said to the patient regarding her magical thinking was excessively accusatory, and consequently, unutilizable by her. It was, however, of value to me in alerting me to the way in which I did not recognize myself in the way I was talking. This understanding, in turn, created a psychological space in which a reverie experience was generated (by the patient and me) in which I experienced a frightening feeling that I did not know who I was, where I was, or who was with me.

Talking with Ms. Q about what I believed to be her feelings of losing herself in her endless reinventions of reality provided an emotional context (a containing way of thinking) that allowed her to dream (with me) an experience of being herself in the world without the need for magic. The patient, both in the tennis ball dream and in talking with me about it, was able to be accepting of herself as she was. Reality was not a threat; it served as a grounding otherness. My otherness and the otherness of external reality were made more immediately present as I “retold” the tennis ball dream in a form that was other to her own telling of it. In hearing my telling of the dream, Ms. Q, I believe, saw something like herself (herself at an observable distance) in “my dream.” The patient made use of the external reality (the otherness) of my version of the dream in a self-defining way, as reflected in her quietly correcting my version of the dream in places where she felt she did not recognize herself. For example, she told me that finding the multitude of tennis balls “didn't feel like discovering a treasure”; rather, she found it “strange” (that is, foreign to the person who she was becoming).

While this section of the paper has focused on magical thinking, the work of coming to understand something of what was occurring in the analytic relationship involved a good deal of dream thinking on both the patient's part and mine. I will further describe this aspect of the analysis in the next section of this paper. (As I mentioned earlier, one's thinking always involves the full spectrum of forms of thinking. What varies is the prominence of one form, or combination of forms, at any given moment.)
Dream Thinking

Dream thinking is the predominantly unconscious psychological work that we do in the course of dreaming. We dream continually, both while we are awake and while we are asleep (Bion 1962a). Just as the light of the stars in the sky is obscured by the glare of the sun during the day, dreaming continues while we are awake, though it is obscured by the glare of waking life. Dream thinking is our most encompassing, penetrating, and creative form of thinking. We are insatiable in our need to dream our lived experience in an effort to create personal, psychological meanings (which are organized and represented in such forms as visual images, verbal symbols, kinesthetically organized impressions, and so on) (Barros and Barros 2008).

In dream thinking, we view our lived experience from a multiplicity of vantage points simultaneously, which allows us to enter into a rich, nonlinear set of unconscious conversations with ourselves about our lived experience. That multitude of vantage points includes the perspectives of primary and secondary process thinking; the container and the contained; the paranoid-schizoid, depressive, and autistic-contiguous positions (Ogden 1989); the mature self and the infantile self; the magical and the real; the “psychotic” and “nonpsychotic” parts of the personality (Bion 1957); getting to know what one is experiencing (Bion’s [1970] “K”) and becoming the truth of what one is experiencing (“O”); the “projector” and the “recipient” of projective identification; and so on. The multilayered, nonlinear “conversations” constituting dream thinking take place between unconscious aspects of the personality, termed by Grotstein (2000) “the dreamer who dreams the dream” and “the dreamer who understands the dream,” and by Sandler (1976) “the dream-work” and “the understanding work.” Such thinking would result in massive confusion if it were to occur consciously while one was attempting to go about the business of waking life.

The richness of dream experience and dream thinking is captured by Pontalis (2003) in his description of waking up from sleep:

I must separate myself brutally from the nocturnal world, from this world where I felt and lived more incidents than anywhere
else, where I was extraordinarily active, where I was more awake than one ever is in what we call the “state of wakefulness.” [p. 15] … Dreams think and they think for me …. Waking up we would like to recover the beautiful, distressing, and disturbing images that visited us in the night and already these images are fading. Yet we also feel that what we are losing then is much more than these images; it’s a realm of thought that progresses continuously, [p. 18] … [Dreaming—and, I would add, dream thinking] unfurl[s] in all directions [p. 50], … unaware of its destination … carried away by the sole power of its movement. [p. 19]

As discussed earlier, the problem with magical thinking is the fact that it does not work: it substitutes invented reality for the reality of who one is and the emotional circumstances in which one is living. Consequently, nothing of substance changes in oneself. The strength of dream thinking lies in the fact that it does work: it does give rise to psychological growth, as reflected, for instance, in the way one consciously and unconsciously goes about making changes in the way one relates to other people and in one's other engagements with the real external world. In this sense, I view pragmatism as a principal means of taking the measure of the value of any aspect of the workings of the mind (as is true of the workings of the body). A fundamental question regarding any given form of thinking is always: Does it work? Does it contribute to the development of a sense of an emotionally alive, creative, self-aware person, grounded both in the reality of himself and of the external world?

Beginning in earliest infancy and continuing throughout life, every individual is limited, to varying degrees, in his capacity to subject his lived experience to dream thinking, i.e., to do unconscious psychological work in the course of dreaming. When one has reached the limits of one's ability to dream his disturbing experiences, one needs another person to help one dream one's undreamt dreams (Ogden 2004b, 2005). In other words, it takes (at least) two people to dream one's most disturbing experience.

In earliest life, the psychological-interpersonal phenomenon that I am describing takes the form of the mother and infant together dreaming the infant's disturbing experience (as well as the mother's
emotional response to the infant's distress). The mother, in a state of reverie, accepts the infant's unthinkable thoughts and unbearable feelings (which are inseparable from her response to the infant's distress) (Bion 1962a, 1962b; Ogden 1997a, 1997b). The mother, who in this way enters into a subjectivity that is co-created with the infant (Winnicott's [1956] "primary maternal preoccupation"; Bion's [1962a] and Rosenfeld's [1987] intrapsychic-interpersonal version of projective identification; Ferro's [1999] "bi-personal field"; or what I call the "inter-subjective third" [Ogden 1994a, 1994b]), brings to bear on the infant's unthinkable experience her own larger personality and greater capacity for dreaming. In so doing, she and the infant together dream something like the infant's disturbing experience. The mother communicates to the infant his formerly undreamable/unthinkable experience in a form that he is now more fully able to dream on his own. A similar inter-subjective process takes place in the analytic relationship and in other intimate relationships, such as the parent-child relationship, marriage, close friendships, and relationships between siblings.

In saying that it takes (at least) two people to think one's most disturbing emotional experience, I do not mean to say that individuals are not able to think on their own. Rather, I am saying that one inevitably reaches a point in one's thinking/dreaming beyond which one cannot go. At that juncture, one either develops symptomatology in an (often futile) effort to gain some measure of control over (which is not to say resolution of) one's psychological difficulties, or one enlists another person to help one dream one's experience. As Bion (1987) put it, "the human unit is a couple; it takes two human beings to make one" (p. 222).

It must be borne in mind that not all forms of mental activity that appear to be dreaming—for example, visual images and narratives experienced in sleep—merit the name _dreaming_. Post-traumatic nightmares that are repeated night after night achieve virtually no unconscious psychological work, and consequently do not constitute genuine dreaming (Bion 1987). In other words, such "dreams" are dreams that are not dreams in that they leave the dreamer psychically unchanged. Again, the measure of whether a dream is a dream is whether it "works," i.e., whether it facilitates real psychological change and growth.
The Ordinary Rescued from the Magical

As I mentioned in connection with my work with Ms. Q, dream thinking was done at several critical points in that analysis. I will focus here on one of these instances: my use of my reverie experience that occurred during a session in which I listened to the patient while my eyes were closed. In that reverie, I was, in an important sense, dreaming with Ms. Q an experience that she had been unable to dream on her own (much less put into words for herself or for me). The reverie itself was a form of waking dreaming in which I not only lived the experience, but—even as I was in the grip of it—I was also able to form questions that addressed the essence of the emotional situation: Where am I? Who am I? With whom am I?

On “waking” from the reverie, I was able to engage in more conscious aspects of dream thinking. This involved my conceiving of my experience of having momentarily lost myself as constituting an unconsciously co-created version of Ms. Q's experience of losing herself as a consequence of her use of omnipotent fantasy to invent and reinvent herself and me.

The thinking I have just described involved apprehending and putting into words multiple levels of meaning that were alive in the emotional experience. I treated my reverie experience both as an experience of having co-created a dream with Ms. Q and as an experience that had personal meanings that were unique to each of us. My own experience of the reverie was one in which I briefly lost touch with my sense of who I was, while Ms. Q's experience of losing herself was lifelong, and at times quasi-delusional.

As I have said, I view dream thinking as a form of thinking that is primarily unconscious, although it operates in concert with preconscious and conscious thinking. The co-creation of the reverie experience itself was principally an unconscious phenomenon that generated preconscious and conscious imagery (as is the case with dreams that one remembers after waking from sleep). In relating my reverie experience to Ms. Q's experience of herself, I was primarily engaged in conscious, secondary process thinking, but that type of thinking would, I believe,
have been stale and empty had I not been speaking from my experience as a participant in the reverie.

An important measure of whether or not the thinking that Ms. Q and I did was genuine dream thinking lies in the degree to which it facilitated the work of helping the patient become more alive and responsive to her experience in the real world, better able to accept herself as she was, and more capable of thinking and talking about her experience with herself and with me. It seems to me that my use of my reverie experience to talk with Ms. Q about her experience of losing herself reflected psychological change in me, i.e., in my own increased capacity to contain the patient's unthinkable/undreamable experience (as opposed to evacuating it—for example, in the form of a chastising intervention). My talking with Ms. Q about her experience of losing herself contributed, I believe, to her dreaming her tennis ball dream, a dream in which she had little interest in, or use for, magical thinking. Her psychological growth was reflected in her capacity to dream that dream and in her enhanced ability to talk and think with me (and herself) about it.

The type of dream thinking that I have described here involved a form of self-reflection in which I drew my own experience, and my conception of the patient's experience, into relation to one another, i.e., I made use of my experience of losing myself to make an inference regarding the patient's experience of losing herself. The category of meaning (the experience of losing oneself) remained relatively constant. As will be seen in the following section of this paper, dream thinking at times involves a radical shift in the structure of the patient's and the analyst's thinking. This form of dream thinking, which I refer to as transformative thinking, may precipitate what Bion (1970) refers to as “catastrophic change” (p. 106), a change in nothing less than everything.

**Transformative Thinking**

The idea of transformative thinking occurred to me in response to a passage from the King James translation of the Gospel of John, which was discussed in an essay by Seamus Heaney (1986). I will treat the writing in that passage as a literary text, not a religious text, and as such, I will treat the figures and events depicted in the story not as expressions of

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theological meaning, but as expressions of emotional truths arrived at by means of a particular form of thinking. Because the thinking is in the writing, I will quote the passage in its entirety:

And the scribes and Pharisees brought unto him a woman taken in adultery; and when they had set her in the midst,

They say unto him, Master, this woman was taken in adultery, in the very act.

Now Moses in the law commanded us, that such should be stoned: but what sayest thou?

This they said, tempting him, that they might have to accuse him. But Jesus stooped down, and with his finger wrote on the ground, as though he heard them not.

So when they continued asking him, he lifted up himself, and said unto them, He that is without sin among you, let him first cast a stone at her.

And again he stooped down, and wrote on the ground.

And they which heard it, being convicted by their own conscience, went out one by one, beginning at the eldest, even unto the last: and Jesus was left alone, and the woman standing in the midst.

When Jesus had lifted up himself, and saw none but the woman, he said unto her, Woman, where are those thine accusers? hath no man condemned thee?

She said, No man, Lord. And Jesus said unto her, neither do I condemn thee: go, and sin no more.

[Gospel of John (8:3-11)]

In this story, Jesus is brought into a situation in which a woman has been taken “in the very act” of adultery. He is asked whether he will obey the law (which demands that the woman be stoned) or break the law (by putting a stop to the stoning that is about to take place).

Jesus, instead of replying to the question, “stooped down, and with his finger wrote on the ground as though he heard them not.” Instead of accepting the terms as they were presented (Will you obey the law or break the law?), Jesus opens a psychological space in which to think in the act of writing. The reader is never told what he wrote. Jesus's writing on the ground breaks the powerful forward movement toward action, and in so doing, creates a space for thinking both for the characters in the story and for the reader/listener.
When Jesus stands, he does not reply to the question that has been posed. He says something utterly unexpected and does so in the simplest of words—a sentence in which all but two of the fifteen words are monosyllabic: “He that is without sin among you, let him first cast a stone at her.” Jesus does not address the question of whether to obey the law or break the law, and instead poses a completely different, highly enigmatic question: how does one bring to bear one's own experience of being human, which includes one's own sinful acts, to the problem of responding to the behavior of another person? And further, the passage raises the question of whether any person has the right to stand in judgment of another person. At the end of the passage, Jesus renounces any intention of standing in judgment of the woman: “Neither do I condemn thee.”

The final words of the passage: “go, and sin no more,” are tender, while at the same time, demand honest self-scrutiny. Language itself has been altered: the meaning of the word *sin* has been radically transformed in the course of the story, but into what? In relation to what moral order is sin to be defined? Is the woman free to commit adultery if her own morality does not deem it a sin? Are all systems of morality equal in their capacity to prescribe, proscribe, and take the measure of the way human beings conduct themselves in relation to themselves and one another?

My purpose in discussing this piece of literature is to convey what I mean by transformative thinking. It is a form of dream thinking that involves recognizing the limitations of the categories of meaning currently thought to be the only categories of meaning (e.g., obey the law or break the law), and, in their place, creating fundamentally new categories—a radically different way of ordering experience—that had been unimaginable up to that point.

The biblical story I have just discussed constitutes one of the most important narratives—and instances of transformative thinking—of the past 2,000 years. No doubt it would have been forgotten long ago had it been less enigmatic, less irreducible to other terms (such as the tenets of a new set of secular or religious laws to be obeyed or disobeyed), or even to abstract principles such as: no person has the right to pass judgment on another person. Had the story merely substituted one binary choice for another, or introduced a new prescription, the thinking achieved in
the writing would not have been transformative in nature and, I speculate, would not have survived as a seminal narrative of Western culture. The story, like a poem, cannot be paraphrased and mined for meanings that stand still.

We, as psychoanalysts, ask of ourselves and of our patients no less than transformative thinking even as we recognize how difficult it is to achieve. Our theoretical and clinical work becomes stagnant if at no point do we engage in transformative thinking. It is this striving for transformative thinking that makes psychoanalysis a subversive activity, an activity inherently undermining of the gestalt (the silent, self-defining terms) of the intrapsychic, the interpersonal, and the social cultures in which patient and analyst live.

Each of the major twentieth-century analytic theorists has introduced his or her own conception of the transformation—the alteration of the way we think and experience being alive—that is most central for psychological growth. For Freud (1900, 1909), it is making the unconscious conscious, and later in his work (1923, 1926, 1933), movement in psychic structure from id to ego (“Where id was, there ego shall be” [1933, p. 80]). For Klein (1948, 1952), the pivotal transformation is the movement from the paranoid-schizoid to the depressive position; for Bion (1962a), it is a movement from a mentality based on evacuation of disturbing, unmentaledized emotional experience to a mentality in which one attempts to dream/think one's experience, and later (1965, 1970), a movement from getting to know the reality of one's experience (K) to becoming the truth of one's experience (O). For Fairbairn (1944), therapeutic transformation involves a movement from life lived in relation to internal objects to a life lived in relation to real external objects. For Winnicott (1971), crucial to psychological health is the psychic transformation in which one moves from unconscious fantasizing to a capacity to live imaginatively in an intermediate space between reality and fantasy.

My focus in this section of the present paper is not on the validity or clinical usefulness of each of these conceptions of psychic transformation, but on the nature of the intrapsychic and intersubjective thinking/dreaming that mediates these transformations. As will be seen in the next clinical illustration that I will present, the achievement of transformative thinking is not necessarily an experience of a sudden break-through.

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a eureka phenomenon. Rather, in my experience, it is most often the outcome
of years of slow, painstaking analytic work that involves an expanding
capacity of the analytic pair to dream aspects of the patient's formerly
undreamable experience.

Transformative thinking—thinking that radically alters the terms by which
one orders one's experience—lies toward one end of a spectrum of degrees of
change-generating thinking (dream thinking). The clinical example that
follows is taken from work with a patient who experienced florid psychotic
thinking, both prior to the analysis and in the course of the analysis. I have
elected to discuss my work with this patient because the transformative
thinking that was required of the patient and me is more apparent and more
striking than in most of my work with healthier patients. Nonetheless, it must
be borne in mind that transformative thinking is an aspect of all thinking and,
as such, is a dimension of my work with the full spectrum of patients.

**A Woman Who Was Not Herself**

Ms. R sat stiffly in her chair, unable to make eye contact with me during
our first consultation session. She was well dressed but in a way that seemed
artificial in its perfection. She began by saying, “I'm wasting your time. I don't
think that what is wrong with me can change. I'm not a person who should be
in an analyst's office.” I said, “The first thing you want me to know about you
is that you don't belong here. I think you're warning me that both of us will no
doubt regret having had anything to do with one another.”

Ms. R replied, “That's right.” After a minute or so, she said, “I should tell
you something about myself.” I said, “You can do that if you like, but you're
already telling me, in your own way, a great deal about who you feel you are
and what frightens you most.”

Space does not allow for a discussion of the initial years of analysis. In
brief, Ms. R spoke with great shame and embarrassment about how repulsive
she felt; she continually readied herself for my telling her to leave. As we
talked about these feelings, the patient slowly became more trusting of me. In
a very unassuming way, Ms. R revealed herself to be a highly intelligent,
articulate, and likable person.
Toward the end of the third year of this five-session-per-week analysis, Ms. R said, “There's something I'm afraid to tell you because you might tell me that I'm too sick to be in analysis. But you won't be able to help me if you don't know this about me, so I'm going to tell you.” Ms. R haltingly went on to say that she had had “a breakdown” when she was in her thirties while traveling in Europe. She was hospitalized for a month, during which she had a hallucination that lasted for several days. “In it, a string was coming out of my mouth. It's very hard for me to say this because I'm afraid of getting caught in it again. I was terrified and kept pulling on the string in order to get it out of me, but the string was endless. As I pulled, I found that my internal organs were attached to the string. I knew that if I didn't get this string out of me, I would die, but I also knew that if I pulled out more of the string, it would be the end of me because I couldn't live without my insides.” Ms. R said that she had felt unbearably lonely during the hospitalization and was consumed by thoughts of suicide.

She and I talked at length about the hospitalization, the experiential level of the hallucination, and her fear that the hallucination would frighten and alienate me, and entrap her. I restricted myself to putting what she was saying into my own words in order to let her know that she was not alone now as she had been then. The hallucination seemed to me to be far too important an event to risk foreclosing it with premature understandings.

Ms. R also felt that I would have to know more about her childhood experience to be able to help her. She said, “I know I've been very vague in talking about my childhood and my parents. I'm sure you've noticed, but I couldn't bring myself to do it because it makes me feel physically ill to think about it. I don't want to get trapped there either.”

Ms. R said that, as a child, she had “worshipped” her mother: “She was dazzlingly beautiful and extraordinarily intelligent, but I was as afraid of her as I was revering of her. I studied her way of walking, the way she held her head, the way she spoke to her friends, to the mailman, to the housekeeper. I wanted desperately to be like her, but I was never able to do it well enough. I could tell that she thought I was always falling short. She didn't need to say anything. It was unmistakable in the coldness of her eyes and in her tone of voice.”

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The patient's father was fully consumed with running the family business, and was at home very little. Ms. R recalled lying in bed trying not to fall asleep so she might hear her father's voice and the sound of his movements around the house when he got home. She did not dare get out of bed for fear of displeasing her mother by “tiring her father out after his long day at work” (as her mother put it). Gradually, in the course of growing up, the patient came to understand that her mother could not tolerate sharing her father's attention. Her parents seemed to her, even as a child, to have had an unspoken agreement that her father could spend as much time at work as he wanted to, and in exchange her mother would run the house and the family as she pleased.

In this period of analytic work, the patient's lifelong, visceral sense of disgust for herself as a person and for her body (particularly its “female excretions”) became so intense that Ms. R avoided as much as possible being around other people for fear that they would be repulsed by her odor. Being in my consulting room with me was almost unbearable for her. As she spoke about her “repulsive body” during one of these sessions, my mind wandered to a book that I was reading in which the narrator discussed the odor that clung to his own body and those of the other prisoners in the concentration camp in which he had spent more than a year. I thought, at that moment in the session, that not to be stained by the odor would have been far worse than being stained by it because being free of the odor would have meant that one was a perpetrator of unthinkable atrocities. A prisoner's terrible odor obliterated his individual identity, but at least it served to mark the fact that he was not one of “them.”

In talking with me about her revulsion for herself and her body, Ms. R gradually began to recognize the depth and severity of her mother's “distaste” for her. “It was as if being a child was an illness that my mother tried to cure me of. Only now do I see that her teaching me how to be ‘a young woman of culture’ was insane. I was able to convince myself that this was what mothers did. On my own, I learned how to rid myself of the [regional] accent with which the other children spoke.”

When the patient's periods began at age twelve, her mother left a box of Kotex and a detailed letter about “how to keep yourself clean.” Not a single spoken word passed between them on the subject. The patient's
mother became significantly colder and more disapproving of Ms. R after the patient entered puberty.

After several more years during which the patient did considerable work with the understandings I have described, she began to experience left-sided abdominal pain that she was convinced was a symptom of cancer. When extensive medical tests failed to reveal a physiological source of the pain, the patient became extremely distressed and said, “I don't believe them. I don't believe their tests. They're not real doctors, they're researchers, not doctors.” She, then, for the first time in the analysis, sobbed deeply.

After a few minutes, I said, “It's terrifying to feel that doctors are not real doctors. You've put your life in their hands. But this is not a new experience for you. I think that you felt you had a mother who was not a real mother, and your life was completely in her hands. Just as you feel you are a guinea pig in the so-called doctors' research, I think that you felt you were merely a character in your mother's insane internal life.”

Ms. R listened to me intently, but did not respond in words to these comments. Her sobbing subsided and there was a visible decrease in the tension in her body as she lay on the couch.

The succeeding months of Ms. R's life, both within and outside the analysis, were deeply tormenting ones. During this period, she was again preoccupied with the string hallucination. The patient said she continued to feel the physical sensation of having her mother (who was now indistinguishable from the string) inside of her, though the sensory experience no longer held the unmeditated realness of a hallucination. Ms. R came to view her fear (and conviction) that there was a cancer growing inside of her as a new version of the string hallucination.

Also at this juncture in the analysis, Ms. R began to correct grammatical errors that I made—for instance, when I said, “people that” instead of “people who,” or when I made an error in the use of the subjunctive.

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3 I also thought that Ms. R unconsciously experienced me as another doctor using her for my own purposes—perhaps using her as a subject for a lecture or paper—but I decided to wait to talk to her about that aspect of what I sensed was happening in the transference-counter-transference until that set of thoughts and feelings was closer to her conscious experience of me. I believe that the patient would have experienced such a transference interpretation at that juncture as a substitution of my story for hers.
She subtly made her corrections by repeating the essence of my sentence, but with the error corrected. I am not sure whether the patient was at all aware that she was doing this. Ms. R openly complained about television news broadcasters and the New York Times “butchering the English language.” I became highly self-conscious regarding the grammatical correctness of my speech, to the point that I felt tongue-tied and limited in my ability to speak in a spontaneous way. I was able, over time, to understand what was happening as the patient’s way of unconsciously forcing me to experience something of what it felt like for her to have her imperious mother inside of her.

In a session in which Ms. R was feeling hopeless about ever being able to free herself of her mother’s physical and emotional presence in her, I said, “I think that you feel today, almost as strongly as you did when you had the string hallucination, that you have only two choices: you can try to pull the string out of you—but that requires pulling out your own insides along with your mother, which would kill both of you. Or, you can choose not to pull out the string, which means giving up your last chance to remove her from you. You would be giving up all hope of ever becoming a person separate from her.”

While I was saying this, I had a strong sense of emerging from a psychic state in which I had felt inhabited by Ms. R in a strangulating way. Something quite new, and very welcome, was occurring between the two of us at this point in the session, though I was unable to put it into words or images for myself or the patient.

Ms. R said, “As you were speaking, I remembered something that plagued me when I was in junior high and high school. I lived in a world of looming disaster. For instance, I had to predict exactly—to the tenth of a gallon—how much gas the car would take at the gas station. I was convinced that if I was wrong, my mother or father would die. But worst of all, there was a question that I could not get out of my head. I haven't thought about this for years. The question was: if my family and I were in a boat that was sinking, and everyone would drown unless one person was thrown overboard, and it was up to me to decide which one was to go, whom would I choose? I knew immediately that I would choose to throw myself into the water, but that answer was a `wrong answer’—it was
against the rules. So I would begin again asking myself the same question, and that went on over and over and over, sometimes for months.”

I said, “As a girl, you were too young to know that it was not the answer you came up with that was wrong or against the rules—it was the very fact that the question had to be asked that was ‘wrong’ in the sense that there was something terribly wrong going on in your life and in the life of your family. I think you've felt virtually every moment of your life, from the time you were a small child, that you have to decide who to kill—you yourself or your mother.”

Ms. R replied, “It was too awful—impossible—as a child to allow myself to know any of this. It's been there as a feeling, but I didn't have words for it. I felt she was everything. I knew that if I got her out of me, it would kill her, and I didn't want that, but I had to get her out, I didn't want to die. I'm so confused. I feel as if I'm in a maze and there's no way out. I have to get out of here. I don't think I can stay.”

I said, “The very first thing you wanted me to know about you in our initial meeting was that you and I didn't belong here together. Now I realize that, despite the fact that you couldn't put it into words, you were trying to protect both of us from yourself. If you allow me to help you, I'll be inside of you and you'll have to kill one or both of us. As a child, you were alone with that problem, but that's not true any longer.”

Ms. R said, “There are times when I'm here that I know that there is a world made entirely differently from the one I've been living in. I'm embarrassed to say this—I can feel myself blushing—but it is a world in which you and I talk like this. I'm sorry I said it because I don't want to jinx it. I feel like such a little girl now. Forget I said anything.” I said, “Your secret is safe with me.” I had grown very fond of Ms. R by this point in the analysis, and she knew that.

It was only at this juncture, with the patient's help—her telling me she felt like a little girl—that I was able to put into words for myself something of the emotions I had sensed earlier in the session, and was now feeling with far greater intensity. I was experiencing Ms. R as the daughter I never had, a daughter with whom I was feeling a form of tenderness and a form of loss (as she grows up) that is unique to the tie between a father and daughter. This was not simply a new thought, it was

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a new way of experiencing myself and Ms. R; it was a way of feeling alive both lovingly and sadly that was new to me.

In the next session, Ms. R said, “Last night, I slept more deeply than I've slept in a very long time. It is as if space has opened up in every direction, even downward in sleep.”

As the analysis progressed, Ms. R was able to experience types of feeling and qualities of human relatedness that were new to her: “All my life I've heard the word kindness being used by people, but I had no idea what the word meant. I knew I had never felt the feeling they were talking about. I now know what kindness feels like. I can feel your kindness toward me. I cry when I see a mother tenderly holding her baby in her arms or holding the hand of her child as they walk.” She said she cried because she could now feel how little kindness she had been shown as a child. But more important, she thought, was the terrible sadness that she felt about having shown so little kindness to her own children. Ms. R had only occasionally spoken of her children up to this point in the analysis, despite the fact that all of them were having emotional difficulties.

Over time, the psychological-interpersonal shift that I have described became stabilized as a way of being and perceiving for Ms. R. The stability of the change was reflected in the following dream: “I was returning home from somewhere and I found that people had moved into my house. There was a whole group of them and they were in every room—they were cooking in the kitchen, watching TV in the living room, they were everywhere. I was furious, I yelled at them, ‘Get the fuck out of here! [I had never before heard Ms. R use profanity.] This is my house, you have no right to be here.” I felt good on waking up. In the dream I wasn't frightened of the people who had taken over my house, I was irate.”

I said, “The house is the place in which you live, a place that is yours and yours alone.” Ms. R and I talked about the way in which the dream reflected her growing capacity to firmly lay claim to a place in which to live that is entirely hers, a place where she need not choose between killing herself or killing someone else who is occupying her. “In the dream, the people who had moved into my house were not going to die if I sent them away. They would simply have to find another place to live.”
Ms. R had been living in a psychotic world generated by and with her mother (with the help of her father), a world in which the patient was, at every moment, unconsciously feeling that she had to choose between killing herself (giving herself over to being a projection of her mother's feelings of her own vileness) or killing her mother by insisting on becoming a person in her own right (albeit a person who had no real mother and no world that held meaning for her).

The thinking that I consider transformative thinking in my work with Ms. R was the thinking that the patient and I did together in the course of years of analysis—thinking that eventually led to a radical transformation in the way the patient and I ordered experience, creating a gestalt that transcended the terms of the emotional world in which she and I had lived. Ms. R, in this newly created way of generating and ordering experience, was able to feel feelings such as kindness, love, tenderness, sadness, and remorse, which up to that point had been only words that others used to refer to feelings she had never been able to feel. The intimacy and affection that Ms. R and I were now capable of feeling were alive for both of us when she spoke of a world in which “you and I talk like this.” Even Ms. R's use of the words “you and I” in this phrase, as opposed to “we,” conveyed a feeling of loving separateness, as opposed to engulfing, annihilating union. So simple a difference in use of language is communicative of the radical transformation in the patient's thinking and being.

The fundamentally new emotional terms that were created did not derive from self-hatred and pathological mutual dependence, but from Ms. R's wish and need to become a person in her own right, a person who was able to give and receive a form of love that she never before knew existed. It is a love that paradoxically takes pleasure in, and derives strength from, the separateness of the other person. Separateness in this new set of emotional terms, this new way of being alive, does not give rise to tyrannical efforts to incorporate or be incorporated by the other person; rather, it generates a genuine appreciation of the surprise, joy, sadness, and manageable fear that derive from the firm knowledge of one's own and the other person's independence.

While I believe that transformative thinking in this clinical account was a product of the entirety of the work with Ms. R, I also think that
there were junctures in the work during which I sensed that Ms. R and I were engaged in something different from “ordinary” dream thinking. For example, as I have described, such a moment occurred in a session as I spoke to the patient about her hopelessness regarding the possibility of ever freeing herself of the need to make an impossible choice: whom to kill, herself or her mother? Though I could feel that a significant (and welcome) shift was occurring at that point, I was not able to attach words to, or even be clear with myself about, what I was feeling. As the session proceeded—a session in which a good deal of psychological work was done—the patient (unconsciously) helped me realize that I had come to experience her tenderly and sadly as the daughter I never had, and never would have. Paradoxically, in the very act of becoming aware of that emotional void in myself, I was experiencing with Ms. R feelings of father-daughter love and loss (separation) that constituted, for me (and I believe for Ms. R), a new way of being with oneself and with another person.

This transformative thinking was inseparable from another level of transformative thinking in which the patient and I were engaged during this session: Ms. R’s coming to feel and understand at a profound psychological depth her self-imprisonment in a world cast almost exclusively in terms of the dilemma that becoming a person separate from her mother required either murder or suicide. The patient was able to begin to experience a way of being that was cast in radically different terms. She began to experience separation (becoming a person in her own right) not as an act of murder, but as an act of creating a place in herself (and between herself and me)—a place in which she was able to experience a previously inconceivable sense of who she was and who she was becoming.

**Concluding Comments**

The shift of emphasis in contemporary psychoanalysis from an emphasis on *what* the patient thinks to *the way* he thinks has, I believe, significantly altered how we, as analysts, approach our clinical work. I have discussed three forms of thinking that figure prominently in the portions of the two analyses I have discussed. The first of these forms of thinking—magical

![Image of a single page from a document with text on it.](image-url)
thinking—is thinking in name only; instead of generating genuine psychic change, it subverts thinking and psychological growth by substituting invented reality for disturbing external reality. The omnipotent fantasying that underlies magical thinking is solipsistic in nature and contributes not only to preserving the current structure of the unconscious internal object world, but also to limiting the possibility of learning from one's experience with real external objects.

By contrast, dream thinking is our most profound form of thinking. It involves viewing and processing experience from a multiplicity of vantage points simultaneously, including the perspective of primary and secondary process thinking; of the container and the contained; of the paranoid-schizoid, depressive, and autistic-contiguous positions; of the magical and the real; of the infantile self and the mature self; and so on. Unlike magical thinking, dream thinking “works” in the sense that it facilitates genuine psychological growth. While dream thinking may be generated by an individual on his own, there is always a point beyond which it requires two (or more) people to think/dream one's most disturbing emotional experience.

Transformative thinking is a form of dream thinking in which one achieves a radical psychological shift—a psychological movement from one's current conceptual/experiential gestalt to a new, previously unimaginable ordering of experience. Such movement creates the potential for generating types of feeling, forms of object relatedness, and qualities of aliveness that the individual has never before experienced. This sort of thinking always requires the minds of at least two people, since an individual in isolation from others cannot radically alter the fundamental categories of meaning by which he orders his experience.

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