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Relational psychoanalysis in clinical teaching: Contributions to the ethical training of psychotherapists

Relational psychoanalysis in the teaching clinic: contributions to the ethical training of psychotherapists

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SUMMARY

This article proposes a reflection on relational psychoanalysis as a clinical practice and its contribution to the training of psychotherapists during the mandatory final internship in Psychology. Based on a theoretical review and adapted clinical reports from the teaching clinic of the University of the Amazon, the intersubjective bond is highlighted as the central axis of listening, shifting the focus from the classic intrapsychic models of Freudian orthodoxy. The relational attitude is sustained by presence, reverie, affective involvement, bodily listening, and ethical recognition—dimensions that guide the clinical gesture and stance of the therapist in training. These axes demonstrate that psychological suffering, as a lived, situated, and shared experience, can be reworked and alleviated by
horizon of meanings that emerge from the analytic encounter. The clinical case reports were written in the first person, inspired by Mauro Amatuzzi's (1996) proposal on the version of meaning, and protect confidentiality through ethical and narrative adjustments. The work demonstrates that, in the supervised internship, relational clinical practice can transform not only the patient but also the therapist in training.

Keywords: Relational psychoanalysis; Training of psychotherapists; Supervised clinical internship; Ethical dimensions of the clinic.

ABSTRACT

This article proposes a reflection on relational psychoanalysis as a clinical practice and its contribution to the training of psychotherapists during the mandatory final internship in Psychology. Based on theoretical review and adapted clinical case reports experienced at the teaching clinic of the Faculdade da Amazônia (UNAMA), the intersubjective bond is highlighted as the central axis of listening, shifting the focus away from classical intrapsychic models of Freudian orthodoxy. The relational attitude is sustained by presence, reverie, affective involvement, bodily listening, and ethical recognition—
dimensions that guide the clinical gesture and the posture of the therapist in training. These axes demonstrate that psychic suffering, as a lived, situated, and shared experience, can be reworked and alleviated through the horizon of meanings that emerges from the analytic encounter. The clinical case reports were written in the first person, inspired by Mauro Amatuzzi's (1996) proposal on the version of meaning, and confidentiality was preserved through ethical and narrative adjustments. The work shows that, in supervised internship, relational clinical practice transforms not only the patient but also the therapist in training.

Keywords: Relational psychoanalysis; Psychotherapist training; Supervised clinical internship; Ethical dimensions of clinical practice.

1. INTRODUCTION

Relational Psychoanalysis constitutes one of the most profound reformulations of contemporary psychoanalytic tradition. Emerging from criticisms of classical models centered on the drive, the intrapsychic structure and the supposed neutrality of the analyst, it proposes a new metapsychology based on intersubjectivity, mutuality1 and in a sensitive and involved ethical listening.

This listening is not limited to the application of techniques or mere theoretical interpretation, but involves the affective presence of the therapist/analyst, his/her emotional availability and his/her ability to be affected by the clinical encounter.

This is an ethical stance that recognizes the patient's uniqueness and supports the bond with responsibility, openness and respect for otherness. More than displacing the focus of isolated interiority to the relational field, this perspective comprises the subject as someone whose constitution occurs in intersubjective experiences — affective, symbolic and historically situated — that permeate their existence.

Subjectivity is woven into relations of otherness, in the ways in which the individual is received, recognized and sustained throughout its history. The analyst, in turn, abandons the position of neutral interpreter and supposed knowledge to assume the role of ethical partner in a co-constructed experience. More than deciphering meanings unconscious, the relational therapist offers presence, listening and affective availability to dream senses with the patient.

The relational perspective stands out for its ability to dialogue with different fields of knowledge — such as phenomenology, hermeneutics, the social-constructivist, studies on caregivers and infants, gender issues, neurobiology, nonlinear dynamical systems, complexity theories, chaos theories, and fractals. The term relational, broad, includes interactions between the individual and the social world, relationships

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Fraile (2009, p. 60) states that mutuality is a psychodynamic process in which patient and analyst/therapist are mutually influenced and regulated, consciously and unconsciously. This mutual regulation gives rise to feelings, thoughts, and actions, each with its own healthy gradient and pathological dynamics. Thus, the analyst's classic authority transforms into a respectful exploration of a joint reality, giving rise to meanings that analyst and patient co-construct.

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internal and external interpersonal relationships, self-regulation and mutual regulation, forming a bridge between the interpersonal and intrapsychic spaces.

Such epistemological openness does not constitute a disjointed eclecticism, but as an expression of an ethics of care committed to complexity irreducible part of human experience. By understanding suffering as a phenomenon historically and culturally situated, multiple and singular, the relational clinic calls upon the therapist to listen attentively to the marks of the social, family and personal context in which this suffering is inscribed.

In this context, ethics becomes a central issue, as it permeates all practice. relational clinic, not as a set of external norms, but as a commitment I live with the care and relief of the psychological suffering of my patients.

In the formative context — the central focus of this article — this ethical stance transforms the very learning of clinical practice. The supervised internship, therefore, ceases to be just a space for applying technique to become an experience of implication intersubjective and ethical construction of the therapeutic function. The therapist in training is invited to experience listening as a gesture of shared responsibility. Learn that classical neutrality gives way to affective availability, and that presence of the analyst is, often, the container2 necessary for the elaboration of suffering.

The training of the psychotherapist therefore becomes a process of development of your ability to create therapeutic bonds — with ethics, sensitivity and listening committed to care. This process is made possible by the psychoanalytic tripod — personal analysis, supervision and systematic study — where each dimension does not act in isolation, but is intertwined in a co-constitutive way in the construction of the clinical function.

Personal analysis allows the therapist in training to confront his or her own history, expanding the capacity for listening and tolerance of otherness. Supervision offers a

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The container function is a concept developed by Wilfred Bion to describe the capacity of a subject—especially the maternal figure or the analyst—to receive, contain, and transform the raw emotional states of another (particularly a baby or a patient in psychological distress). Bion calls these inassimilable contents *beta elements* and proposes that, when received by a mind capable of the alpha function (capable of symbolizing), they can be metabolized and returned in a thinkable form. In the analytic *setting* , this function is exercised by the analyst by listening to and containing unsymbolized affects, becoming fundamental to the process of emotional transformation and development of thought. Cf. BION, W. *Learning from Experience.* Rio de Janeiro: Imago, 1991.

intersubjective space of elaboration, where theory and practice meet and where the future professional learns to reflect on their feelings, interventions and impasses. The study systematic provides the conceptual framework necessary to support practice with rigor, discernment and openness to the complexity of human experience.

Likewise, the writing that accompanies this path cannot be understood as the mere exercise of explaining accumulated knowledge or of an instrumental prescription of acquired practices. Like the relational clinic, the academic writing expresses itself as experience: not just technique or competence, but as a way of life that involves body, thought and affection. As Larrosa (2015) highlights, experience is “what happens to us, what touches us”, and the writing that is born from it it is not a simple transmission of knowledge, but a journey that transforms the subject itself who writes.

In this sense, both clinical training and academic writing can be understood as ethical and existential crossings. Both call for openness, vulnerability and willingness to be affected. More than transmitting knowledge already sedimented, the gesture of writing — similar to relational listening — is an exercise of presence and responsibility towards others and oneself. And it is in this horizon semantic and dialogic that this article is organized.

2. BUT WHY RELATIONAL PSYCHOANALYSIS?

Before beginning the presentation of the theoretical-methodological apparatus prepared for this article, I consider it relevant to share how and for what reasons constituted my decision for Relational Psychoanalysis as a clinical locus for my professional performance. I emphasize, from the outset, that this choice was more than an adherence theoretical: it was an ethical and clinical call, which has been transforming my knowledge and constituting my practice, as well as my vision of existential care in praxis psychotherapeutic.

[3] For FREIRE (1987, p. 40), *praxis* is the action and reflection of men on the world to transform it.

My academic journey in Psychology was marked by forays into various theoretical approaches. However, it was from contact with authors 4 of thought phenomenological-existential and hermeneutic that I found a fruitful space to welcome my inquiries into the complexity of human experiences. Reading these philosophical texts was essential for epistemological rigor and for the constitution of a vision of the human, the world and the relationships that constitute and permeate the analytical process.

Just like Orange (2012, p.5) I understand that reading philosophy teaches us to read and listen differently and realize what we are missing if we only read the theoretical formulations from our own clinical experience.

However, I also believe that philosophical reading *per se* does not provide the fabric necessary and sufficient methodological framework to guide clinical know-how. This gap fed and feeds my anguish in the face of the constitutive modes of the process psychotherapeutic. In other words, I realized that the transposition of the philosophical-epistemological — as in Husserl and Heidegger — for the daily routine of the clinic remains an open task, which still requires a lot of theoretical maturation and methodological formulation.

It is quite true that Medard Boss, a Swiss psychoanalyst, developed Daseinsanalyse from the dialogue with Heidegger. However, his complete work has not been translated in Portuguese, with the exception of *Anguish, Guilt and Liberation (1997), Last night I dreamed (1979) and Zollikon Seminars (2021).*

A similar situation occurs with Ludwig Binswanger, of whom we only have with some translations edited and published in our mother tongue, such as: *Three forms of Failed Existence (1977), Dream and Existence: Writings on Phenomenology and Psychoanalysis (2013) and Psychotherapy and existential analysis (2019).*

More recently, Alice Holzhey-Kunz [5] — Swiss philosopher and psychotherapist, direct disciple of Medard Boss and one of the main representatives of the second generation of Daseinsanalyse — has published works, given seminars and participated in events

[4] Authors such as Kiekergard, Edmund Hussel, Heidegger, Merleau-Ponty, Wilhelm Dilthey and Medard Boss, among others, guided the introductory path of my studies in the Phenomenological-Existential and Hermeneutic field.

5 He was president of the Society for Hermeneutic Anthropology and Daseinsanalysis, a Swiss-based institution that focuses on the philosophical deepening of Daseinsanalysis as an existential psychotherapy, especially based on the hermeneutics of Heidegger and Kierkegaard, as well as a critical reinterpretation of Freudian psychoanalysis.

in Brazil. She developed her own methodology within the phenomenological tradition. existential, inspired by Heidegger and Freud. Despite its international relevance, its contribution is not yet fully recognized in Brazil by the Brazilian Association of Daseinsanalyse (ABD), the only institution authorized to carry out the training of daseinsanalysts in our country.

In addition to these authors, two internationally renowned Brazilian psychoanalysts — Zeljko Loparic and Gilberto Safra — both heavily influenced by Winnicott, discuss the connections between psychoanalysis and existential thought, enriching this interdisciplinary dialogue.

It was therefore curious and even paradoxical that my most intimate contact with the psychoanalysis has occurred through authors who precisely set out to criticize and emancipate oneself from it, contrasting it with Heideggerian postulates.

In short, my approach to Relational Psychoanalysis did not result from a mere theoretical choice among many others available, but from a search process traversed by epistemological, clinical and ethical concerns. If, on the one hand, philosophy phenomenological and hermeneutic opened fruitful horizons for understanding the condition human in its complexity, on the other hand, also revealed its limits with regard to methodological and technical direction6 of psychotherapeutic praxis.

Relational Psychoanalysis has shown itself, in this sense, to be a space for encounter between theoretical rigor and clinical sensitivity, offering a new metapsychology, critical of Freudian orthodoxy, consistent and, at the same time, open to interdisciplinary dialogue.

By assuming intersubjectivity as a constitutive axis of experience, this perspective made it possible to articulate my formative concerns with a methodology capable of sustaining the clinical gesture in its existential density and in its ethical dimension.

It was at this point that I understood the clinic no longer as the application of models ready, but as a place of shared creation, where analyst and patient constitute each other in the process of elaborating the suffering. This

[6] In its modern usage, technique refers to the instrumentalization and utilitarian vision of human endeavor. *Techne,* the meaning adopted in this article, is linked to creative know-how, close to art and *poiesis,* understood as the act of bringing something new into being. Heidegger (2002) shows that modern technique expresses a mode of unveiling, which can reduce the world to a resource or open up a more original sense of existence.

understanding resonates, as Orange (2012) states, in the need to listen in a different, that is, to cultivate attentive listening to what escapes previous formulations and that can only emerge in the living encounter.

Thus, the choice for Relational Psychoanalysis represents for me not only the definition of a theoretical framework, but the affirmation of a committed clinical stance with the care and subjective transformation that results from it.

This decision also delimits the epistemological horizon that guides this article, whose path now considers the historical and conceptual antecedents that allowed the emergence of this clinical position and its consolidation as one of the most fruitful reformulations of the contemporary psychoanalytic tradition.

3. HISTORICAL AND EPISTEMOLOGICAL BACKGROUND

Relational psychoanalysis did not emerge as an isolated school, but as a critical and creative convergence movement that was consolidated from the 1980s onwards in the United States. Its emergence is linked to a series of theoretical transformations, clinical and institutional practices that challenged the classic assumptions of Freudian metapsychology, especially the drive model, technical neutrality and conception of the analyst as an external observer. Throughout the 20th century, various voices began to question the centrality of the drive and the monadic structure of the psyche, proposing that the subject is constituted in relationships and that the clinical field is, by definition, intersubjective[7] .

One of the first and most important precursors of this transformation was Sándor Ferenczi, who in the first decades of the 20th century broke with Freud in some aspects crucial aspects of clinical technique and ethics. Ferenczi innovated by highlighting that the analyst is not just a neutral vessel, but a real person, whose subtle attitudes and gestures are perceived and interpreted by the patient. Thus, transference is not a phenomenon

[7] Intersubjectivity refers to the ability to recognize others as having a separate center of initiative and different feelings, and with whom feeling states can be shared. Analyst and patient, for him, mutually construct their relationship and regulate their interaction, as well as the experiences each has of this interaction. SAUBERMAN (2019, p. 122).

exclusively internal to the patient, but is also shaped by the actions and interventions of the analyst, revealing a complex and intersubjective relational dynamic in the process analytical.

For Sauberman (2009), Ferenczi's innovative work brought the depth of analytic relationship between patient and analyst. His reflections on trauma, transference and countertransference anticipated contemporary debates, highlighting that the analyst can repeat the role of the original aggressor in the patient's traumatic experience. Ferenczi observed that the patient, when reliving the trauma in the analysis, projects expectations onto the analyst transferences, leading him to occupy this symbolic place. This dynamic, later recognized by other theorists decades later, reveals how the patient reacts and elaborates the trauma from the analytical experience.

Despite his relevance, Ferenczi was marginalized for decades and progressively silenced in institutional psychoanalytic circles after his divergence with Freud, especially for questioning analytical neutrality, defending authenticity of the analyst and propose a more affective and mutual technique. His ideas on empathic listening and validation of trauma—particularly in situations of child abuse—were considered dangerously close to suggestion, and their clinical stance was labeled as risky, especially after his last work on the confusion of tongues, written shortly before his death. This position distanced him from the psychoanalytic orthodoxy of period, which sought to preserve a standard technique and a metapsychology centered on the drive.

For decades, his work was treated with reservations or simply ignored, both by Freud's followers and by emerging schools. His early death, followed by internal disputes in the psychoanalytic movement, contributed to the systematic forgetting of his thought — unfairly reduced to the role of dissident disciple. It was only from the 1980s onwards, with the critical resumption of his texts by psychoanalysts such as Judith Dupont that Ferenczi was once again recognized as an original, sensitive and deeply ethical.

After Ferenczi, the decisive role of the British school in the transition and in the reconfiguration of the theoretical and clinical foundations of psychoanalysis. Due to the Second World War and the migration of several European analysts to the United Kingdom, between the mid-1930s and 1950s the axis of psychoanalytic thought shifted

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significantly to London, where the British Psychoanalytical Society was consolidated as the main institutional nucleus of the post-Freudian psychoanalytic field. In this scenario, the tradition of sensitive and involved listening initiated by Ferenczi found resonance partial in the proposals that emerged in English psychoanalysis — albeit with different theoretical and political inflections.

The British institutional context was marked by intense controversies, especially between Anna Freud, representative of ego psychology and the Viennese Freudian tradition, and Melanie Klein, creator of a metapsychology centered on the unconscious fantasies of child, in primitive defenses and in the theory of paranoid-schizoid and depressive positions. The dispute between the two, known as the Freud-Klein Controversies (1941–1945), involved disagreements about child psychoanalysis, clinical technique and foundations theorists — and culminated in the reorganization of the British Psychoanalytical Society into three distinct groups, which would remain as a reference for decades.

The first was the Freudian Group, led by Anna Freud, which emphasized the child's adaptation to external reality, the analysis of conscious defenses and the interface between psychoanalysis and pedagogy. Its main representatives developed models of intervention aimed at structuring the ego and strengthening the adaptive function.

The second was the Kleinian Group, centered on the formulations of Melanie Klein. The intensive technique of early interpretation and the analysis of the child's internal world as Wilfred Bion who developed a theory of thought based on the container function of mind, crucial for the psychoanalytic listening of non-symbolized affects.

The third, known as the Independents Group or *Middle Group,* brought together analysts who sought a clinic freer from orthodoxies, valuing the dimension experiential, ethical and affective aspects of the therapeutic bond. Among its main names are Michael Balint, with his theory of basic failure and benign regression; Ronald Fairbairn, and Masud Khan, who dedicated himself to the clinic of perversions and the privacy of the *self.* In this group, Donald Winnicott became a central figure, developing decisive contributions such as *holding,* good enough environment, transitional space and true *self,* concepts who profoundly redefined clinical work with children and adults.

British psychoanalysis, especially through the independents, paved the way path to the relational turn by repositioning the analyst as a figure involved in

clinical field, and not as a neutral observer. The concepts of environment, bond, and function symbolic of the analyst introduced by Winnicott, Klein and Bion prefigure many of the foundations that would come to form relational psychoanalysis in the following decades.

It was on this basis that North American authors such as Stephen Mitchell, Jay Greenberg, Lewis Aron, Philip Bromberg, Donnel Stern, Donna Orange, Robert Stolorow and Jessica Benjamin (among others) — deeply influenced by this tradition — formulated, in the 1980s, a new psychoanalytic paradigm centered on intersubjectivity, in the ethics of presence and in implied listening. In the United States, this movement gained strength with the opening of psychoanalytic institutions to non-professionals doctors, especially psychologists, philosophers, anthropologists and academics of science human beings. This change, which occurred between the late 1970s and the 1980s, broke with the medical hegemony that until then dominated psychoanalytic training, allowing the entry of new epistemological perspectives, more critical, reflective and sensitive to subjective experience. The incorporation of these voices contributed decisively to the emergence of relational psychoanalysis as a clinical and theoretical paradigm, by shifting the focus from individual intrapsychicity to the intersubjective field of emotional experience shared.

Parallel to these North American formulations, relational psychoanalysis began to dialogue intensely with phenomenological-hermeneutic philosophy, incorporating contributions that broadened its epistemological and ethical basis. Authors such as Donna Orange and André Sassenfeld are exponents of this integration.

These philosophical influences not only enrich relational psychoanalysis, but also differentiate it from more interpretive technical approaches. By integrating the body, affection, language and context, this clinic establishes itself as an ethical and transformative practice, committed to listening to suffering, to the radicality of the encounter and to creation shared meaning.

Thus, the legacy of Ferenczi, of the independent British school, of the philosophers of existence, of contemporary relational authors not only redefine clinical listening but they position psychoanalysis in a new horizon of responsibility and otherness.

With this ethical and epistemological horizon, relational psychoanalysis offers not just a technical renewal, but a profound reconfiguration of the clinical attitude:

listening comes to mean welcoming and being with, more than interpreting and translating what unconscious.

In this sense, relational psychoanalysis represents not only a change of technique, but a paradigm shift: a psychoanalysis that listens with the body, responds with ethics and builds meaning in otherness. It is in the shared field, where the thought is elaborated in presence, which inscribes the power of relational listening as living, transformative and deeply human practice.

4. CLINICAL FOUNDATIONS OF RELATIONAL PSYCHOANALYSIS

The figure of the relational therapist represents a profound inflection in the way of conceive clinical work in psychoanalysis. Instead of the neutral, distant and observer, the presence of the analyst begins to be recognized as an active part of the field analytical — someone whose subjectivity, affects, and personal history influence, and are influenced by the therapeutic bond. This transformation implies a more lively listening, involved and responsive, in which the encounter between analyst and patient becomes the true core of clinical experience.

For Mayorga, Forli, Piccolo and Saravia (2023), the relational therapist is not only a technician applying methods. He places himself in the analytical scene as a real subject — present, sensitive, willing to be affected and to build, with the patient, an experience of joint elaboration.

This arrangement requires abandoning the idea that the analyst observes from the outside. In in its place, the commitment to a legitimate bond is established, crossed by intersubjectivity, where suffering can be heard, legitimized and transformed.

Some of the ways in which this clinical relationship is constituted will be presented in the following subsections: follow.

4.1. SENSES OF SENSE - APPREHENSIONS OF CLINICAL EXPERIENCE

The clinical experience, in its living and dynamic fabric, demands a field of listening sensitive space where the phenomenon of human suffering can emerge in its complexity. By

entering the psychotherapeutic space, patient and therapist share an atmosphere phenomenological, marked by ambiguity, silence, gestures and speech.

In this scenario, it becomes essential to think about the notion of meaning in its semantic multiplicity, because it is from it that the experience is welcomed, understood and transformed.

The first aspect of the term sense refers to the idea of direction—sense as orientation or vector of experiential movement. In the clinic, this direction is not prescribed technically, but emerges from the intersubjective encounter itself. The therapist, by being willing to phenomenological listening, follows the direction of the patient's experience, without trying to guide him along pre-established paths.

The second unfolding of the concept of sense is linked to meaning — that is, to the symbolic construction that gives comprehensible form to what is experienced. The ability to naming and symbolizing psychological suffering is an essential step in the elaboration of experience, allowing the subject to integrate fragmented aspects of the self. From the perspective relational, this production of meaning is always co-constructed: the analyst does not interpret from height of knowledge, but shares with the patient the task of giving meaning to what, until then, was unspeakable.

Finally, there is meaning as a verb in the past participle: the felt experience. It is about embodied affection, about what is experienced in the skin even before it can be named. It is the ground of sense-perception8 , because here not only the patient but also the analyst can capture the unspeakable of the other through their own affections, bodily impressions and states of being presence. This dimension is the basis for the exercise of *reverie,* as described by Bion (1991) and expanded by Ogden (2013), allowing the transformation of the unsymbolized into thinkable elements.

These three senses of meaning converge in the constitution of clinical experience as a field in which direction, meaning, and sensation intertwine in action. Each session is, therefore, a space of lived meaning — a crossing in which the self can be rescued of its traumatic dispersion and reinscribed as a subject of its history. This crossing is

In the context of Somatic Experiencing, developed by Peter Levine, the term "sensed perception" refers to the bodily perception of internal sensations, which occur before cognitive interpretation. For this author, the body maintains a sensory memory of the trauma, and sensed perception is essential to the healing process, allowing the individual to recognize and integrate these sensations consciously and safely.

favored when the therapist positions himself as a present body, affective container and co-author of the meeting.

Thus, understanding the clinical experience requires not only listening to what is said, but also pay attention to what is experienced, sensed, and emerging. After all, every therapeutic act is a gesture of openness to meaning — in all its forms: direction, significance and bodily perceptions and/or feelings.

4.2. RECOGNITION AND *REVERIE*

In this section, I address the role of recognition and *reverie* in relational clinic, taking as central references the work Reconocimiento mutuo: La intersubjectividad y el Tercero, by Jessica Benjamin (2016), and *Rêverie* and Interpretation: Capturing Something Human, by Thomas Ogden (2013). While Benjamin highlights recognition as a intersubjective process, in which the subject is constituted by being recognized by the other, Ogden, inspired by Bion, highlights *rêverie* as the analyst's ability to welcome affects not symbolized.

Jessica Benjamin proposes that recognition is a founding experience of subjectivity, which emerges in the tension between autonomy and bond. For her, the subject does not constitutes in isolation, but to the extent that it is recognized as an active agent by a another equally subject. This mutual recognition is not reduced to an empathic gesture, but it configures a relational structure that allows the individual to affirm his existence without nullifying otherness.

In the relational clinic, this dynamic is updated in the intersubjective field, where the analyst, by offering himself as a responsive presence, sustains a symbolic space that transcends the dyad and favors emotional co-regulation, repair and construction of sense. Recognition, in this context, is not a one-off event, but a practice continuous that involves the analyst's ability to tolerate difference, sustain the bond in the face of rupture and validate the patient as a subject of desire, pain and transformation.

By recognizing the patient as someone who affects and is affected, the analyst contributes for the reconstruction of a more integrated internal narrative, in which the self can assert itself without resorting to submission or withdrawal. This perspective broadens clinical listening to

beyond interpretation, placing it as an ethical gesture that welcomes the other into its singularity and invites you to exist in the shared space of the relationship.

In the relational clinic, *rêverie* is configured as a psychic function that transcends interpretative listening and approaches an embodied affective presence, capable to embrace the formless and the unspeakable. Inspired by Thomas Ogden's (2013) reinterpretation of concept originally formulated by Bion, *rêverie* is understood as the ability of the analyst to dream the patient's undreamed affects — that is, to feel with before understand. This listening is not guided by logic, but by sensitivity to the field intersubjective, where diffuse images, sensations and emotions emerge as expressions legitimate of a pain that still has no language.

Reverie manifests itself when the analyst perceives, in his own body, *the* suffering of the patient who has not yet found words. These bodily perceptions of the analyst emerge as a poetic reverie, an imaginative scenario that seeks to translate and give meaning to what is captured by its bodily and unconscious dimensions. This process is a transmission between the unconscious of the patient and the analyst, allowing the analyst dreams what the patient cannot yet express.

This clinical gesture is neither solitary nor unilateral: it occurs in the in-between, in the space shared in the relationship. *Reverie* not only welcomes suffering, but recognizes its psychic dignity, legitimizing it as an experience that deserves to be inhabited and elaborated. Thus, *reverie* can emerge in both the analyst and the patient, creating a space of symbolic dialogue. The analyst can share these perceptions with the patient, transforming these images into elements of understanding and elaboration of suffering.

When the analyst allows himself to be crossed by internal images, poetic reveries or sudden emotions, he is not just capturing the patient's content, but participating of the emotional plot that links them.

Thus, *reverie* and recognition intertwine as complementary functions: while recognition validates the emotional existence of the other, *reverie* offers form psychic to that which has not yet been thought. Together, they support an ethical listening, not invasive, which transforms the therapeutic bond into a fertile field for the creation of language and subjectivity.

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5. RELATIONAL SESSION: THE CLINICAL ENCOUNTER IN ACTION

The door opens. The patient enters with his body carrying gestures still without words. The way he walks, how he sits, how he avoids or holds his gaze already communicates internal states that may never have been named. The relational therapist welcomes with attention and openness. There is no rush. There is no expectation of well-written narratives. structured. There is presence.

The relational session begins there — in shared silence, in respected time, in the space that offers itself as a container. The therapist is attentive to what is said, but also to what pulses between the words. He listens with his body, with the rhythm, with the affectation that emerges within oneself and that resonates with the experience of the other, listening relational is also gesture, posture and sensitive availability.

As the session progresses, the patient may begin with a vague complaint, a feeling of emptiness, a disconnected memory. The therapist does not interpret it immediately. He welcomes. It is available to accompany the emergence of what is not yet shaped. It can to make a light proposition, such as a metaphor or image—for example: There seems to be a "knot" there, something difficult to name — allowing the patient to appropriate or refuse, but feeling heard.

This stance sustains the bond. By not imposing oneself as an interpreter or judge, the therapist offers recognition. Such recognition, as discussed in the previous section, is the ethical basis of care. It does not demand coherence—it legitimizes what exists.

As the bond deepens, the session may bring out emotional expressions more intense, sudden withdrawals or even progressive withdrawals. The therapist observes these movements with clinical attention, aware that he is involved in the field analytical and that its presence can activate old relational patterns — *enactments*[9] . When this happens, he does not respond with detachment or technical rigidity, but with affective elaboration.

With this, the analyst recognizes his own participation in the scene and seeks to name the what happens in the bond. You could say, for example, that you noticed the patient's absence in the

Enactments are unconscious enactments that emerge between analyst and patient, revealing relational patterns and unsymbolized contents, especially those linked to the trauma of both.

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last session and who also felt more cautious in the current conversation, asking if something would be being repeated between them.

It is a gesture of involved listening, which embraces the emotional field shared and transforms repetition into the possibility of symbolization. These interventions do not aim to reveal hidden truths, but to open space for the patient think about what is happening in the bond established or under construction there. The relational therapist is there, sharing the symbolic construction.

At other times, silence may dominate the session. Instead of interpreting it, as resistance, the therapist listens to this silence. Breathes along. Recognizes that not even there are always words. The analyst's body becomes a regulating presence where corporeality is a legitimate clinical tool. A steady gaze, a receptive posture, a breath rhythmic are forms of care.

If the patient becomes emotional, the therapist is present. He can gently name it. the intensity of the moment: “I can see how much this touched you. We can sustain this together?” *Reverie* emerges in this context as a clinical attempt to dream the undreamed: an image, a provisional name, a shared metaphor. It is not about deliberate elaboration, but of an affective response that emerges from embodied listening — a way for the analyst to welcome the information before it becomes language.

As Ogden (2013) proposes, *reverie* is a way for the analyst to capture something human that cannot yet be symbolized by the patient. It is he who dreams, so to speak. that is to say, the undreamed-of affections, offering a sensitive and provisional form to suffering that has not yet found words.

Throughout the session, self-disclosure10 may emerge as a legitimate resource in the clinic relational — not to shift the focus away from the patient, but to validate the therapeutic bond. Thus, the therapist does not hide behind a false neutrality, but presents himself as a real person, committed to the co-construction of care. A comment like “that

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In relational psychoanalysis, the analyst's self-disclosure occurs when they share, carefully and with therapeutic intent, something about their own experience or feelings with the patient. This action is not done impulsively, but rather to help the patient feel more understood, strengthen the bond between them, and open pathways for certain emotional contents to be worked through more deeply.

reminded me of something that also touched me" can break the defensive logic of isolation and open a space for mutual recognition.

During the meeting, the patient's psychic time is respected. The therapist relational does not lead in a directive way, does not rush the process or impose interpretations previews. The session becomes a space for co-construction: each affect that emerges is accompanied, every silence is sustained, every gesture is heard. The relational clinic takes place there — between two bodies, two stories, two subjects trying to construct meaning from pain. The language can come later; the bond comes first.

In clinical training, this type of listening requires the therapist in training to abandonment of technical rigidity and the development of presence as a therapeutic tool. Caring is being available to feel, name, and support. The formative process is also personal crossing — the therapist learns to care by being cared for, to listen to being heard.

The session, then, is the place where the bond makes psychic existence possible in its singularity. There is no single model, but there are principles: presence, responsiveness, listening sensitive and committed to recognition. The relational therapist does not cure—he supports the process of emotional reorganization that the patient undertakes. He makes himself present, attentive, committed.

Next, in subsections 5.1 and 5.3, clinical care provided is presented. by the author in the context of the school clinic, conducted under the principles of relational listening.

It was decided to present adapted clinical reports, rather than literal descriptions. of diagnostic pictures or therapeutic results. This choice aims to respect the confidentiality of experiences, preserving the identity of patients through circumstantial changes that align clinical events with ethical objectives and academics of this document.

Each report presents scenes in which the time of listening, the support of affections and the recognition of the patient's uniqueness has become fundamental elements of care. It is through shared experience that the clinical field is constituted—as a space of presence, silence, bewilderment and construction of meaning. Language here does not interpret the lived: accompanies.

5.1. BLACK HOLE

From the beginning of the consultations, Rosa presented herself with a melancholic and a speech marked by tiredness. He shared his daily routines with exact description, but without enthusiasm. He reported that he did everything he needed to do—house, work, medicine —but that had lost its taste. The phrase he said to me in one of our first meetings remained with me: “I am no longer even a remnant of the woman I once was.”

With each session, I began to understand that her story was marked by loss, responsibilities and little opportunity for care. Since childhood, she had to take care of herself with household chores and farming, with no time for herself. Her mother's death at the age of five and the successive referrals to different family members made Rosa get used to the lack. When he spoke about it, there was no anger—only contained sadness. The feeling was of someone who had learned to fend for herself, but who carried a old feeling of abandonment.

Her current support network is fragile. She lives alone. She is occasionally visited by a daughter and takes care of her grandson due to her parents' neglect. The grandson does not represent a relief—it is another overload. The boss at work was understanding when returning post-pandemic and proposed its inclusion in the senior citizen community center. This proposal had some positive effect, but not enough. Rosa acknowledges that the center helps, but it doesn't change the general feeling of discouragement. The strategy of strengthening the network is pertinent, but comes up against the children's indifference and the absence of other consistent bonds.

During some sessions, Rosa was quieter. Sometimes the silence remained disconcerting to both of us. She seemed unwilling to talk about it anymore. which distressed her, but at the same time, it was clear that she wanted to get rid of it. I I also felt like I didn't know how to drive. There was no active resistance, but a way very effective in keeping everything as it is. She did everything she was told to do—nothing was missing, followed the routines — but remained sad. When he said to me: “I’ve done everything in my life... But now what do I do? Is this what life is?” This question opened the same void in me that seemed to pass through it. It was as if a huge black hole was sucking us into a unfathomable abyss...

After this session there was an unexpected interruption due to the program's schedule. center where the services were provided. I was divided: worried about the effects

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that this pause could provoke in Rosa and, at the same time, relieved that she wouldn't have to face the impasse that had arisen.

At the reunion, Rosa appeared more excited. She said she missed the sessions, but which continued normally. He commented lightly on a new dance activity in the square near the center, which I had been following with more enthusiasm. Also mentioned not wanting a new clinical referral, as he felt good about the current medication and that psychotherapy was helping.

I felt something move. It wasn't a drastic change, but a small displacement. Not because something had been resolved, but because Rosa allowed herself inhabit that space with more presence. I was still affected, but I could already talk about it with less weight, and so did I. The clinic there was not interpretation — it was support.

5.2. RAINING ON THE WET

The patient arrived at the first session with a resolute posture, but demonstrated a certain apprehension. She shared that she was referred by a psychologist who previously accompanied his son for many years. He said that this professional even offered punctual support to her, but recommended that she start a new therapeutic process specific to your demands.

I presented the guidelines on how the sessions worked and asked how could help her. She spoke of the difficulties in communicating with her eldest son, of the fear about his future, and the guilt he carried for not having been there when he was child. He reported that, after the separation, he left the boy, then six years old, under the care of care of his father and his new partner. After a legal dispute, he regained custody of his son. Later, around the age of sixteen, the boy declared his homosexuality.
The patient showed discomfort when approaching this topic, stating that he welcomed it, but without fully accept the condition as natural.

Today, the young man is 23 years old, does not work, remains at home dependent on her, spends the days confined to the room and on the computer. The patient relates this behavior to sexual orientation and the lack of it in important moments of childhood. He expressed the

idea that, by “having gone to live life”, she neglected her maternal role and believes that the current situation is a consequence of this and therefore, she feels guilty.

From the initial encounters, it was clear that something was moving beneath the surface of the patient's speech. He spoke a lot, articulated well, but his speech seemed to run safe tracks, skillfully avoiding what most needed to be touched. The complaint main issue—the relationship difficulties with the child—was barely mentioned. In its place, reports of everyday life emerged: commitments, activities, demands of both jobs. Everything narrated with logic, but without affection.

Little by little, I realized that, behind the functionality that the patient presented, there was a continuous attempt to keep his life running without allow himself to feel. It was as if he defended himself from pain through hyperactivity and rationalization. With each session, I felt something essential slipping away—an absence that imposed itself not by the lack of words, but by the lack of depth. The emotions seemed forbidden, hidden under layers of pragmatism.

In the fifth session, something unexpected emerged. Upon returning from a canceled session, he began with an apology and a confession: “I lied to you. I said that everything was fine, but it wasn't.” His sentence came as a break in logic instrumental that supported his speech until then. It was the first tear on the surface. At ask if he didn't want to talk to anyone or if he specifically didn't want to talk with me, he seemed taken aback—his gaze interrupted by silent astonishment which lasted a few seconds, but resonated intensely within me.

That moment moved me. It was as if, finally, we were leaving the concrete ground and stepping, albeit hesitantly, on the ground of pent-up emotions. I felt need to return to him not an interpretation, but an authentic sharing: I said that what he said made me apprehensive, because I perceived a latent restlessness that I could not matched the fluidity of his speech. He said a lot, but didn't seem to say what he really meant. needed to be said.

Perhaps, with the intention of creating a favorable environment where emotions and affections could be expressed without fear, I felt the need to tell you what I, as psychotherapist, I was feeling at that moment. I told him that I felt a bit apprehensive, as he perceived a uneasiness that did not seem to emanate from the content itself. He

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said many things, but did not express what he really seemed to want to say. And then a an image came to me: torrential rain running down the asphalt, sliding along the curb, without being absorbed. All that water ran off, but did not penetrate the soil — because there was a waterproof layer underneath.

When I shared this image with him, his eyes welled up. He confessed that it was difficult to talk about feelings, but I was beginning to realize that way automatic way of avoiding affection. I then made a careful invitation to return to the topic of his son. He accepted. And in that gesture, something in me rested.

For the first time, his presence felt more complete, and mine did too. The rain continued, but perhaps now it was starting to seep in.

FINAL CONSIDERATIONS

Relational Psychoanalysis is configured as a clinical and ethical movement that, when shifting the focus of interpretation to the intersubjective encounter, redefines the foundations of listening and the very constitution of subjectivity. More than a technical review of psychoanalytic tradition, it proposes an ontological turn: suffering is not only expression of the repressed unconscious, but testimony of absent links, experiences unsustained and silenced affects. The conduct of the therapeutic process does not result from analysis of hidden content, but of the legitimate recognition of the subject in his pain — pain that needs to be sustained before it can be named and symbolized before it can be interpreted.

During my supervised internship at the UNAMA teaching clinic, I had the opportunity to experience this clinical position in practice. I was called to occupy a place different from what was initially imagined as a therapist: not that of the one who deciphers, but that of the one who sustains. I didn't just hear words, but I was also struck by silences, gestures, pauses and presences that required availability, affectionate listening and ethical stance. This experience showed that the relational clinical gesture does not arise from technique, understood in its sense modern of utilitarian instrumentalization, but of bonding and shared care. In terms closer to classical Greek thought, we could speak of *téchne,* a creative and humanistic know-how, linked to *poiesis,* that is, to the act of bringing something new to

presence. Being with someone in pain therefore implies making space to welcome the
that the body also communicates and for the joint creation of meanings in the clinical encounter.

In this context, body listening proved to be a fundamental dimension. Postures withdrawn, held breathing, changes in voice, repetitive movements or states of paralysis are expressions loaded with meaning, which are not interpreted as symptoms isolated, but they are welcomed as signs of relational experience. I have been learning to listening with the body and through the body — both the patient's and my own — recognizing that the clinical encounter also occurs in what is non-verbal.

Reverie , affective implication and ethical recognition are consolidated, together with body listening, as guiding axes of my training: not as techniques to apply, but as clinical gestures that involve presence and acceptance in the face of the suffering of another. The internship offered a fertile field to transform learning into experience live. Each session was an opportunity to build not only technical repertoire, but also posture: be available, acknowledge the pain, sustain the times of bonding and allow care if it were a crossing between singularities.

I conclude, then, that Relational Psychoanalysis is not just a theoretical approach — it is experience that forms, encounter that affects and care that is built in between. To integrate its principles into practical training, especially during the internship supervised, not only do the services qualify, but a psychotherapist is also trained able to listen with responsibility, sensitivity and embodied presence. Listening relational transforms both the patient and the listener, establishing the bond as space of more powerful care.

This training, however, does not end with the institutional time of the internship: it opens there. Becoming a therapist is an ongoing process, renewed with each meeting clinical, delves into supervisions, structures itself in systematized studies and is supported in the psychotherapist's own analytical experience. Each session, each silence and each affective involvement opens space to continue learning — not just about the other, but about the gesture of caring and about oneself as a clinician in constant training.

Relational practice, when inserted into the daily routine of the teaching clinic, transforms not not only the bond with patients, but the institutional training culture itself,

inviting teachers, supervisors and students to rethink care as an ethical gesture,

situated and intersubjective.

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