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On the Royal Road Together: The Analytic Function of Dreams in Activating Dissociative Unconscious Communication

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I propose a new analytic function of dreams: the use of dreams to activate powerful forms of unconscious affective communication between patient and analyst, which crucially facilitate the transformation of dissociative mental structure. Moments of what I call dissociative unconscious communication serve to “seek-and-find” the unconscious mind of the analyst and open up channels of unconscious empathy. Such analytic dream communications are particularly likely to occur when certain overwhelming experiences are dominating the treatment: (a) the accessing of dissociated early trauma, and (b) the loosening or crumbling of dissociative structure as the patient begins to come alive.

INTRODUCTION

Many years ago, in my midtwenties, I was in the early stages of my first therapy and feeling the inevitable deflation of my youthful omnipotence as I began to discover all the ways my childhood had not been as rosy as I had labored to believe. I brought in the following dream: I was in my sunny apartment watering my plants, and when I got to my precious Boston fern, which was sitting there next to the sand candle on my cinderblock bookshelves, I found to my dismay that someone had cut off all of its fronds. All that was left was a sad-looking, little mound of brown fuzzy stems in the dirt. After reporting the dream, I told my therapist how horrified and grief-stricken I had felt. Without missing a beat, he said, “Yes … and you know … spring is coming … and it will all start to grow again.” I remember my reaction to this day. I felt this powerful, visceral feeling of something “going right IN,” not just into my mind but into me and opening up my entire body. I believe that I became so suddenly and dramatically permeable not only because my therapist spoke to me from within the dream metaphor but, even more important, because we came together within the dream field—that is, he joined that part of his mind with that part of my mind where dreaming happens. It was at this moment that I understood the unique ability of dreams to catalyze powerful unconscious communication between analyst and patient and to promote what Ferenczi called “a dialogue of unconsciousess” (Dupont, 1988).

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In this paper, I first look at the extraordinary power of dreams: to stimulate and provoke us, to process and communicate our ongoing experience, and to evoke and gather up dissociated material within the analytic relationship. My discussion of the dream literature is necessarily selective, following some of the intellectual tributaries to my main ideas, and does not attempt to review all of the many well-discussed functions of dreams. I then propose a role of dreams that has been little explored: The dream’s function to activate powerful forms of unconscious affective communication between patient and analyst, which can be crucial in the transformation of dissociative mental structure. I suggest that such moments of what I call dissociative unconscious communication can give us dramatic glimpses into the relational dissociative unconscious and serve to “seek-and-find” the unconscious mind of the analyst. My understanding of this particular dream function grows out of a relational and dissociative view of the mind, in which the unconscious is viewed as a processing, meaning-making apparatus. Finally, I argue that dreams are most likely to elicit such communicatory processes during those times in treatment when the patient is engaged in two particularly arduous and overwhelming pieces of work: (a) the accessing of dissociated early trauma, (b) the loosening or crumbling of dissociative structure as the patient begins to come alive.

THE POWER OF DREAMS: A SELECTIVE REVIEW

I’ve dreamt in my life dreams that have … gone through and through me, like wine through water, and altered the color of my mind.

— Emily Bronte

The Emotional Impact of Dreams

Dreams clearly have extraordinary power to affect us emotionally. As Meltzer (1984) wrote, “All but the most powerful evocations of literary and graphic art … pale in comparison with dream material for ability to stick in the mind” (p. 159). Why, we may ask, are dreams so powerful? One factor, certainly, is the intensely visual nature of dreams—a picture is worth a thousand words. Dreams employ “dual modes of cognition—the imagistic, sensory-dominated, primary-process mode as well as the linguistically-anchored secondary-process mode” (Fosshage, 1997). The metaphorical nature of dreams also helps accounts for their power. As Hartmann (2001) put it, “The dream, provides an explanatory metaphor for the dreamer’s emotional state. … The dream image ‘contextualizes’ (finds a picture context for) the dreamer’s dominant emotion” (p. xi) Relevant here is recent brain research which shows that metaphor lights up more brain centers simultaneously than any other form of human communication (e.g., Modell, 1997), encouraging interhemispheric connectivity and the movement of material from right-brain implicit memory into left-brain explicit knowledge and memory.

The Communicatory Function of Dreams

Freud focused mainly on the function of dreams to provide wish fulfillment of latent drives and to protect sleep, and he only alluded to their communicatory function when he reported patient dreams motivated by the desire to prove him wrong (Freud, 1900). It was Ferenczi who first ex-
explored the bidirectional nature of dream-inspired analytic communication. A remarkable passage in his diary describes his own dreams interacting in uncanny ways with his patient’s dreams:

The patient feels that this dream fragment is a combination of the unconscious contents of the psyches of the analysand and the analyst. The analyst’s associations in fact move in the direction of an episode in his infancy; meanwhile the patient repeats the dream scenes of horrifying events at the ages of one-and-a-half, three, five, and eleven-and-a-half, and their interpretation. The analyst is able, for the first time, to link emotions with the above primal event (that is, his) and thus endow the event with the feeling of a real experience. Simultaneously the patient succeeds in gaining insight, far more penetrating than before, into the reality of these events that have been repeated so often on an intellectual level.

... It is as though two halves had combined to form a whole soul. (as cited in Dupont, 1988, p. 13)

Since then, others—notably Kanzer (1955), Blechner (1995), and Eshel (2006)—have focused on how dreams function to “supervise” the analyst on countertransference issues as well as how the dream interpretation process itself may enact problems in the analytic relationship (e.g., Greenson, 1970). Blechner (1995) views dreams as “commentaries on the analyst’s personality and functioning that either cannot be said by the patient or, if they can, are not being heard by the analyst” (p. 3). Dream, Blechner wryly suggested, “may provide a road to the unconscious of the analyst too” (p. 1).

It must be noted, of course, that analytic communication is not a one-way street. As Laplanche (1997) suggested, every dream in an analysis is somehow called up by the desire of the analyst and by the analytic process itself. Far from being a passive recipient, the analyst must actively seek out the unconscious mind of the patient.

The Processing Function of Dreams

Freud (1900) famously divined that dreams were the “royal road to the unconscious,” but he viewed dreams as disguised versions of fully formed, conflictual, wishes that resided in repressed form in the dynamic unconscious. It was Bion’s (1962) prescient view of the unconscious as a processing, “digestive” apparatus that opened the door to a completely different use of dreams than that suggested by Freud and that makes it possible for me to imagine the dream function I am proposing. Fosshage (1997) felicitously captured the shift from the Freudian model of dreams to more contemporary views when he wrote, “We might change Freud’s aphorism that ‘dreams are the royal toad to the unconscious’ to ‘dreaming is a royal expression of unconscious mentation’” (p. 430).

Bion (1962) proposed that dreams (as well as dream-thinking in waking life) are responsible for “rendering pre-communicable material ‘storable’ and communicable,” a mental process (“dreamwork alpha”) that is “analogous to the digestive processes in the alimentary life of the individual” (p. 45). In Bion’s view, the raw, unprocessed elements of experience (“beta”) need to be transformed into elements (“alpha”) that can be used for thinking, feeling and communicating. This “digestive” process, which goes on continuously within a separate “stream” of consciousness during the day as well as the night, is what structures the mind; it progresses most fruitfully in the

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1 Modell (2008) pointed out that the early Freud, in *The Interpretation of Dreams*, did see the unconscious as a kind of knowledge processing center before he developed instinct theory, in which the unconscious is viewed as a repository of repressed, unacceptable impulses and fantasies.
presence of another mind engaged in its own unconscious processing. It follows, then, that those dreams that are reported in analysis represent, for Bion (1992), a kind of “mental indigestion”—that is, experience that is too unsettling to be processed in normal, everyday dream work.

Today, a burgeoning body of experimental dream research (see Levin, 1990, for a review) converges with cognitive theory (e.g., Bucci, 1997) and contemporary psychoanalytic dream theory to confirm that dreams are indeed responsible for the processing, organizing, and connection making of experience and the consolidation of memory. Fosshage (1983) was one of the first to propose a revised psychoanalytic model of dreams as functioning, in various ways, to organize and process data and consolidate self-experience. As Hartmann (2001) suggested, “Dreams make connections more broadly than waking in the nets of the mind. … The connections made are not random, but are guided by the dominant emotion or emotional concerns of the dream” (p. 13). Dreams appear to have a particularly vital role in the processing, consolidation, and integration of affectively arousing material (Levin, 1990). Studies by Solms and Turnbull (2002) reveal dreams’ particular importance in the processing of states of fear, anger, anxiety, or elation. Many decades ago, Kohut (1977) described the power of a particular kind of dream he called the “self state dream” to portray and bind the nonverbal tensions of traumatic states like overstimulation or disintegration.

Ferro (2008), following Bion, made the interesting suggestion that night-dreaming represents a kind of processing of the processing, a digesting of the digesting—that is, a sort of “super alpha function”:

Night dreams are inevitably the fruit of a process of redreaming of all the elements produced in the waking state—whether we postulate the existence of a “super-α function” that acts on all the α-elements produced in waking life and gives rise to a kind of “super-α-elements,” or content ourselves with a mere “director’s function,” performed by an “internal director” who edits, cuts and pastes the huge volumes of α-elements stored during waking life. Seen in this light, night dreams are a second level of the oneiric process, which is more elaborate than the continuous daytime weaving of dreams. In this sense, night dreams are more precious and richer in communicative value in both intrapsychic and relational terms…they are so refined—made up as they are entirely of reprocessed α-elements—that they need virtually no interpretation, but should instead by treated as pure “poetry” of the mind.” (p. 8)

Ferro’s idea that night dreams are “richer in communicative value” is particularly germane to my argument that an important analytic function of dreams is the activation of dissociative unconscious communication within the analytic relationship.

Dreams’ Access to Unconscious Dissociated Experience

Another important tributary to my thinking about the analytic use of dreams is the contemporary, relational view of the mind as fundamentally dissociative, rather than repressive, in nature (Bromberg, 1998; Davies, 1994; Stern, 1997). The view of the mind as dissociative, in conjunction with the view of the unconscious as a processing apparatus, suggests the importance of analytic dream work with dissociative patients, who are cut off from their unconscious “digestive” capacities and thus severely compromised in their ability to lay down new memories and learn from experience.

Bromberg (2006) argued that dreams provide unique and direct access to dissociative realms of the unconscious mind. He evocatively called the dream “a voice from a dissociated part of the pa-
tient’s self that is ready to be heard, but that the patient is not quite ready to acknowledge as ‘me’” (p. 31). According to Bromberg (2006),

> When a patient brings in a dream, the analytic task is to enable him to bring in the dreamer (p. 38) … [to create] a dialogue between the waking self-state of the patient-as-patient” and the sleeping self-state of the “patient-as-dreamer. … The dream must be related to as a nonlinear reality, not as a kind of story or a kind of movie, but as a real space in which the patient has been” (p. 39) [and] which he can re-enter … while simultaneously retaining [his] waking reality (p. 40) … our “dreaming” reality is simply a different state of consciousness and … its taking place during sleep does not make it more unbridgeable to waking reality than any two dissociated self-states are to each other (p. 41).

I suggest further that the visual, sensory nature of the dream makes it a particularly effective vehicle for working analytically with trauma, which is by definition too overwhelming to be stored as narrative, linguistically encoded memory and must usually be encoded and retrieved as static images or bodily sensations. The dream, which is itself imagistic and sensory in nature, is a more effective medium than waking mentation for accessing, representing and formulating traumatic, dissociated experience. Bucci (1997) argued that all images, because they are nonverbal but symbolic, function to link nonverbal and verbal experience.

Dreams, in fact, may be viewed as a kind of “hinge” between conscious and unconscious. According to Bion (1962), “dreaming” (in both sleep and waking) generates a semipermeable barrier that separates as well as connects conscious and unconscious life. Using dreams to recover trauma thus affords a certain safety, because, as Blechner (1995) has suggested, dreams are “transitional between consciousness and unconsciousness, between repression and deliberate expression” (p. 3). The patient who dreams does not have to consciously admit that he knows what he knows, because dreams allow certain experiences to be known and not known at the same time.

To summarize: Dreams’ visual, metaphorical qualities; their superprocessing and connection-making capabilities; their unique access to dissociated experience; and the relative safety offered by their transitional status give them unparalleled power to elicit and gather up dissociative material within the analytic relationship.

**An Unexplored Analytic Function of Dreams**

As just discussed, most analytic thinkers, when considering the communicatory function of dreams, have focused on the use of dreams to let the analyst know something about the vicissitudes of the transference–countertransference relationship. When Blechner (1995) called the dream a “royal road to the analyst’s unconscious,” he was referring to the patient’s unconscious commentary on the analyst’s personality and functioning. These contributions have not focused specifically or in depth on dreams’ unconscious activating influence per se on the other—an influence that can call forth particular responses from the analyst. The one exception, to my knowledge, is a fascinating paper by Eshel (2006), which focuses solely on telepathic dreams. She suggested that a patient will use a dream to telepathically discover personal details of the analyst’s life at times when he has lost emotional contact with the analyst. The telepathic dream serves to pursue the analyst to prevent collapse into a state of early traumatic abandonment. In speaking solely of telepathic dreams, however, Eshel is narrowing her focus more than I wish to. I intend to look more broadly and generally at the impact of dreams on the analyst’s psyche.
I propose an analytic function of dreams that has not been explored: the use of dreams to activate powerful forms of unconscious affective communication between patient and analyst, which crucially facilitate the accessing, symbolization, and integration of dissociated experience and the transformation of dissociative mental structure. Moments of what I call dissociative unconscious communication, which arise out of the relational dissociative unconscious, serve to “seek-and-find” the unconscious mind of the analyst in order to procure desperately needed responses. This proposed function of dreams obviously does not supplant the many other well-known and well-discussed uses of dreams. Drawing upon Bromberg’s idea that dreams are voices from dissociated self-states that the patient is not yet ready to acknowledge and Bion’s notion that reported dreams represent a kind of “mental indigestion,” I suggest that such dream communication is particularly likely to emerge when certain sorts of “undigested” overwhelming experience are dominating the treatment. The first is the accessing of dissociated early trauma, which, when communicated in dream form, can activate the analyst’s own unformulated trauma, opening up a channel of unconscious empathy between the dissociative unconscious of patient and analyst and providing a crucial form of validation of the original trauma. The second arena involves overwhelming experiences of “coming alive” or “being born” as dissociative structure begins to loosen or crumble, which, when communicated via the dream, can activate the analyst’s own vulnerability, followed by an intensification of her containing and selfobject functions, which allows the patient to tolerate the terror of emerging out of the dissociative membrane and into a dangerous world.

While many of our patients’ dreams can activate us unconsciously, I confine myself in this paper to those individuals who have undergone early, severe, pervasive, and ongoing trauma in the absence of an empathic and containing caregiving environment. In other words, I focus on minds that are pathologically dissociative in nature. Because so much of their experience is not consciously available to them, survivors of severe trauma have a particularly desperate need to penetrate us through dream communication in order to create particular kinds of shared unconscious experience and to procure certain kinds of responses from us that will allow the work to progress. Because dissociative patients are at the extreme in terms of their need to make the unthought known, we can use them as a “case in point” to better understand all of our patients’ efforts to make themselves known through dream communication.

THE ROLE OF DREAMS IN ACTIVATING DISSOCIATIVE UNCONSCIOUS COMMUNICATION

Case Illustration

The patient, Lillian, arrives looking pale and drawn, saying she has “blunted feelings.” She talks for a few minutes, then says, “I had another one of those icky dreams. I HATE my dreams.” Lillian (at this point in treatment) feels persecuted by her dreams, as well as by many other things in life. She has little curiosity about her dreams beyond railing at them for being so disagreeable. She tells me the following dream looking irritated but with little other affect:

I’m in some kind of a downtown bar situation with [two neighbors she knows slightly]. Police come up and give breathalyzer tests, and it turns out both are legally intoxicated and will be going to jail. One goes around the corner and takes a gun to his head and kills himself. Then the other one goes into my
house and in the hall facing the bathroom takes a gun out and blows his brains out. My concern is not
him but how icky it is. So I avoid going home, but then when I do go home I find him all crumpled up
and blood all over. I call the police, but they say it’s not an emergency, that they’ll be there in 3 to 5
hours. I say, “But I don’t want to have to look at him. Can I put a sheet over him?” They say, “Well,
maybe, but don’t disturb the crime scene.” They leave me dangling. And he’s in rigor mortis now, a
hunk of bloody tissue.

When Lillian says a “hunk of bloody tissue,” I see the horrific image rise up before me in the most
intensely visual and vivid way, as if it were my own dream. I suddenly feel hot, slightly nauseated,
and dizzy. I stare at her dumbly for a few moments, unable to find any words. She notes my reac-
tion but then hurries on to talk about her shame about not being more concerned about the dead
man. I stop her, saying something like, “Wait, wait … that image of the hunk of bloody tissue …
it’s so awful … and it’s right there in your house.” I watch her tune into me and get hit by my state.
She tears up, then just as quickly says angrily and bitterly, “OK. So now you get it. The story of my
life! … It was SO bad!” She cries for a few minutes, and then goes on to talk about having had to
live day in and day out with her violent, mentally ill, sexually abusive mother, and later on she also
finds herself discussing that ugly, disgusting part of her that she repeatedly and violently kills off
internally.

I continue to have flashbacks to Lillian’s dream throughout the day and even in the middle of
that night. When several years later I decide to include the dream in this paper and go back to my
notes to find it, I realize that I have conflated the image of the hunk of bloody tissue and what she
said about the police leaving her dangling and have inaccurately recalled that the dead man is dan-
gling from the rafters. My brain has done dreamlike, condensing things to her

The Dissociative Unconscious

My interaction with Lillian reveals the power of the dream to bypass the conscious mind, pene-
trate deeply into the unconscious mind of the analyst, and help activate the particular unconscious
process I call dissociative unconscious communication, which I discuss further after some brief
comments on trauma, dissociation, and the unconscious.

I join many contemporary relational writers (e.g., Bromberg, 1998, 2006; Davies, 1994; Stern,
1997) in finding it often useful to conceive of the unconscious structure of the mind as fundamen-
tally dissociative rather than repressive in nature, in the sense that the we are all made up of multi-
ple, shifting self-states. So many of the phenomena of an analysis—projective identification and
enactment, for example—can be viewed as arising out of projective/introjective processes involv-
ing dissociated self-states. But my focus in this paper is not on “normal” dissociative processes but
on dissociation that is a response to trauma—both massive life-threatening trauma and severe,
ongoing, pervasive developmental trauma. The essence of trauma is “the disruption of the conti-
nuity of being (the ‘illusion of being one self’)” (Pizer, 1998, pp. 141–142), or it can be even more
simply be defined as the “event(s) that cause dissociation” (Howell, 2005). The advantage of both
definitions is that they focus on trauma’s effect on the psyche rather than on the nature of the exter-
nal events.

In my view, dissociation refers to both a defensive strategy and a psychic structure. As a defen-
sive strategy against overwhelming experience, dissociation alters consciousness and banishes
patterns of self-experience that cannot be tolerated as part of “me.” Dissociation “protects the sta-
bility of the self by controlling unsymbolized traumatic affect that it cannot regulate” (Bromberg, 2006, p. 7). Dissociation also describes a psychophysiological process that prevents the laying down of verbal, symbolic memories in the first place.

A **dissociative mental structure** is that which develops over time when trauma (and, hence, the need for dissociative defenses) is severe, pervasive, and ongoing, and when there is no alleviating responsiveness from the environment. A dissociative mental structure “hynoidally sequesters certain self-states and limits their communication with one another as a proactive defense against the repetition of what has already happened” (Bromberg, 2006, p. 6)—a state of affairs that seriously compromises one’s capacity for intersubjectivity, mentalization, and learning from experience. A dissociative structure works in conjunction with omnipotent defenses to regulate relatedness to others (Sands, 1994)—all of which is discussed further in the last section.

In my thinking about trauma and dissociation, I make use of various theories of the unconscious; these include the Freudian unconscious, in which trauma is “preserved”; Stern’s (1997) unconscious, in which trauma remains “unformulated” until symbolized through analytic enactment; Stolorow & Atwood’s (1992) “unvalidated unconscious,” in which experience remains unarticulated in the absence of a validating intersubjective context; and the neuroscientific unconscious, in which trauma triggers a cascading of biochemical effects that overwhelm brain function and the encoding process and make symbolic representation impossible.

Such models of the unconscious remain incomplete and contradictory—in part, of course, because they pertain to unconscious processes—and it is beyond my capabilities to try to resolve the tensions between them here. I can only offer my necessarily incomplete thinking on the subject at this point. I do not believe that there can ever be a purely intersubjective unconscious, since we are not created anew in every moment, nor can there ever be an already-formed, “preserved” unconscious, because so much remains unsymbolized and because our minds are always creating and revising experience. My view is that something traumatic continues to reside in our minds—often more-or-less scant visual images or bodily sensations—which can be called up by the analytic process and by dreams within the analytic relationship.

Therefore, while keeping in mind that the nature of unconscious experience is fundamentally dynamic and relational, let us imagine for heuristic purposes a **dissociative unconscious** within one’s larger unconscious, consisting of traumatic material that has remained unformulated and/or appeared for a short time before being cordoned off because it was too overwhelming to be processed and symbolized as conscious or unconscious memory. Picture, if you will, a topological model of the mind, which is divided horizontally into conscious and unconscious levels—with the boundary between them constantly changing—and in which unbearable self-states are vertically separated-out through dissociation. The dissociated sectors are associatively unavailable to the rest of the personality and, unlike repressed content, cannot participate in psychic elaborations.

What I am calling the **dissociative unconscious** is but one part of the larger unconscious, which also includes the repressed contents of the Freudian dynamic unconscious, as well as “procedural knowledge,” “invariant organizing principles” (Stolorow & Atwood, 1992), and so on—that is, all that which is not conscious. In persons who have been severely traumatized, the **dissociative unconscious** has become particularly “large” and the barrier around it particularly impermeable due to the subjectively overwhelming affectivity they have had to endure. The traumatic self-states (actually, self-Other states) included in the dissociative unconscious contain not only traumatic affects—like terror, horror, helplessness—but also those associated relational longings that have been sequestered because they have been “forbidden” by the environment and have become “not me.”
The Dissociative Relational Unconscious

With that preamble, let me return to the unconscious communicatory process that occurred between Lillian and me—the process I call **dissociative unconscious communication**. This form of implicit communication, an emergent property of the analytic process, is characterized by a powerful and visceral resonance between patient and analyst, as something dissociated in the patient grabs hold of and enters into deep communion with something dissociated in the analyst and opens up a channel of unconscious empathy (Sands, 2007).

As suggested above, I view dissociative unconscious communication as that subset of unconscious communication which occurs most often when the patient (and sometimes the analyst) is a survivor of severe trauma and, therefore, unusually reliant on dissociative defenses. Dissociative individuals have a particularly urgent need to share their minds with other minds in order to re-enter the stream of unconscious processing and “unfreeze” their traumatic experience.

When communication becomes mobilized between the **dissociative unconscious** of the patient and that of the analyst, we get a glimpse into what I call, building upon Gerson’s (2004) concept of the “relational unconscious,” the **relational dissociative unconscious**, which may be defined as the ongoing creation of the reciprocal and mutual influence of dissociative unconscious minds upon one another. The relational dissociative unconscious can be viewed as a “third”—an intersubjective third that is an ongoing creation of the dyad. It exists in and between minds. Of all the different kinds of “thirds” that have been enumerated in past years, my phenomenological experience with Lillian is perhaps best captured by Benjamin’s (2004) notion of “the one in the third” because it is based in resonance, attunement and identification. Benjamin described “the one in the third” as

> a nascent or energetic third … present in the earliest exchange of gestures between mother and child, in the relationship that has been called oneness. I … suggest that we call the principle of affective resonance or union that underlies it the one in the third. (pp. 16–17)

Needless to say, during the analytic hour, this experience of oneness must soon be joined by an “observing third” in order for the patient to feel contained and recognized.

The intensity of the unconscious communications will depend on the degree to which a **personal vulnerability** of the analyst is engaged (Coburn, 1998; Sands, 2007). Patients “know” the analyst deeply and will actively, albeit unconsciously, though a process of trial and error, search for some unresolved or vulnerable aspect of the analyst’s subjectivity to “hook onto” and resonate with. This vulnerable aspect can function as an internal contact point, opening up a river of unconscious resonance between patient and analyst. Then, during the rapid sequence of reciprocal interactions that follow, the unconscious affective communications become amplified within the intersubjective field to the point of intolerability. Patient and analyst become joined in a momentary traumatic state, although their subjective experiences are necessarily very different, since it is traumatic affect, not specific content, that is (usually)2 communicated implicitly. My understanding of this process, of course, presupposes what Spezzano (1995) calls “a theory of

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2Content can also be shared. Indeed, the telepathic dream may be viewed as a kind of “impossible,” mysterious extreme of the kind of patient/analyst interconnectedness I am exploring. In a fascinating article, Eshel (2006) traced the suppression of accounts of telepathic dreams by Freud and others throughout the history of psychoanalysis.
mind that posits an unconscious psyche constantly driven to bring its contents into consciousness” (p. 24).

How might we attempt to visualize this communicatory process schematically? Let us imagine that the dissociated material in the patient’s mind makes initial contact with the dissociative unconscious of the analyst, then moves into that part of the analyst’s unconscious mind where processing is possible—we might call it the “processing unconscious.” There it may be formulated in some way and somehow transmitted back into that domain of the patient’s unconscious mind that is capable of processing, or it may rise up into the analyst’s conscious mind, where it may become verbally symbolized (or not) and then may or may not be given back to the patient and taken into the patient’s processing unconscious. It is through this ongoing process of transformation-through-the-mind-of-the-other that the dissociated trauma of the patient gradually becomes unstuck, unfrozen, and gradually symbolized and integrated into the lived experience of the patient.

Of course, the intersubjective transformation of raw into processed (“beta” into “alpha”) has been well discussed by contemporary Bionians. The piece that I am adding is the first step of the process—in which dissociated content moves from the dissociative unconscious of the patient to the dissociative unconscious of the analyst—which is so critical in the treatment of the dissociative disorders. I suggest that these dissociative communications are particularly mutative—perhaps even essential—for the deepest levels of healing with survivors of severe trauma.

How can the transformative communicatory process I am describing here be distinguished from the concept of “enactment”? Major contemporary accounts of dissociative enactment (e.g., Bromberg, 2006; Davies & Frawley, 1994; Stern, 1997) describe analyst and patient as adversaries caught in a painful struggle. Stern (2004), in particular, emphasized the centrality of conflict in enactment, in which “the conflict that cannot be experienced within one mind is experienced between or across two minds” (p. 213). According to Bromberg (2006), the analyst during enactment is “immersed, at least for a time, in a dissociative process of his own that is linked with the patient’s and is objectifying his patient no less than his patient is objectifying him” (p. 34)—which makes it difficult or impossible to receive or resonate with the patient’s dissociated experience. By contrast, what I am describing as dissociative unconscious communication does not involve conflict. In Racker’s (1968) familiar terms, these communications involve “concordant” identifications—that is, they involve interactions of concordant, rather than complementary, dissociated states. Patient and analyst are “beyond ‘doer and done-to’” (Benjamin, 2004) and share experience in powerful ways, as particular “not-me” self states of the patient enter into deep communion with particular not-me states of the analyst. Thus, while enactments are crucial way stations to toward symbolization, I am arguing that we must also acknowledge the importance of non-conflictual, resonant dissociative experiences between patient and analyst in furthering the formulation and integration of intolerable, unformulated experience.

If I may be permitted a very brief foray into neuroscientific speculation, such dream-inspired dissociative unconscious communications would likely occur between the cortical/subcortical right brains (Schore, 2007) of patient and analyst, since the hyperarousal of trauma functionally inactivates the left hemisphere and leaves traumatic experience to be encoded primarily on the right in amygdaloidal memory. Our dream life—charged as it is with the processing of intense emotion—also appears to take place primarily in the same region, as PET scans taken during REM sleep reveal activation of the limbic system, especially the amygdala, and deactivation of the frontal areas of the brain (e.g., Panksepp, 1998). Finally, current research on “state-sharing” suggests
that dream states as well as dissociative states could be neurobiologically *shared*—probably by means of “right amygdala to right amygdala projective communication” (A. Schore, personal communication, 2008).

**DREAMS’ SPECIFIC ACTIVATING FUNCTIONS WHEN OVERWHELMING EXPERIENCE DOMINATES THE TREATMENT**

Dreams, as I have suggested, are particularly powerful vehicles for activating unconscious communication because of their visual and metaphorical power, their unique access to dissociated experience, their superprocessing abilities and their transitional location between conscious and unconscious. When patient and analyst enter the dream field together, it is as if two “superprocessors” have become linked up. Accordingly, such dream-activated communications can provide unequalled forms of shared experience, which, among other things, can help access and formulate traumatic experience, alleviate the excruciating aloneness and persecutory anxieties of trauma, provide validation of traumatic experience, and create a holding environment for the transformation of dissociative structure and recovery of affectivity.

As mentioned, I have found that such analytic dream communications are most likely to occur when two particularly overwhelming therapeutic endeavors are dominating the treatment: (a) the accessing and formulation of dissociated early trauma, and (b) frightening experiences of “coming alive” as the patient’s dissociative mental structure begins to loosen or crumble. It is at these times that the patient may most need to pursue and find the analyst—that is, to access and activate the unconscious of the analyst in order to procure the empathic responsiveness needed to endure and benefit from the harrowing analytic work.

I. Accessing, Formulating and Validating Early Traumatic Experience

The case of Lillian, discussed above, is an example of the powerful role that dreams can play in the first overwhelming therapeutic task—that of accessing, formulating, and validating early traumatic experience. In the years following the dream of the “hunk of bloody tissue,” it has become even clearer that the dream captured a seminal “felt experience” of her childhood and that our interaction around the dream was a watershed moment in the treatment. During the dream interaction, I became powerfully activated and flooded by Lillian’s dissociated affect, which had been captured metaphorically in the dream. Her dissociated experience passed through the sectors and layers of my mind and back through those of her mind and, in so doing, was metabolized and “spelled out” (Stern, 1997) enough so that in the ensuing weeks she found herself more affectively vitalized and real. Some of her dissociation was undone. Indeed, what I have been calling Lillian’s dream might be more accurately called a “proto-dream” or a “dream-in-the-making” (P. Goldberg, personal communication, 2009), since it had to pass through my unconscious mind before it could become a true dream capable of organizing and making meaning of her experience.

Of course, the utility and productivity of such dramatic moments of analytic communication depend in part on what we *do* with them. We have a performative as well as a receptive function. Not only do we receive, register, and digest the patient’s experience at unconscious and conscious levels, we must also use it in some way—if we have our wits about us enough to do so at that moment. With Lillian, technically speaking, I had to do three things: stop the action and make room...
for something to happen in me and between us; name and *amplify* the traumatic nature of the material; and, finally, communicate my overwhelming experience with enough affect that Lillian could “get” it and recognize it as her own.

**The analyst’s vulnerability.** As I suggested earlier, when engaged in the work of accessing dissociated trauma, the patient may search for the personal vulnerability of the analyst (Sands, 2007), who may become temporarily traumatized herself, as I was with Lillian. By “traumatized” I mean that I underwent an actual, momentary experience of affective overwhelm, which led to an actual, momentary disruption of my sense of self (see also Hartke, 2005). I realized upon later reflection that Lillian’s dream images could have interacted with a specific vulnerability of mine: my long-standing fear of blood, which I have come to understand is related to early loss, and which may well have contributed to my reacting so powerfully. In other words, my experience with Lillian could in part have involved my fear of reliving something that had actually and already happened (Winnicott, 1974) and thus, could have involved a *breaching* of dissociation for myself as well as for the patient. My unconscious vulnerability served as an internal nexus of affective resonance, making me more receptive to the terror that Lillian could not feel completely in her dream or in her waking life. Needless to say, such experiences can also allow us to work with our own trauma as an integral part of the patient’s symbolization process.

With other profoundly traumatized patients I have had equally strange and perplexing experiences—on one occasion, becoming so spatially disoriented that I felt myself tipping this way and that in the room; at another time, feeling briefly as if I were being sucked into a dark tunnel; and, in another instance, feeling like I was peeking over the edge into a ravine of writhing chaos. I must add that I do not think that the analyst needs to have experienced major trauma in order to resonate with patients in this way. I think that the life of every analyst contains enough trauma to fuel such discrete dissociative meetings of the mind.

**Validation.** I believe that dissociative unconscious communication can carry a crucial form of therapeutic action—a particular kind of *validation* that facilitates the deepest levels of healing with survivors of massive trauma (Sands, 2007). Because so much of these patients’ trauma has been unacknowledged, unvalidated, or unencoded, they have a particularly pressing need for both explicit and implicit confirmation that the trauma actually happened. Because their desperate reliance on dissociative defenses derails the development of their ability to mentalize (Fonagy, Gergely, Jurist, & Target, 2004), they find it difficult or impossible to imagine that others could share or resonate with their internal affect states. One of the only ways that traumatized patients can believe that their experience has been deeply understood is for others to join them “there” and “live” what they have been through mentally and, most crucially, viscerally. I have called this process “experiencing through the other” (Sands, 1998).

Because of the unspeakable loneliness of their trauma, human beings who have been profoundly traumatized need, at certain important times during treatment, the particular validation offered by these dissociative unconscious communications. Their experience is so relatively “abnormal,” so near the edge of psychic and/or physical death, so outside the realm of usual human discourse, that they feel terrifyingly alienated within their traumatization (Stolorow, 2007). Their overwhelmed selves inhabit “a zone of annihilation characterized by solitude, in which events and affects are absolutely present and absolutely absent” (Grand, 2000) with which no Other can ever fully empathize. I believe that we can approach this particular “zone” only by opening ourselves up to the patient’s traumatic affect, which grabs onto our deepest vulnerabilities and shakes us to the core.
The analyst’s personal, temporary traumatization within the dyad can let the patient know not only that she “gets” the trauma but also that she believes it and experiences it as real (S. Cuzillo, personal communication, 2007)—not necessarily the particulars but the affective big picture of it. This, for the traumatized patient, is the essence of validation—and why, conversely, if the patient lacks the experience of an Other joining her in her trauma, she remains vulnerable to plunging into painful states of doubting that the trauma “really happened.”

After joining with Lillian in the dream field, I became momentarily overwhelmed by her/my dissociated affect but was still somehow able to let her know that I had understood at a deep, visceral level something about her trauma. Lillian was apparently then able, unconsciously, to find her experience in my experience, her knowing in my knowing so that she could “ac-knowledge” what she knew. Certain dissociative barriers became more permeable. Moreover, our having come together in the dream field created a joint internal mental space that allowed us to continue to reflect upon her early trauma. As her traumatic memories became further articulated and validated, she became more and more able to feel them as, in her words, “something that really happened.” The dream, which she had “hated” and called “icky,” could now be called “horrifying” as it became more deeply felt. Over time, Lillian’s dreams in general came to be held as deeply valued communications from herself.

As Lillian’s traumatic memories continued to take form and be reflected upon, she felt less and less internal pressure to enter into and to bring her traumatized child states into the consulting room. She also felt, significantly, more often like the agent rather than the victim of the events of her life. In retrospect, I could see that the dissociative communications that had passed between us had helped move Lillian along a spectrum of disowned-to-owned agency (Annie Sweetnam, 2007, personal communication)—from “it’s happening to you” to “it’s happening to both of us” to “it’s happening to me” as she inched toward a future, possible “I make it happen.”

II. Transforming Dissociative Structure: “Waking Up”

Alongside the accessing, formulating, and validating of traumatic experience, there is, in the treatment of dissociative patients, the intertwined and equally (if not more) difficult task of transforming dissociative mental structure—a process that also requires the deep involvement of the analyst on unconscious as well as conscious levels and often the use of dreams.

When our ongoing treatment of a trauma survivor is “working,” there will come a time when dissociative structure begins to loosen and dissociative defenses begin to fail. There develops a “crisis” in the treatment—a time when the patient feels precariously poised on the edge of a precipice and suddenly, desperately, needs not only our help but our very being to sustain her. It is these moments that can make or break a treatment.

As I suggested earlier, such a dissociative mental structure has developed in response to trauma that is ongoing and pervasive; it sequesters certain unbearable states of mind, and it provides a proactive but painfully overactive “early warning system” (Bromberg, 2006) for potential trauma, causing the patient to respond to stimuli even slightly reminiscent of the original, overwhelming events as if they were about to happen again. Bromberg (2006) wrote,

What was formerly a fluid and creative dialectic between self-states through the normal process of dissociation is slowly replaced by a rigid Balkanization of the various aspects of self. The process of dissociation has now become enslaved to a dissociative structure that takes as its highest priority the pres-
ervation of self-continuity through turning the act of living into an ongoing reminder that trauma is always waiting around the next corner and that it will be more than the mind can handle. Self-states that were formerly parts of an overarching configuration … become sequestered islands of “truth.” … Past trauma is not allowed to enter narrative memory as an authentic part of the past; it is transmuted into affective and body memories in the form of experiences that are beyond relational self-regulation and that shape the present and the future in a way that plunders life of both genuine safety and of spontaneity. (p. 5)

A dissociative structure also works in conjunction with omnipotent defenses to regulate relatedness to others. By vertically splitting off relational needs which may threaten the mental stability of the other (Kohut, 1971), the dissociative patient attempts to stay enough in relationship with the (painfully depriving or abusive) human environment to survive the present while keeping the needs for more intimate relatedness sequestered but alive (Sands, 1994).

During successful treatment, when dissociatively omnipotent defenses begin to fall away, the patient will feel desperately defenseless and raw and will need to somehow “find” and engage the “unconscious analyst” —often through dreams—to obtain the kind of containing and sustaining connection she needs to endure this harrowing process. The analyst will then need to temporarily surround and shore up the patient’s collapsing dissociative scaffolding with her own more flexible yet structuring responsiveness. If the patient can feel truly held in this way, her dissociative structure can begin to loosen up, and she can slowly, tentatively “wake up” and “come alive.”

Case illustration. When she came in to see me, 35-year-old Carla had been struggling since adolescence with severe anorexia, rising above 87 pounds only a few times when she was hospitalized for her eating disorder. I have come to understand anorexia as one of the most severe dissociative disorders, because it operates so pervasively and incessantly in the patient’s life that neither traumatic memory nor genuine desire can penetrate its symptomatology. Carla and her husband, Clark, had had little affectionate—much less sexual contact for years. With me, Carla was depressed, brittle, and taciturn. Progress was painfully slow, but, during the first 6 months, she was able to talk sporadically about the states of dread that prevailed in her childhood home because of her father’s terrible betrayals. About 9 months into our work, Carla got into a dangerously weakened state, and we both swung into action. With intensified treatment and the help of other professionals, she very, very slowly began to gain weight, for the very first time without hospitalization, until reaching the mid-90s. At this point, her anxieties became almost insurmountable, as her past traumas as well as the usual anxieties of adult life began suddenly to bear down on her without her strict anorexic regimen to help her dissociate her fears. During this period, Carla brought in a dream, a very short one, which, notably, was also her first dream of the treatment.

I am getting into a car, an old car of mine, like from my family growing up, and I was driving, but I couldn’t open my eyes. Somebody was with me, maybe a dog, maybe a person, I don’t know. I am struggling and struggling to get my eyes open, and then I wake up.

When I ask for her associations, she says rather factually yet softly, “Well, some animals are born with their eyes closed.” I am first stunned by her association to birth, rather than death, and then without warning that thing happens again. I feel something go “into” me, and I feel shivery and teary, soft and vulnerable, and then, the next moment, intensely maternal and protective. The room shimmers with light. I say, “Newborn … and not yet equipped for a dangerous world.” She nods, and after a brief silence, says something even more surprising, “I was lying in bed this morn-
ing with Clark,” she says, “and all I wanted was for him to hold me.” I am dumbstruck, having never heard anything like this from her before. I tell her how important it is that she let herself feel that longing. She says, “It’s been years since I’ve wanted that.” In the sessions following this interaction, there is a noticeable change in her demeanor. She is more present and slightly more lively and forthcoming, and there is more color in her cheeks. She begins to speak, in one way or another, almost exclusively about her desire for, and painful anxieties about, having more human connection.

Carla’s dream and associations contain many of the metaphors that emerge in treatment as dissociative barriers begin to become more permeable: images of birth, opening one’s eyes, waking up, coming out of a cocoon, coming alive. These experiences of psychic birth are accompanied by intense anxiety, as the patient feels thrust into the world as a kind of newborn—raw, wet, vulnerable, and unequipped for the challenges and responsibilities of adult life. With the relaxing of dissociative structure comes the terrifying task of encountering dissociated dependency and desire with all of the attendant risks of being hurt, shamed, disappointed, or otherwise retraumatized if the patient dares to rely again on another human being. These relational needs have, in the case of the anorexic, been dissociated, then displaced to and concretized in the body, where they are brutally subjugated by means of food restriction and overexercise, and/or they have been “detoured” into the obsessional relationship with food (Sands, 2003). The brutal anorexic regimen also plunders the body for experiences of pseudovitality to counteract inner feelings of deadness (Goldberg, 2004). During treatment, therefore, the patient’s renounced desire must be somehow “de-somaticized”—that is, lifted out of the body and into the relational mind of the analytic dyad with food (Sands, 2003). The brutal anorexic regimen also plundered the body for experiences of pseudovitality to counteract inner feelings of deadness (Goldberg, 2004). During treatment, therefore, the patient’s renounced desire must be somehow “de-somaticized”—that is, lifted out of the body and into the relational mind of the analytic dyad where it can be felt and reflected upon. The patient’s shy revelation of her hidden yearnings is frightening and disorganizing in the extreme and marked by the greatest heroism. Indeed, it is the recrudescence of relational needs and fantasies that accounts for so much of the tumultuous nature of the treatment of trauma survivors (Sands, 1994).

During such periods of “waking up” from dissociation—as with the accessing of trauma—the patient must often “come after” the analyst to get the kind of holding and containment she needs to withstand the earthquakes of major psychic change. Such “coming after” is often done most effectively through dreams, which are called up by the analytic process itself. These dreams, which so eloquently capture and communicate the patient’s anxieties about “coming alive,” must be understood as bids for interactive regulation (Beebe & Lachmann, 2002) at a time when the patient’s usual dissociative, self-regulatory strategies are losing their potency. The patient’s “cries,” like those of an actual newborn infant, reach and activate the analyst’s own dissociated states of vulnerability and helplessness, evoking the deep resonance of shared dissociative-unconscious experience. Then, moments later, the containing and self-object functions of the mother/analyst kick-in. Our response to the patient’s acute vulnerability becomes intensely maternal and protective, rooted no doubt, in part, in the biological imperative to preserve newborn life. We take on an archaic selfobject function (Kohut, 1977)—that of restoring or consolidating the patient’s organization of self-experience. We are taken in as supporting, regulating, containing, soothing, organizing and structuring—even as part of the patient’s fragile emerging self. During these precarious therapeutic moments, the patient cannot stand alone. At the same time, the emotional and visceral force of our response to the patient’s dream work amplifies the patient’s affectivity and helps mobilize in real time an actual experience of intersubjective aliveness, which in itself can be mutative. The intensity of our responsiveness also signals that we understand the momentousness and deep psychological and spiritual
significance of what is transpiring during this profound moment in the patients’ healing process.

As I was sitting with Carla during this “birth” process, I was reminded of a remarkable dream from another patient emerging from her particular experience of death-in-life:

It was about a baby, then a child, who everyone thought was dead. The child is sewn together with thread. The arms are stitched to the body, and the fingers are stitched together, and it was put in a white cardboard box and placed on a shelf in a closed room. But then someone decided the baby was not dead, and the box was opened. The child’s skin has petrified and turned brown. I am working and working to clip the threads that hold its fingers together. I can feel someone else with me as I work. I’m getting more and more frustrated, because my scissors are not small enough to get at all the stitches, but somehow it doesn’t matter because the child is being released and coming alive. The last thing I remember is the child—she’s alive but still awkward—tottering down a hallway.

CONCLUSION

From a broader perspective, I have been grappling with the question of how one human being can ever “reach” another human being who has been plunged by overwhelming life experience into a traumatic zone of unbearable absence and aloneness. I have suggested that the severely dissociative patient will rely in part on the unique power of dreams to “seek and find” the dissociative unconscious mind of the analyst and to activate the kind of transformative analytic process needed to withstand the terror of recovering and integrating traumatic experience and the almost-unbearable anxiety of emerging from the dissociative membrane into life.

REFERENCES

CONTRIBUTOR

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