Dreams: Commentary of Paper by Hazel Ipp

Steven J. Ellman, Ph.D.

It is somewhat awkward to admit that, although I have spent a reasonable amount of my career involved in dream research (Ellman and Ambrobus, 1991), I have never written a clinical paper on dreams. This undoubtedly has to do with a conflict that is a constant background presence in my clinical work—whether I am interested in the dream or the dreamer. In other words, is my interest in dreams moving the patient to dream in particular ways to satisfy the demand characteristics of my analytic stance? Of course, Freud faced this question when he hypothesized that dreams were the royal road to the unconscious. Subsequent clinical experience led him to realize that royal roads were rapidly proving to be dead ends in Europe and in psychoanalysis. It was his intellectual discovery of the importance of transference (and, implicitly, countertransference) that influenced him to abandon his reliance on dream interpretation and state that, although he did not doubt the importance of the dream, he realized that to rely fully on dream interpretation will put a clinician “into conflict with the most immediate aims of the treatment” (Freud, 1911, quoted in Ellman, 1991, p. 110).

Theoretical Statement

In this brief theoretical statement, I feel I have to separate to some extent my views on the function of the dream and how the dream is used in the clinical situation. It is my view that the dream represents a person’s attempts to deal with issues of survival that usually (perhaps always) involve issues of pleasure and unpleasantness or pleasure—unpleasantness pathways. The self in some manner is always represented in the dream, and, as the infant develops, its self and objects are also represented. My views on dream formation are closely linked to a theory of the function of rapid eye movement (REM) sleep (Ellman and Weinstein, 1991; Ellman, 1992; Ellman and Catesky, in preparation). In this theory, REM is thought to (some may say has been shown to) activate pleasure through intracranial self-stimulation (ICSS), stimulation of pathways or neural networks that are intimately tied to basic behavioral functioning. In the rat (to pick a species with a good deal in common with humans), what I have called basic behaviors might include nest building, food seeking, courtship, and, most fundamentally, aggression. Whenever a mammal goes into REM sleep, the ICSS or pleasure pathways are activated and in turn are a factor in regulating these behavioral areas. The memories associated with these areas are also stimulated. In humans, activation of these areas frequently (virtually always) activates memory systems that involve conflict, and most typically the dream or the mentation present in REM sleep contains material about issues that are most important at the time and/or most threatening to the individual. Under optimal circumstances, the dream provides some way of resolving the conflict, and the dream is forgotten. If the dream is particularly stimulating or anxiety provoking (painful) in some way, the dream is more likely to be remembered. In traumatic dreams, the dreamer cannot envision a pain-free resolution. These dreams involve issues perceived as continuously threatening, and no resolution is seen as possible. I have stressed the survival nature of dream mentation, but I should point out that, in optimal or good enough development, the first dream is hypothesized to be a memory of a satisfying event. Why is it important to repeat a satisfying event during REM sleep? The infant in this state envisions satisfaction of a need state that is important to its survival, and this memory is in turn consolidated. In good enough development,

1 These areas of the brain are where the animal will work to receive stimulation. The assumption is that the animal finds the stimulation pleasurable.

2 The demand characteristics of analysis change the function of remembering dreams. Dreams are often remembered for the sake of the analysis or the analyst. Conversely, at certain stages of the treatment, dreams are forgotten that might ordinarily be recalled.

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the dream state is seen as adaptive rather than regressive. To fully discuss the issues that I have implicitly raised would go beyond the present discussion, but I should state that I have tried to revise Freud's (1900) ideas of primary process and have tried to point out that the first images of the infant are adaptive and self-enhancing, thus moving the infant to adaptive attachment behaviors. It is my view that Freud's view of the ontogeny of primary process is a bio-psychological impossibility; how could an organism that survives begin life by turning away from reality with a hallucinated wish? From my perspective, REM sleep is designed to facilitate a mutually gratifying interplay between infant and mother. Even if Winnicott is correct in his view of absolute dependence (a view similar to Freud's), there will of necessity be conflict early on in the infant's life. No matter how dedicated the parent, optimal gratification will not always take place, and to some extent even the healthiest of infants will experience what Winnicott (1958) called "falling to pieces" or annihilation anxiety. Thus, registration of perceived survival issues will enter the infant's dreamworld early in life. The issues that are brought up in REM sleep mention are survival issues that from my perspective, usually (virtually always) involve an element of the body-self represented in the dream. If one wants to see this as a wish, then it is important to recognize the adaptive function of wishes. This is a clinical stance that I would take in terms of most issues; before I interpret, I want to be able to experience why the person felt that this conflicted solution was the only possibility open at some point in life or developmental history for that person.

In my view, this emendation of Freud's ideas addresses a logical difficulty in Freud's views on drive development or what I have called endogenous stimulation. To finish this theoretical summary in this conceptualization, REM sleep is one form of endogenous stimulation. In addition, the same mechanisms that caused REM to be activated every 70 to 90 minutes during sleep are also activated during waking hours. This endogenous rhythm tends to periodically activate mammals.  

3 These issues are not always brought up in a painful manner; the infant may dream of successfully eliciting gratifying experiences. Nevertheless, this success at some level is perceived as necessary for well-being to continue.

4 In my theoretical world, I have returned to an earlier Freud, the Freud who referred to the self as opposed to the ego. It is a historical mistake to think that Freud ever completely abandoned the concept of self for the concept of ego.

As I have stated this theory in more complete form, I will move on to the main topic—dreams in the clinical situation.

**Dreams in the Clinical Situation**

Having stated a biologically based theory, now I will undo this formulation to some extent. It is my view that humans are extremely flexible organisms and that it is rarely if ever the case that biology is destiny. Rather, biology is one influence on an individual's functioning, and the dream in the clinical situation has to be seen as one more way for the patient to communicate with the analyst. Under optimal clinical conditions, the dream not only will bring up issues about what is presently in conflict but will be a key to the person's life experiences that have continued to be in conflict. In the treatment situation, the dream frequently (virtually always) has important transference—countertransference implications. To be more precise, I would say theoretically that it always contains important transference—countertransference implications, but these implications are not always usable in the treatment situation. How then do I view dreams in the clinical situation? In many ways, it depends on when the dream is reported in the treatment. Frequently, in the early stages of treatment, a dream is the easiest way a patient has to relate important feelings and thoughts without completely owning these feelings. The dream is viewed as coming from "outside influences," despite the fact that the patient usually knows that the dream is hers. Later on in a treatment, what is of primary interest to me is how the dream is used in the treatment situation. As in my view the dream always contains transference—countertransference elements, later in the treatment a crucial question is how the transference is responded to in the patient's associations to the dream. As important is the countertransference that is stimulated in a form that is usable by the analyst. Is the occasion of a dream report a way to combine early memories with the ongoing

5 It is interesting that, despite a reasonable amount of laboratory evidence about the meaning of dreams, Crick and Mitchison's (cited in Ellman & Weinstein, 1991) model of dreams as random events gains a considerable amount of currency even though they cite little or no data for their assertions.

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transference, or is it a way to separate these memories from the transference—countertransference sequence? In other words, is the
dream loved as a creation, or can it be used as a reclaimed aspect of the self? If taken as part of the self, the dream not only will include the ongoing transference but will lead to the inclusion of new elements of the defended or vulnerable self. I have stated only two dichotomized ways of viewing the dream, but obviously there are many other possibilities (as many as there are for any other aspect of the treatment), and one frequent occurrence is of the dream as a statement of the position of analyst and patient in the treatment.

To explicate my view of the dream more concretely I point to a patient's dream recently reported by Ogden (1997):

An old man was sitting in his study reading. It was like your office, but it wasn't actually your office. It was dark and had a dank, seedy feeling to it. People were peering through the window at him. I was one of them. It was terribly important to be perfectly still so as not to be caught. I was afraid I would pee. He seemed like a depressed, dirty old man. I thought he was only pretending to read or forcing himself to read. I also had the feeling that he was trying to turn himself on sexually by reading, but it wasn't working. I'm not sure if I thought this in the dream or as I was waking up, but it felt as if he knew how badly I needed to pee [p. 79].

Ogden (1997) reports that, after this dream, he realizes that the patient “must have been watching me watch her” (p. 81). He is embarrassed by her observing that he was looking at the labels of her clothing. After a time, he realizes that he felt that his “immaturity (and voyeurism) had been unmasked” (p. 82). In the continuing exploration of the dream, Ogden and the patient come to realize that the “old man (simultaneously representing me, the patient's internal world and the analytic relationship) was depressed and lonely, going through the motions of reading or perhaps attempting to escape his (her) depression by means of solitary empty sexual excitement” (p. 83).

In this dream and in the subsequent exploration of the dream transference–countertransference elements are raised (and partially enacted). Once these elements are brought into the analytic space, there is a further exploration of the patient's internal world and her psychic reality and history. This dream occurred because both participants were ready to receive it (obviously in different ways), and it could be brought into the treatment because what I have called analytic trust had been established. The patient trusted that the analyst would not be destructive when she brought up the previous enactments that had occurred. Ogden in turn was not overwhelmed by his shame but was able to use it to help understand the continuing transference–countertransference that was now being symbolized in the dream. Imagine for a moment that in this dream the patient did not say that the study was like Ogden's office but rather that she focused on how it reminded her of her father's office or of a teacher's office, which always seemed cold to her. What would the transference–countertransference sequence following the dream then look like?

I use this simple example to point out that transference–countertransference sequences are frequently overlooked. In fact, it is, in my opinion and as Freud pointed out, the most difficult aspect of the treatment. It might have been easily masked at an earlier point in the treatment by even the slight changes in the manifest dream that I have suggested. Thus, I find that I can tell where in a treatment I am by the extent to which a dream facilitates a transference-countertransference understanding of the dream material. In Ogden's example, I would assume that he and the patient are well on their way to understanding an aspect of the patient's internal world that had previously been enacted in the treatment. In the case of Barbara, Dr. Ipp's patient, I will try to keep in mind how the transference–countertransference is used in the treatment.

Barbara

In the lovely clinical vignette that Ipp has provided, Barbara is an attractive woman in her early 50s. Barbara has certainly undergone experiences that at least border on the traumatic, and it would seem to me that most clinicians would view her life circumstances as traumatic and complicated in a variety of ways. Given her past, it is interesting that Barbara “preferred the couch.” It seems as if the face of the therapist did not enhance her experience of the treatment. Rather, Barbara felt freed by the couch, where she did not have to consider the therapist's expressions or considerations of the therapist in any realistic mode. Ipp tells us that the

earlier dreams [unreported] were highly constricted, monothematic, terse, and dominated by themes of “moving from dark house to dark house,” attended by feelings of despair and helplessness.... Gradually, with her growing tolerance of
our evolving relationship, her dreams yielded a new dimension.... Now the homes were light, airy, spacious, posited in sunlight and in settings surrounded by water. Feelings of hope and possibility stirred.

Turning to the the first dream, Ipp tells us that, during the period before the dream, Barbara was talking about “mother issues” and was worried that she was freezing “powerful feelings over time, feelings centered on issues of spontaneity, sexuality, and vitality that were too painful to hold in awareness or too shameful to give expression to.”

**Dream 1**

This dream is interesting in that Barbara is active in several ways; she and her husband Dan are at the club dancing around the fountain. She also cooks dinner for her friends, Sarah and Jacques. Jacques announces that the fish is frozen in the middle, and Barbara is embarrassed. She wants to take it from him and “nuck it.” She stands wanting to disappear—“like I often felt when I was a child.”

Barbara’s associations included sexual allusions in which she dances around the fountain with her former husband (Mark) and other men (males). She remembered another dream in which Mark dances around the fountain and leaves with one of her friends.

Barbara linked the fish with Dan’s Catholicism. We find out that Dan is religious. We also learn that, like Barbara, Jacques is very wealthy and an excellent cook. Sarah is not wealthy and could be “left high and dry by Jacques.” Barbara expressed that, partly due to her and Sarah’s difference in wealth, Sarah is tough on her and Barbara can’t level with Sarah.

Barbara responded to the analyst’s inquiry by recalling her hospitalizations which involved difficult, frightening, and, I assume, humiliating experiences. The theme of freezing and unfreezing led Barbara back to feelings that she had with Dan’s hospitalization for depression. This in turn led her to think about experiences with both Mark and her father. None of these memories came as a surprise to her, but all or at least many seemed to be moving for her. Thus, as we

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move to the second dream, we can say that there seems to be a good working relationship between patient and therapist.

However, before we go to the second dream, we might wonder about the intervention—or interpretation, if you prefer—that marked the unfolding of the associations following the first dream. Glover (1931) would of course have been troubled by what must be characterized as an inexact interpretation. I, however, feel that Ipp’s lack of specificity was just right for this stage of the treatment. One might have speculated that, in the dream, Barbara was trying to get rid of Dan and Sarah, two “poor” people, and was feeling terribly guilty and ashamed. The frozen white fish that she thought of nuking might indeed relate to the inhibitions symbolized by Dan’s Catholicism. It was also a way to defend against her wish to display her talents and her wish to seduce Jacques. These inhibitions (based on early guilt) were strong enough to leave her wanting to be invisible—a feeling she traced back to childhood. Yet we also see in the dream a theme of her dancing at the club with Dan and in her associations with Mark, and other men as well. Of course, Dan and Sarah don’t quite fit at this wealthy club, but she and Jacques clearly are at home with wealth.

One could go on with this fantasy, but suffice it to say that Ipp was wise not to indulge in this type of fantasy, for Barbara was trying to find a home for her feelings and thoughts, and, up to that point in time, there had been no place where she could continue to thaw out.

Do I believe my fantasy? Well, yes and no. If I really was to completely fantasize about this situation, I would wonder about the aggression tied to her nuking the fish, and I would assume that not only did she worry that Sarah would be left high and dry, but she wished to see this happen. My main concern, however, involves the position of Ipp in this dream. My assumption is that she is somewhere near Sarah and that, in the treatment, she and Barbara wanted to move away from the transference-countertransference sequences as quickly as possible. I suspect that that was a good idea, for undoubtedly at this point in treatment there were several split-off versions of Ipp that needed to be consolidated before what I have called analytic trust (Ellman, 1991, 1997; Ellman and Moskovitz, 1998) could be established. In conclusion, we can say that this dream allowed Barbara to express humiliating feelings and thoughts to Ipp. My view is that both parties in the treatment did not want to look at each other’s face but needed to deflect the other’s gaze outward. Again, I would repeat that, with a traumatized patient like Barbara, it is a good idea to allow her to thaw out.

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One can say that, although theoretically one might have assumed there was a good deal of material expressed in the first dream, Barbara’s associations led to no new understandings. Rather, they led to a dramatic and meaningful consolidation of a process that had been under way for a while. Ipp did not join Sarah and criticize Barbara for having a variety of “extravagant” thoughts and feelings. An interpretation at this point in the treatment, in my view, would have seemed like a criticism of Barbara.

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Dream 2

In the second dream, Mark appears directly. He is on a plush train traveling with Barbara. His mother asks why they are traveling together. Barbara replies, “It doesn’t matter.” In Cologne, Mark departs but leaves luggage on the train with her; when Barbara sees him returning, it turns out to be Dan. She is shocked, and woke up shouting, “I don’t believe it!” After Barbara explored the differences between Mark and Dan—Mark was “egotistical, exploitive, detached, and shaming and discounting of her”—Barbara and Ipp likened Mark not only to Barbara’s father but also to her sexually abusive brother [Dennis]. With both, she was left feeling shamed, ‘dirtyed,’ used, afraid of sex. With Dan, sex always felt “good, free, and mutually satisfying.” Ipp reports that she “explored Barbara’s potential disappointment at this transformation” of Mark into Dan, but Barbara “denied being disappointed and claimed instead that the transformation represented her fear that Dan could become Mark or someone like Mark—which would start the whole abuse—rejection cycle again.” Ipp tries again and says, if only the two husbands could be merged. However, Barbara seemingly leaves this theme and goes on to her mother.

Barbara’s mother “always debase[d] her for being attractive and interested in men.” When Barbara joined Alcoholics Anonymous, she “moved into a world that differentiated her from her mother for the first time.” During that period, she started enjoying sex; she started an “unfreezing of important ‘life juices.’” A few months before her mother’s death, she withdrew sexually and didn’t want to be touched. She stopped cooking for Dan. Her mother hated cooking and sex. Ipp interprets that withdrawing from both sex and cooking “represented a mother identification that embodied the unconscious fantasy of holding onto this connection in the face of the imminent loss of her mother.” This is, of course, an interesting idea, but what does it have to do with the dream? Ipp does not tell us how she views the relationship of Barbara’s mother to the dream—or to Mark’s appearance and Barbara’s seeming disappointment that Mark turned into Dan. What of this disappointment? Barbara denies that she was disappointed when she woke up shouting, “I don’t believe it!” But here I must admit that the form of the write-up leaves me outside what I would consider analytic understanding.

I don’t know how Barbara’s associations actually were structured, and for me that is a crucial element. When Ipp writes that “further associations took Barbara back to her mother,” I am not sure how this happened. How did the transition take place? Did the transition represent mostly a defensive process? And so on. I would also ask what or whom Mark’s mother represented in the dream. Now, as the treatment is progressing, I am becoming more concerned about the state of the transference. Ipp has not mentioned the transference, and, seemingly from her viewpoint, transference material is not represented in either of the first two dreams. Again, one could fantasize an interpretation, but here it seems more important to point out several elements of the therapeutic process.

The first I have already mentioned—transference material is not available, and, at this point, one would have to guess as to the state of transference. Perhaps we can infer something from a fantasy about the nature of the therapeutic interaction. It seems that Ipp is still walking on eggshells with Barbara. When Barbara denies that Ipp’s intervention is correct, there is no ambiguity that I can detect—Barbara sees the issue one way only. The capacity for multiple perspectives is not yet emotively present in Barbara. Thus, what I can conclude from the dream is that Barbara is horrified that aspects of her disassociated (split) versions of Mark are coming together. She in a far distant manner is beginning to recognize the appeal of a sadistic relationship, and she can’t believe it. She doesn’t want to believe it, and, when Ipp tentatively begins to explore the possibility that Mark has a certain kind of appeal, she rejects this possibility entirely and sees the relationship only in terms of her receiving unwanted abuse—this despite the fact that she represses Mark’s mother in the dream that it doesn’t matter that they are together again. I would assume that the mother questioning the relationship is Ipp and that Barbara, even in the dream, wants to silence the questioner.

Barbara, however, can tolerate talking about her mother and about how, despite the fact that her mother had not been an ideal mother, she still wanted to hold onto her (part of the split transference?). Barbara developed somatic symptoms after her mother’s death, and

both her difficulties with her neck and her hives were traced back to her relationship with her mother. Her symptoms cleared up, and she averted surgery, which, in Ipp’s words “validated her profound faith in the analysis.” During the period just before and after her mother’s death, Barbara withdrew from Dan sexually and stopped cooking for him. After recognizing her attachment to her mother, Barbara’s symptoms abated, and her relationship with Dan improved. How are we to understand this dramatic improvement? Again, to attempt to answer this question without analytic material, we would have to present our fantasies about the patient’s internal world. What we can say is that there are no indications that the patient is aware of any of her active negative fantasies about her mother, and

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there is no hint of negative transference toward Ipp. Now, if one believes as I do that all symptoms are compromise formations, it is difficult to understand the compromise formation in Barbara's symptoms. Does she have no unconscious hostility toward her mother? Is it possible that her passive, unsuccessful husband in some way represents her mother, whom she is afraid to touch? Is her dream a move toward possessing what her mother could never fully control—an active, sadistic male similar to her father? Are there elements of regression toward this sadistic object to control her sadistic wishes toward her mother? Are her symptoms in part the result of a defensive struggle to control her destructive wishes toward her mother? Who knows, but in my view the only way we eventually can know is if the conditions are developed for the unfolding of an interpretable transference relationship. This has not happened during the period that surrounds the second dream.

**Dream 3**

In the introduction to the third dream, Ipp relates that Barbara became aware of her mother's positive attributes: “Interspersed with memories of anger and hurt were warm recollections of her mother's indomitable style and courage in her forthrightness.” These seem to be important memories, but one must distinguish memories from unconscious phantasy or the dynamic unconscious. My assumptions about the dynamic unconscious are that there are active fantasies that are induced at the time of conflict or trauma and that are reworked under the sway of subsequent events. (This is what Freud, 1918, meant by Nachtraglichkeit and what Lacan [in Laplanche and Pontalis, 1973] and Laplanche, 1976, have called *apres coup.*) These types of fantasies are not addressed in any of the material that led up to the third dream. Consequently, Barbara's memories of her mother's positive attributes are mirrored by and isomorphic to her view of Ipp's strengths and caring attitude. I will look at the third and last dream in somewhat more detail.

The dream starts off in an idyllic setting. Friends and family are floating on mats down a beautiful river. The dream “had a feel of some of our better times when we were young.” Barbara, uncomfortable, is on a mat with her mother. Notice the juxtaposition in content: Barbara stated that the river is beautiful and that the dream reminds her of better times, but suddenly she was uncomfortable.) “I was on a mat with my mother…. I couldn't stretch my legs or find my own position. I didn't feel angry with my mother. (Here is what I would consider to be at least a negation, if not a denial. The material that follows could have occurred without her mentioning that she didn't feel angry, but she has the need to insert it.)

I just felt that I had to do something different. My mother was quite distant but pleasant. She was a younger version of herself … not the frail self of her last few years. I felt a need to break away and find my own independence but in a gentle way this time. I looked around and saw you floating on your own mat—separate from the group. You smiled at me. It felt reassuring. I found my own mat and continued to float down the river alongside my mother … together, but separate. It felt very peaceful.

In her discussion of the dream, Barbara was excited and felt glad that she could be symbolically close to her mother, could be liberated “from her brothers' financial and emotional control of her,” and could feel safer in her dependency on Ipp. She felt that Ipp would not “shoot her down,” and she trusted that Ipp's “pleasure [in Barbara's accomplishments] would not yield to a destructive envy.”

If one is to comment on the dream, one would again say that it is a reassuring dream for both patient and therapist. There is no expression of conflict in the associations to the dream, and nothing is discovered that goes far beyond the manifest content of the dream. Ipp is reassuring in the dream, and she is seen as reassuring in waking life. As we are told, Barbara is more reconciled to the memory of her mother and now sadly wishes that she had a mother who could have been more enabling and directly caring. This is now expressed “with a quiet sadness rather than with the raw and intensely painful affect that had earlier punctuated her accounts of her deprivations.” Her dream images of her mother are also expressed in this quiet way as they glide down the river. The dream, although affirming relationships, has not led to any place that is not present in the manifest content.

In my reading, the dream had an excited quality, and Barbara was excited about its symbolic aspects, which for her had a liberating quality. I have to remind myself and the reader that Barbara had grown up with two alcoholic parents, had been sexually abused as an adolescent, had been married to an abusive husband, and was currently married to a man hospitalized for depression. In addition, one of the things that I think we can safely say about offspring of alcoholics is that they have either a tendency toward alcoholism or a religious fervor that rails against the evils of alcoholism. Thus, it is not surprising that one should either identify
with a parent who is otherwise unavailable or hate the malady that destroyed one's parents. None of this is apparent in the treatment of Barbara. What is apparent is what she tells us—that her reliance on Ipp has allowed her to feel "more alive than I ever have."

Barbara's exuberance seems well earned, and Ipp has certainly been instrumental in helping her come alive. Throughout my commentary, however, I have noted that the dream material did not take this analytic pair into uncharted territory. Rather the dreams seem to mark certain progress that they had made and to confirm the importance of memories and affect states that had already been explored. In my opinion, there were (and I believe there always are) new elements in the dreams, but these elements went largely unexplored. It seems to me that this happened because Ipp and Barbara were engaged in a more important task—establishment of what I have called analytic trust (Ellman, 1991, 1997). Here the analyst shows the patient—through empathic resonance, containment and the ability to synthesize conscious and preconscious states—that it is safe to allow the analyst to enter the patient's world. With patients who have had traumatic pasts, establishment of trust frequently does not allow for interpretations to be a large factor in the initial phases of the treatment and does not

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6 When I talk about the dreams, it should be clear that I am talking not simply about the reported dream but about the dream and what the analytic dyad is able to discover from it.

7 Of course, this is a silly distinction, as the field is always a two-person field in analysis. The difference is in the focus of the field.

allow for a true two-person field. In the initial phases of treatment, the focus typically is on the expression and interpenetration of the patient's painful states. Interpenetration allows the analyst to feel and communicate the absorption of the patient's states. The patient is not interested in and frequently is not emotionally able to entertain another's view, particularly if that view is in conflict with some of the patient's entrenched defenses.

My view, as I conclude this truncated version of the concept of analytic trust, is that it is best to consider analytic treatment in terms of transference cycles. During each cycle, there is to some extent a reestablishment of analytic trust. With some patients, this may happen seamlessly; with patients who use splitting and projective identification as a main defensive position, establishment of analytic trust frequently is a significant event in several of the transference cycles, and, at times, this is bewildering to analysts and patients alike.

Returning to Barbara, I would say that she is in the final part of the opening phase of treatment. This may sound like a strange statement, but it is my belief that the opening phase is often the longest and most important phase of the treatment with traumatized patients. Ipp has entered her world, and I would expect that, in the future, Barbara will be able to self-reflect in a way that will allow her to transform the other into another. Thus, conflictual elements in her dream productions will not have to be expelled, negated, or rationalized but rather accepted as part of the self. When this occurs, it will be important for Ipp to translate the transference-countertransference sequences into material that Barbara can utilize.

References

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