Dreams as Subject of Psychoanalytical Treatment Research

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An overview on the various functions of dreams distinguishes six functions of dreams:

1. Dream as by-product of the biological phenomen of sleep,
2. adaptive functions
3. creative functions,
4. defensive functions,
5. “negative functionen” f.e. in the repetition of a trauma in a nightmare and
6. socalled „demand functions “ f.e. dreams during a therapy.

(Strunz 1989).

This paper will focus on the last of the six functions and shall by providing three empirical illustrations point to to the rather meager attention given to dream reports in treatment research. When we speak about dreams in psychoanalytic therapy, we tend to think of a specific dream; rarely enough it is considered that the repeated communication of dreams belongs to the core features especially of psychoanalyic therapies. How else could one understand that an expert panel of North-American psychoanalysts places this feature on rank one of a list of features that discriminates as „analytic prototype“ from other prototypes of other therapies (Ablon & Jones 2005).

Rank Ordering of Q-Items by Factor Scores on Ideal Psychoanalytical Process Factor. 8 of the 20 most characteristic items of an ideal psychoanalytical treatment.

PQS	Item description	Factor score
90	P’s dreams or fantasies are discussed.	1,71
93	A is neutral.	1,57
36	A points out P’s use of defensive manoeuvres (e.g., undoing, denial).	1,53
100	A draws connections between the therapeutic relationship and other relationships.	1,47
6	A is sensitive to the P’s feelings, attuned to P; empathic.	1,46
67	A interprets warded-off or unconscious wishes, feelings, or ideas.	1,43
18	A conveys a sense of nonjudgmental acceptance.	1,38
32	P achieves a new understanding or insight.	1,32

cit. Ablon & Jones (2005)

From the psychoanalytic literature of the middle of the last century I want to remind you of two documents that illustrated the usefulness of systematic studying of complete dream series. The one document is Alexander Mitscherlich´s book on „The origin of addiction“ (1947) where the author tried to convey „what the patient was able to communicate about her unconscious atttitude expectation, shortly about her psychic contents “ (cit. Mitscherlich, GW vol 1, 1983, p. 285). From his third case he provided a complete list of all 103 dreams in the appendix. The other document – also widely forgotten – is Thomas French´s three volume opus „The Integration of Behavior“ (1952, 1954, 1958). As introduction to the second volume he wrote: „In this volume we shall try to show that every dream has also a logical structure and that the logical structures of different dreams of the same person are interrelated, that they are all parts of a single intercommunicating system“ (French 1954, S. V).
Let me mention one more example from the beginnings of psychoanalytic dream-related treatment research. The founder of cognitive therapy Aaron Beck, at that time still psychoanalytically orientated, reported with his colleague Hurvich (1959) about the psychological correlates of depression. They investigated the frequency "masochistic" dream contents based on a sample of patients from private practices. Looking back later Beck motivated with the findings from this study his moving away from psychoanalysis.

I shall now report on three studies on dreams that I could perform collaborating of a number of colleagues.

Study I Patient´s Dreams and the Theory of the Therapist[1]

A often repeated opinion within clinical quarters is the critical statement, that patients dream correspond to the theory of their therapists. If at all some kind of proof could be based on the famous study of Hall and Domhoff (1968) that compared Freuds and Jung´s own dreams with the content-analytic system developed by Hall und van de Castle (1968). My doctoral student Christoph Fischer and me, decided to examine this issue (Fischer 1978; Fischer & Kächele 2009).
Based on the Hall/Domhoff study and on Klugers (1975) study we constructed content-based expectations which we called , Freud or Jung syndromes’ like:

In the Freudian series, as compared with the Jungian:
(1) more intensive affective contents
(2) more sexual fantasies and manifest sexual contents
(3) more active conflicts between the dreamer and his environment.

In the Jungian series, as compared with the Freudian:
(4) more regressive situations and contents oriented to the past, or familiar from mythology
(5) more irrational situations and contents, far removed from the dreamer's everyday, common world of experience
(6) more contents dealing with nature and its description.

To analyze the dream materials we trained students of a school of documentation to

[1] Based on Fischer & Kächele (2009)

identify reliablly the defining features.

We assumed that this "different-content dreaming" would be noticeable in the opening phase of treatments with both Jungian and Freudian patients. During this opening phase, we expected Jungian patients to emphasize archetypal and mythological dreams, which, in the sense of the compensatory function of dreaming, would indicate underdeveloped personality characteristics and thus point to final aspects of the treatment. In this phase, the Freudian patient would primarily actualize his repressed sexual and aggressive conflicts and open to his analyst the "royal road" to his unconscious.

We hypothesized that, toward the end of the treatment, both the actual conflict situation and the analyst's expectations of the patient would change so that the dreams would display less unresolved archetypal or drive content. Both Freudian and Jungian dreamers would have gained independence and thus would dream more independently and "self-assertively" toward the end of the therapy. We thus assumed that in the later phase the dreams of Jungian and Freudian patients would be more alike than they had been at the beginning of the analysis.

Thirty dreams from each of eight patients - four in Freudian therapy and four in Jungian therapy - were compared both in terms of kinds of content and in terms of changes over time. The patients were matched in diagnosis, age, sex, and social background.

In the first third of the dream series, Freudian patients dreamt more "Freud-syndrome" dreams, and Jungian patients dreamt more "Jung-syndrome" dreams, producing a significant difference. In the last third the difference was no longer statistically significant. These findings support the hypotheses that the theoretical orientation of the therapist exercises an initial influence on the dreams of the patient, and that this influence diminishes as the treatment progresses and the patient becomes more independent from the therapist.

Study II Relationship Patterns in Dreams[2]

The study group of Lester Luborsky reported ten years ago that in reported dreams and relationship narratives the most frequent components of the CCRT-method agree, as well in terms of content as in terms of the valence of the reaction components; both in dreams and in the narratives negative reactions prevail. In view of these authors this confirms that there is a core relationship pattern, which is expressed in dreams as in relationship episodes likewise (Popp et al., 1998).
To check this claim we studied the 330session long psychoanalytic therapy of the 27year old patient Franziska X[3], who had received the diagnosis "Anxiety hysteria with obsessional, phobic features".
Franziska X suffered from intense bouts of anxiety attacks that were tied to situations where she had to display her professional competence. Her training as a lawyer had been very successful and she could expect to start a good career, if she could get over these anxieties. With her husband whom she had met during studies times she

[2] Albani et al. (2001)
[3] See Thomä & Kächele (1994) chap. 2.2.2

enjoyed a satisfying psychological and social relationship where sexual demands did not play a major role.
Her development was complicated as Franziska X in the age of six was confronted with the sequelae of mother´s eclampsia in the context of giving birth to a younger sister. Franziska remembers only a mother unable to talk in a clear way. The father had to take of care of the children, but she always was afraid of him.
We were able to analyze one third of all the sessions, there were 113 transcribed sessions spread out evenly across the whole treatment. We identified 57 dreams in which 21 relationship episodes were located.

In the dreams we found positive reactions of the subject (SO) above chance, yet in the immediate relationship episodes after a dream more negative above chance. The same was true also for the reactions of the object (RO) that in the dreams the positive reactions dominate, although this could not be statistically secured.
The wishes in dreams and in the narratives are widely congruent; however anticipated reactions on the object and the subject diverge clearly. In her dreams the patient is connected to friendly objects, feels respected which is in clear contrast the to frustrating reaction expressed in her relationship narratives.
Sexual wishes dominate most of the dream episodes and she dreams of the fulfilment of these wishes. In the relationship episodes after a dream sexual wishes are more infrequent. So this study contradicts the claim by Luborskys group. The expectations towards other significant others clearly are at variance between dreams and narratives. In her narratives the patient feels rejected.

We also noted that in the majority of the relationship episodes excerpted from dreams or narratives "men" are the prevailing partner of interactions (z.B. doctors, "boys", music teacher); among the the analyst most frequently. In her dreams the husband does not show up at all. There are few very relationship episodes with the father; the patient talks a lot about him, and clearly the father is an important object but the episodes were often imcomplete and thus could not be used the the formal evaluation. It seemed to us that the "object father" was a relevant topic but not the relationship to the father. We found very few relationship episodes about the mother which demonstrated the psychological absence of the mother figure; only late in the treatment the relationship to the mother became a salient topic; as the treatment was interrupted prematurely due to external circumstances the study was not able to observe change in this pattern to the mother. Our findings confirm that that “salient aspect of dream and dreaming resides in der modeling of affectiv-object related references“ as Ilka von Zeppelin and Ulrich Moser have pointed pointed out (1987, p.122).

Summarizing the findings of the study we can say that the differences between dream episodes and narratives do not result from different topics. As well in dream episodes as in the first narratives after a dream the topics are congruent, but the organizing relationship patterns are quite divergent. These findings do not corrobate the claims by Popp et al. (1998). The core relationship patterns in dreams and narratives do not correspond in this case. In the dreams of the patient positive expectations towards objects and the self prevail. This means the the patient reverts her frustrating experiences in her dreams. In her narratives and her dream reports the patient presents her relationship experiences in the frame with the interaction with her analyst displaying quite substantial qualitatve differences. This could mean

that the manifest dream content is therapeutically relevant. It represents her internalized, conscious near relationship experience. Therefore narratives about daily experiences and dream reports may have a diagnostic and a communicative function as Mark Kanzer (1955) already pointed out.

Study III Dream Series Analysis as a Measure of Processl[4]

This study explores the issue how the development over the course of treatment can be portrayed by the study of dreams? Particularly for the long-term treatments, what kind of models do we have to map the process? In our work in the long-term processes we have seen different courses for different variables (Kächele & Thomä 1993); however we assume that a linear trend model for changes in basic cognitive functioning is the most plausible.

To test this assumption we need data covering the course of the analysis from beginning to the end phases of a treatment. By using a single case design we might find out which of the descriptors are most likely to follow the linear trend model. The study following up an earlier study by Leuzinger-Bohleber (1989) on cognitive changes that had studied the begin and end phases of the treatment utilized the total dream materials that we could identify in the transcribed sessions of the psychoanalytic treatment of patient Amalia X[5].

At the time when we performed this study we had a large number of transcribed sessions: out of 517 recorded sessions 218 had been transcribed for various studies. In these sessions a student rater (M.E.) identified all dreams. A total of 93 dream reports were identified with some sessions containing multiple dreams; so the total number of dreams used in this replication study was 111.

The Reliability Study:
Three raters — two of them medical students (M.E. and M.B.) and one of them a psychoanalytically experienced clinical psychologist with more than ten years of clinical experience (L.T) — were intensively trained to understand Clippinger's and Moser's models of cognitive processes. In several pre-tests they were acquainted with the kind of material to be rated. The training was very time-consuming; the inter-rater-reliability achieved was quite impressive: The three raters jointly judged 1/3 of all identified dream reports (N = 38 out of 111 in 93 sessions):

Item B2.1, B2.2, C4:	Kappa 0.82 - 0.89
Item A1, A2, C1, C3:	Kappa 0.90 - 1.0
Item A3.1, A3.2, B1, C2:	Kappa 0.47 - 1.0

It is noteworthy that 84% of all values are beyond 0.7

Guided by principles of U.Moser´s dream theory and detaied by Leuzinger-Bohler´s study the study focused on the various aspects of dream content which will be commented upon now:

[4] based on Leuzinger-Bohleber (1989) for theory and hypotheses; data analysis based on Kächele, Eberhardt & Leuzinger-Bohleber 1999 and Kächele & Leuzinger-Bohler (2009)

[5] See Thomä & Kächele (1994) chap. 2.4.2

Expressed Relationships

A1. How does the dreamer appear in the dream action?

Most frequently during the whole course of the treatment the dreamer is actively involved in the action. This is more surprising since the patient came with a depressive basic mood to analysis.

A2. Do dream partners occur in the dream?

Again the patient is heavily involved with more than one partner all the time. A clinician might "see" in the data a slight increase of dyadic relationship, probably reflecting the patient's gain in intimate relationships of which one is the relationship with the analyst.

A3.1. What kind of relationship occurs between dreamer and dream partner?

Statistically there are more loving, friendly, respectful relationships and less neutral relationships. We see this as a shift to the development of more pronounced positive qualities in relationships.

To summarize the findings we use a graphical illustration to make our point that the overall impression of these items, along the course of the analysis, allows quite straight forward conclusions. There is less dramatic change and more stability as the findings from an earlier study comparing beginning and end sessions only had suggested:

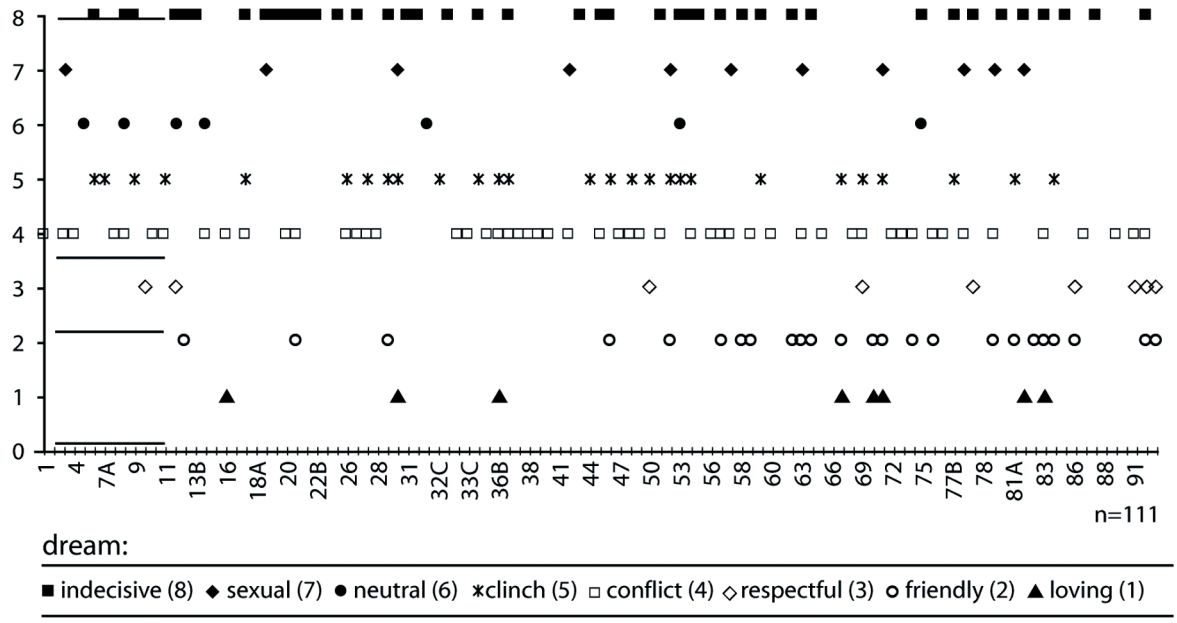

Figure: What kind of relations do you find between the dreamer and the dream partner in the manifest dream content?

Dream Atmosphere

B.1.1 Does the dreamer comment about the atmosphere of her dreams more often?

No obvious change.

B1.2 If yes, how does she comment?

The findings are presented as a ratio of neutral-positive in relation to the total amount of sentences where she comments about the atmosphere in the dream:

Phase / Sessions	Dreams	Sentences with neutral-positive to total	Percentage
I 1- 99	1-18	1/11	9%
II 100-199	19-34	3/14	21%
III 200-299	35-54	5/16	31%
IV 300-399	55-70	6/08	75%
V 400-517	71-111	6/10	60%

Table: Atmosphere in the dreams

There is a definite increase in the second half of the analysis of neutral-positive comments in regard to the dream atmosphere. From our clinical knowledge we find this is in good correspondence to the development of her personal life.

B2.1 How do you judge the atmosphere of the manifest dream?

By Spearman rank correlations of time and bipolar adjective list we find rather impressive systematic changes in time in some of the bipolar adjectives like pleasurable / non-pleasurable (-0.56), euphoric / depressive (-0.64), harmonic / disharmonic (-0.42), hopeful / resigned (-0.70), happy / sad (-0.58), easygoing / painful (-0.61), peaceful / dangerous (-0,52), happy / desperate (-0.68); all of these correlations are below <0.001 p value.

By Spearman rank correlations we also find rather impressive systematic changes with time in some of the unipolar adjectives such as anxiety ridden (-0.43), neutral (-0.26). However, aggressive atmosphere remained the same shifting from very low to very high level along the treatment.

By factor analytic technique[6] we identified a strong general factor that demonstrated the development of dream atmosphere over the course of treatment from negative to positive.

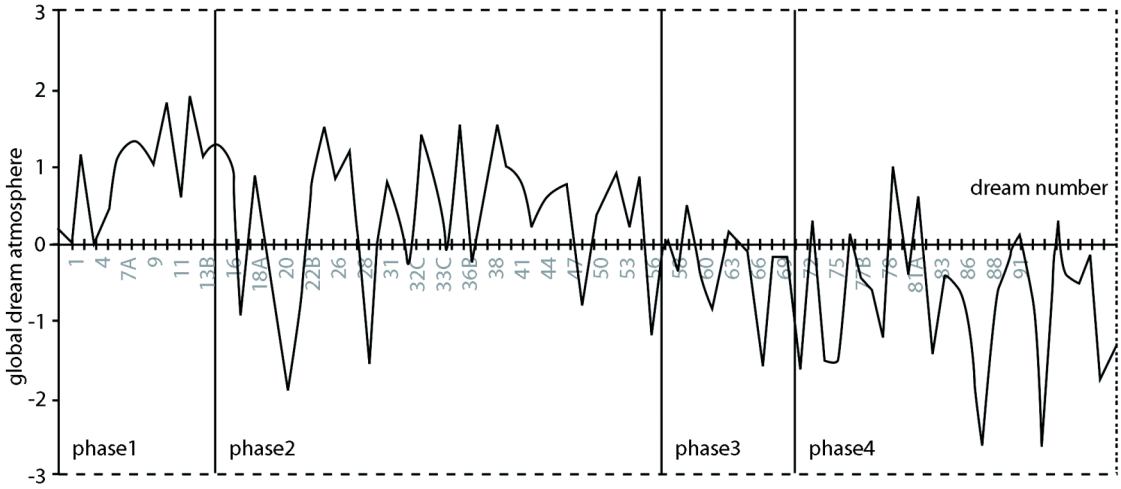

Figure Global dream atmosphere: General factor: negative (high) versus positive (low) emotions.

[6]We acknowledge the help of Dr. Pokorny

Keeping in mind the diverse findings on the level of single items an orthogonal varimax rotation was performed. The outcome of this operation pointed to two components. The factor “negative me” using Dahl’s system of classification of emotions (Dahl et al. 1992) incorporates the self emotion states and displays a decreasing trend from whereas the factor “negative it” assembles the aggressive and anxious states that are object-oriented showing an up-and down across treatment.

Problem solving

C1 Are there one or more problem solving strategies?

One or two problem solving strategies are equally distributed across the treatment. There is no substantial change.

C2 Is the problem solving successful?

The percentage of successful problem solving strategies is increasing and the unsuccessful strategies are decreasing; furthermore partially successful solutions tend to be increasing.

C3. What problem solving strategies do you find?

The patient throughout the analysis is actively seeking solutions of problems; there is a slight increase in deferred actions. A clinician might be surprised by this result.

C4. Are the problem solving strategies reflected upon?

There is a powerful increase of the reflection upon these strategies continuously taking place over the course of the analysis. This finding is well represented in a graphical representation (Fig. 5.9). The changes occur in a continuous non-dramatic fashion along the continuum of treatment.

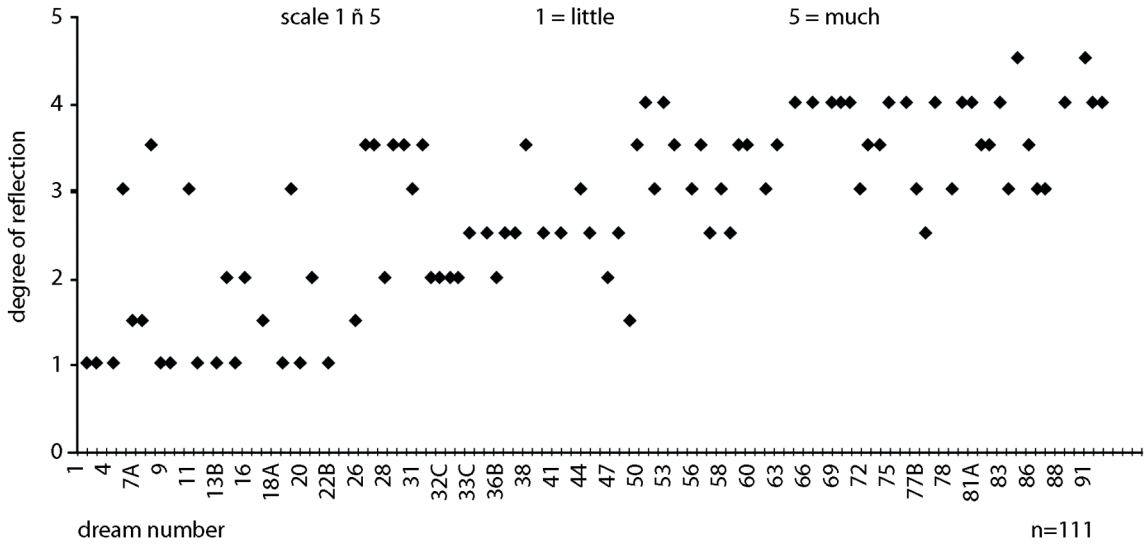

Figure Reflection of problem solving

The overall hypothesis of this study focused on the issue whether the changes can be modelled as linear trends or whether other, non-linear models, are necessary. Here the findings are very unequivocal: either we find stationary processes with variations in intensity (such as in aggressive or anxious feelings) or the changes incline or declines that are patterned along the time axis in a linear fashion.

Some surprises in the findings have to do with the patient's particular capacities that she already brought to the treatment. From the start she brought the capacity to actively organize relationship patterns in her dreams; however the change occurred in the quality of these relationships: they became more friendly and caring.
The impressive findings concern the systematic change in dream atmosphere along the time axis: "negative me" emotions decreased, but "negative it" emotions display a stable variability. Another impressive finding is the systematic tendency for the capacity to shift from unsuccessful to successful problem strategies along the analysis.

Our conclusion is that the process of change in psychoanalysis in basic psychological capacities – insofar as they are represented by the capacity to organize a dream space - , take place all along the way. If the textual material dreams are made of is considered a valid extract from the patient psychic life, than this study has demonstrated the following:

a) psychic change does occur
b) psychic change mainly takes place in linear trend
c) Relationship, atmosphere and problem solving in dreams are valuable dimensions of capturing a patient's psychic change process.

I have tried to illustrate with three studies that formal research on dream reports can be a useful tool to investigate certain phenomena which usually escape clinicians´ attention whose curiosity is more often directed to the single dream which make clinically perfect sense. The function of formalized treatment research thus occupies a different space from the clinical work and has another task.

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