Sleep, Dreams, and Dreaming –
From Experimental Dream Research to Clinical Dream Research

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In the wake of the 2oth century, in November 1899 Sigmund Freud, the founder of psychoanalysis, convinced his publisher to date his book “The Interpretation of Dreams” as appeared in 1900. It is fair to state that this book became a centennial publication as it tackled the old issue how to understand dreams by providing the clinical notion that by interpreting a dream one achieves at the same time explaining the nature of dreaming.

The interpretation of dreams has been the most popular area of psychoanalytic theory and technique. The analyst's interpretations of dreams are as dependent on his conception of the function of dreaming as they are on his theory of the genesis of the dream and on the modification of the dream up to the moment of the manifest dream report. Which dreams a patient remembers, the way in which he relates them, and the point at which he relates them in the particular session and in the framework of the analysis as a whole are all factors contributing to the interpretation.

First I shall outline the recent important findings of experimental dream research as they show that interpreting dreams appears more problematic than before.

Experimental Dream Research

The discovery of the phenomenon of Rapid Eye Movements (REM) in babies sleep by Aserinsky and Kleitman in 1953 questioned the up to then prevailing dominant psychoanalytic way of looking at dreaming and dreams and open the field of experimental dream research. What Freud could not know was that everybody goes through different sleep phases and moves into the REM phases four to five times per night.

During these REM phases sleep researcher identified the occurence of dreaming activity with very vivid imagery. But only one third of people report dreams memories in their daily life. These vivid dreams with a action story line make up two to three hours per night; this means that a 75 year old person has spent six to seven years of life life a dreaming mentation.

Today it is more sensible to speak of dreaming as a process imstead of using the term ‚dream’. Dreaming describes a dynamic process that appears in various shapes. Mental psychic activity takes place throughout the process of sleeping; it is still true memories of dreamlike sequences have been found indeed more often after waking in the REM phases whereas waking in non-REM phases generates more rational memories..

Hobson & McCarley (1977) published a famous paper on the activation-synthesis hypothesis that dominated for a long time the academic discssion. This publication

shapes the general notion prevailing in the seventies of the last century: dreaming is only the outgrowth of the brain to make sense out of senseless sensations. Freud´s view seemed to be outdated.

Today leading dream researchers like Mark Solms (2000) prefer to speak of two processes, REM-sleep and dream activity, that do have a correlative relation but do not have a causal relationship . So the more recent research speaks of two processes that are controlled of different brain mechanisms; dreaming is organized by frontal brain structures that represent complex instinctual motivational connections. The neuroscientist Panksepp (1998) postulated a biological seeking-system driving these processes.

An exciting hypothesis has been put forward by Weinstein & Ellman (2012). They connect REM-sleep and dreaming with attachment experience and drive reduction. Following Freud´s ideas they speak of an endogenous stimulation activated by the REM sleep that would explain the vivid nature of the dreams in the REM phases. They point out that deprivation of REM-sleep leads to a REM-rebound effects as if there is a need for a certain amount of REM sleep necessary for survival. Dreaming in their view has an adaptive function.

This fairly new topic in dream research has to do with the role of the neuro-hormone oxytocin. The same brain regions that are involved in attachment-relevant situations, i.e. amygdala and anterior temporal and orbito-temporal cortex, have been shown to be activated during REM-sleep. Oxytocin secretion reaches a climax early in the morning around four o clock at a time when the amount of REM-sleep surpasses the NREM-sleep.

One assumes that this supports the internalization of relationship experiences. Dreaming thus contributes to adaptation of the „inner working models“ as John Bowlby called these internal representations of our relationship experiences.

It is now interesting to note that in the early development REM sleep phases are organized in the third month of life which is the time when attachment relationship are beginning to grow. Daniel Stern (1985) described this process as „representations of interactions that have been generalised“ - short hand called RIGs. These RIGs are supported by the mirroring functions of the caregivers that contain and modulate the interaction with the baby (Fonagy et al. 2002).

This developmental step signifies the begin of social relations. In this vein dreaming during the REM-sleep may be looked at continous internal stimulation for the work of internalization of experience.

The development of the capacity to dream has been the object of only a few longitudinal studies. Foulkes (1999) reported that children reach the level of adult dreaming only áround the age of 13 years. Three-to five year old children only have short memories of static dreams with little actions involved. These dreams often are populated with animals (40%) and only rarely with people (20%).

In most of these dreams there is no dream-Ego. Only in the age of 7-9 he found a dream-ego with more actions. Between the age of 11-13 the influence of social experiences becomes more present: girls dream more of their female friends, boys

more of their male companions and not surprising more of aggressive actions.

Freud's view that dream is the guardian of sleep must now be regarded as disproved; on the contrary, sleep is the guardian of dream. This is one of the fundamental conclusions which must be drawn from the many psychobiological investigations of dream and sleep.

Dreaming, the mental activity of the psyche during the sleep is much more encompassing as Freud and the following generations of psychoanalysts have assumed. In order to devise an adaequate psychoanalytic theory of dreaming one has to respect the findings of the recent dream-sleep research.

One of the first fact is to accept that there is no such thing as the dream; dreams have many shapes and configurations, they have different features. Today it is useful to distinguish between different types of dreams f.e. dreams from REM-phases, NREM dreams, sleeping in dreams, night terrors dreams, lucid dreans, wet dreams, day dreams.

In most of the dreams visual components dominate (60%) but also acoustic phenomena or body sensations appear. Never or rarely never (1%) smell or taste sensation appear. Also thought processes appear that are more frequent than emotions. If they are reported most of the times the exhibit the same qualities as in waking life. The most frequent affect in dreams with normal people is joy followed by anger and anxiety.

Day residues are regarded as the main features of the manifest dream. More than 70% of the subjects, objects and sceneries that appear in dreams can be connected to event oft he last week. Furthermore most dreams of healthy people are more likely to be banal dealing with daily life aspects are are not- in contrast to what many people think, loaded with sexual or agressive content (Strauch & Meier 2004).

Another salient finding is the socalled Wake Dream Continuity (Revonsuo 2000). What has been salient during the day, and has not been resolved, most likely will appear in the dreams in the following nights. Other researchers like Hobson (1998) stress the alternative hypothesis, the so-called complementary hypothesis. They focus on the loss of logical thinking pointing out a specific reduction of frontal brain activity in in dreaming.

Dreams by no means are ready made products. After waking up the process of dreaming is not finished. Dreams are continously worked over and changed. What is told during psychotherapeutic sessions are selective products that sometimes have little in common what was dreamed during the nights. When a dream is told a second time it may become obvious that changes have been made. Some parts are left out, other are added to it.

The person to whom a dream is told seems to play an important role in this process. This feature is important to understand this reporting of dreams in a psychoanalytic session. Often dream reports are fitting into the onging therapeutic relationship (Kächele & Deserno 2009). Therefore the working with dreams in sessions can be understood as part of the dream process itself.

So today dream is regarded as a multifunctional activity. Freuds main thesis that dreams have a wish fulfilling task is only one of many functions. Consolidation of memory, problem solving, affect regulation, coping with stress and conflict solution are all functions of the dream process.

Now comes the second part.

Clinical Dream Research

After Freud, clinical work concerning dreams was regarded as routine and the amount of clinical publications about dreams and dream analysis progressively decreased. Questions relating to the meaning of transfer and countertransference became the focus of interest. Dream lost its status as the royal road toward the unconscious. However, in the following decades to this day, important advances in psychoanalytical dream theory have been developed.

Erik H. Erikson (1954) made an important step toward the rehabilitation of the manifest dream content in his paper “The Dream Specimen of Psychoanalysis” in which he carefully analyzed Freud’s Irma dream. In his multi-stage schemata, concerning dream interpretation, are Freud’s known initial approaches of free thoughts or the symbolic interpretation of manifest dream contents; however, Erikson describes, at the same time, a systematic examination of manifest dream contents in light of place, time, person, affects, channels of perception, etc.

Dream contents are connected via present conflicts and day residues as well as the relationship with the therapist. This is described in connection between dream and transfer toward inner psychological conflicts and the tasks of life and development concerning the respective life-span of the dreamers. Erikson paves the way for the appreciation of dream contents, the evaluation of relationship capacities, and the inner conflict condition of the individual.

Formal dream content analyses show (compare Domhoff, 1995) that one can work fairly close with the systematic analysis of components and processes in the manifest dream and assess how the subject experiences and evaluates oneself in the world and toward other persons in the dream.

The emphasis of the manifest dream and the focus on the subjective realm of living in the way it presents itself in the dream as well as the attachment con-stellations, designed in the dream, characterize the progression of psychoanalytical dream theory and dream interpretation. For psychoanalytic work with dreams, the connection of dream and transmission are important. In this case, the relationship that the dreamer has to his dreams is formulated anew ..

Dream and Transference

For the psychoanalytic work with dreams the connection between dream ad transference became a ‘leitmotif’! This line of clinical dream research was initiated by Lewin (1948), and was continued by Gill (1966/1982) and Morgenthaler (1986). They insisted specifically in connecting the analysis of transference with the analysis of dreams (Deserno 1992, 1993, 1999).

The dreaming quality of the psychoanalytic situation and the implementation of unconscious transference is underlined. Deserno (2005,) developed his ideas even further by combining different psychic realities with different symbolic modes in the psychoanalytic situation. He identifies the dream and the memory character of transference actions with different forms of symbolizations

If one concentrates on how a patient experiences dreams or current relationships to the analyst in the situation of transference and how the characteristics change in the course of treatment one can find indications for the connections of interpersonal events and intra-psychological functions. The essential idea is that the dream does not develop like a solitary, detached from daily life experience, but is closely connected with the interpersonal experiences and is sensitive in catching and depicting events that happen during psychoanalytical treatment including both transference and counter-transference.

The next step is to examine the dream concerning its interpersonal contexts. Apart from the disclosure of latent dream thoughts and repressed drives, the main point is the examination of the interpersonal inner realm of the dreamer. What are the object representations brought into dreams and how does the dreamer act accordingly?

In this approach, context and subjective meanings are generated (Stolorow and Atwood 1993), i.e. the interpretatitive work of dreams seeks themes of configuration that structure the self and the object in the recounting of the dream. Understanding of the dream's meaning takes place through conceptual elaboration of these attachment configurations. They assume that these topics are an additional possibility to be able to better understand "pre-reflective unconscious expriences that structure the subjective individual inner universe of the dreamer" (p. 216).

Dream interpretation does not happen simply because of a causal mechanical model with which dream work can be made retrogressive in order to identify the underlying wish. Instead, it concerns the occupation with current emotionally relevant problems in the life of the dreamer. However, it does not mean that the attempt for wish fulfillment via the dream does not have any significance.

Dreams are now rather understood in a broader sense and interpreted as such. Thus, other individual preferences and intentions of the dreamer appear to be relevant as well. These processes can be shown best in a particular type of dream that cannot be explained with the idea of wish fulfillment as the function of dream - anxiety dreams and nightmares.

Hartmann on Nightmares

E. Hartmann (1998, 2011) described the processes in nightmares as exemplary for all dreams. In this case, the function that plays an essential role in all dreams is most clear: contextualizing of emotions. Following a traumatic experience, for example, earthquake, fire disaster, accident, act of war, terror, torture, violence, etc., a typical sequence of dreams can be observed.

In the beginning, immediately following the traumatic experience repeated nightmares appear. This is described as "re-enactment" in the dream. Comparable to

a film, the events repeat unchanged in the dream (as if one would watch the same sequence over and again). However, the unchangeability was put into question, for example, in the case of chronic post-traumatic disorders (compare Varvin et al., 2012).

Moreover, Hartmann describes how this sequence of events changes i.e., locations or events are exchanged or persons appear suddenly and are integrated in the actions or happenings, respectively. For example, the victim of a fire disaster dreams after a while about a gigantic flood approaching. However, also this picture changes after some time and becomes in the dream a train approaching. Thus, the content of the images change to an everyday character and decreases in affect intensity. Hartmann describes this as changing contextualization as an essential function of all dreams.

A tram driver was entangled in a deadly accident, which he experiences in its sequence again in a nightmare. In the framework of therapeutic work, the dream went through changes. Finally, he was no longer driving the tram but a suspension railway high above the ground. Via this change, he could be sure to no longer run over the person in the dream (1999, p.115).

By reason of this example one can deduce that the dream has a “therapeutic function”. New contexts are found from everyday life and because of that an originally overwhelming experience, expressed in nightmares, can eventually be contextualized. In the continuing process, nightmares change more and more into common dream experiences. In a safe place, the dream creates connections, helps in decreasing highly affective conditions of experience and gives them a grip.

What appears clearly in nightmares takes place also in all other dreams. Whenever discrepancy exists or disturbing experiences, a conflict occurs, a problem must be solved, a dangerous situation develops for the ego. As long as the ego capacities are intact, one attempts to connect the problematic event in the dream with other experiences in the waking state showing less affectivity. This view, concerning dream functions, can be brought into accord with Freud or Stolorow’s psychoanalytical dream theories. Nightmares and anxiety dreams can be integrated into a more general model.

Donald Melzer´ Contribution

Donald Melzer (1984) attributes autonomous symbolic value to the dream. Through experience of early interaction with the mother, who communicates via physical contact and in rhythmic exchange with the child, the first emotional symbolizing conditions and experiences are developed. Later in a second step this process is linguistically interchanged and made describable. With this comes expansion or inclusion, respectively of the experiences and information from and with the outer world.

Melzer speaks of two differing grammars that come close to the pre-verbal and verbal self, and comes very close to, for example, Stern’s (1985) view, however, this

can also be brought into relation to the concept of primary processes and secondary processes according to Freud or to the process of mentalizing as well (compare Fonagy, Gergely, Jurist, & Target, 2002).

In the dream concept of Melzer, the secondary process in dream interpretation receives a central role. In the verbalized dream, thoughts become accessible to the meaning of the dream. In this case, a transformation - information coded by dreamwork - occurs and experiences from the early symbolized body experience from which emotional conditions and unconscious thoughts originate.

The transfer of these unconscious symbollized experiences in the symbolic discourse of the secondary process is not a translation step but a transformation of the often visual and physical representation into linguistic symbols. Thus, the reported dream is another product as the experienced dream in which the dream work seeks and finds visual-bodily representational solutions for bodily experiences and emotional states.

Ogden and Bion

As a continuation of this thought Ogden (2005) describes the ability to dream as symbolic activity that must be established in the course of development. This is not automatically the case. Ogden views the ability to dream in relation to Bion's concepts. According to Bion, alpha function serves to digest the immediate experience (beta elements) and "metabolizes" them into understandable symbols (alpha elements) such as a communicable form which can be communicated.

As a result of this process, a symbolic inner world of meaning within the individual develops. For Odgen, the ability to dream is an indication of efficient alpha function. The dream takes place in sleep (as a visual dream experience) as well as during the waking state (as unconscious process).

Dreaming is, therefore, a continuous process that is granted a particular possibility of expression during sleep. If this symbolizing process is disturbed i.e., a transformation of the immediate experiences (beta elements) into symbol carrying alpha elements is limited, it is not possible for the individual to be really asleep or awake. Ogden is concerned how far dreaming can be seen as an indicator for the specific human capacity to give unconscious psychological experience via the symbolization and mentalization of psychological meaning.

Now comes the third part
Let me report some **examples of my own research on issues of clinical relevance.**

A) 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). Freud´s dreams clearly portrayed his social insecurities as a Jew whereas Jungs dreams reflected his stabile social situation as a Swiss well established bourgeois.
My doctoral student Christoph Fischer and me, we decided to examine this issue (Fischer & Kächele 2009). We conceived typical features of Freudian dream´s based on Hall and Domhoff ´s findings and likewise typical features of Jungian dreams.

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 "Freudian" dreams, and Jungian patients dreamt more "Jungian" dreams, producing a significant difference.

However in the last third of these treatments 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´s theoretical orientation.

B) In a systematic study of the patient Amalia X´s dreams during a longer psychoanalytic treatment we coded about 111 dream reports using the Affective Dictionary Ulm (Dahl et al. 1992). Thus we could identify a systematic decrease from negative affects to positive affect in the course of the treatment (Figure 1) and a growing capacity of self-reflective commentaries in the dreamer´s associations to her dreams (Figure 2) (Kächele and Leuzinger-Bohleber 2009).

C) A 26-year-old woman, Franziska X, came for treatment because she suffered from intense attacks of anxiety, which occurred especially in situations in which she was supposed to demonstrate her professional ability. She had brilliantly completed her training in a male-dominated profession and could count on having a successful carreer if she could overcome her anxieties. The latter had developed after she had completed her training, so to speak when things became serious and the rivalry with men no longer had the playful character of her student days.
Franziska X had met her husband during her training and they were united by satisfying intellectual and emotional ties. However, she did not get much satisfaction from sexual intercourse in her marriage; it took a lot of concentration and work for her to have an orgasm, which she could have on her own much faster and simpler.
She quickly reacted to the initiation of treatment by falling in love, the first signs of which were already apparent in a dream she recalled in the fourth session. It described, first, a scene between an exhibitionistic girl at a police station and a man who was reacting sexually. The second part of the dream depicted a medical

examination in which the patient was observed by someone with X-ray eyes; only a naked skeleton was visible.

The patient's dreams contained repeated permutations of the subject of forbidden love with subsequent punishment or separation. She vacillated greatly between her desire to please me, like a schoolgirl doing her homework, and her disturbing desires, which she also mentioned in her associations.

By the eleventh hour I had already become a "really good friend," who was all her own and who also satisfied the condition that "it" could never become reality. What "it" meant was clarified by her next association, when she asked me, "Did you see the movie late night about the priest who had an affair with a woman convert?" In the fourteenth session Franziska X told me about a dream.

P: You told me that you were in love and then you kissed me, when I am in love it only goes to kissing, that's the most beautiful part, then the rest comes whether you like it or not. Then you said that we had better stop the analysis. I was satisfied with your decision because I got more this way.

The purpose of this intensive manifestation of eroticism seemed to be to fight her experience that analysis is a phase of "hard times" (17th session). Obviously she dreamt the fullfilment of her narcissistic wishes that were in sharp contrast to her real disappointing life situations.

In a systematic study we compared her narratives about relationhips in the session with her dream materials and demonstrated for this patient that daydreams and night dream were a complimentary: real life was full of frustation wheres the night life was full of gratification (Albani et al. 2001; Thomä and Kächele 1992, chap. 2) contradicting the findings of Popp et al. (1990)

Clinical Dream Work

Let me conclude that clinical work with dreams remains a controversial issue: some analysts are lovers of working with dreams, others are not. Dreams certainly are no longer the royal road to unconscious motivation, but they are one way to access these processes. Many issues have not been studied extensively, f.e. whether to face-to-face situation in most treatments nowadays impedes working with dreams.

To provide a detailed example of dream interpretation I take up the issue of self-representations in dreams.They open up a hidden dimension because of the scenic character of "dream language." Deformities of the body image then occur in an interactional context. In comparison with dream language and in contrast to the vividness of hypochondric complaints, the descriptions of imagined deformities are one dimensional.

Self-representations in dreams exhibit latent dimensions lost to conscious experiencing and absent in descriptions of symptoms except for the fixed imagined final product. The scenic context of the dream thus makes it possible for the analyst

to have insights into the genesis and meaning of disturbances that in conscious experiencing take the form of psychopathological phenomena, that is of a "damaged body image" to use a brief but appropriate expression.

Dream About an Injection

At the beginning of the 37th session Erich Y delightedly told me about his discovery of things that he had in common with his boss. He used to have many disputes with his boss; both had been "blinded by our ambition." Spontaneously and without any apparent transition the patient started telling me about a dream he had had the previous night.

"I saw a younger doctor in a hospital. I told him about my illness, and he gave me some hope. He claimed he knew something that would help. He experimented by giving me injections in my back, and while he was giving me a shot - it took a long time - I pulled away because it hurt."

He then came to speak in a vague manner of agreeable experiences, ones he might have had together with his wife. The day before, for instance, he had experienced something good at home. It had become clear to him how important mutual confirmation is. Following his longer statement there was a pause, which I interrupted by pointing out that the patient had received something good in the dream but that it had also caused pain.

The topic shifted to the patient's ambivalence to therapy. A few sessions earlier the patient had been at a loss as to what he could answer curious questioners who wanted to know what he got from analysis. The experience that he frequently had not received any concrete support from me could have led the patient in his dream to turn to a young doctor who - as I interjected - knew of a particularly good form of medication.

P: Yes, it took a long time.
A: You mean, the injection.
P: Yes, and I got uneasy. I wanted to get it over with.
A: Hum.
P: It took too long. And then I had to think again about whether it was already working.
A: Yes.
P: While he was still giving me the injection, I tried to move my head again.
A: Hum.
P: Well, it worked right away.
A: Yes, and that is where the treatment situation comes into play, with the worrisome expectation: Yes, does it help? It's taking a long time.
P: Hum.
A: I'm sitting behind you. In your dream something is happening to you from behind, isn't that right? Behind.

P: Hum. [Long pause]

The patient formed the image of a piece of granite that he himself or someone else was chiseling at. He also had, in contrast, weak impressions that he lost without being able to describe them. To me, the patient seemed a little unhappy, which he confirmed. I viewed the patient's statement that he could not hold on to anything and that he had the impression he were on a turntable as a sign of resistance. At this point the patient mentioned his dream again, including a few key words such as the sudden stop and the departure, which he then summarized.

P: There are so many things going through my mind again today. Lots of weak impressions.
A: You sound a little unhappy, as if you would change your mind too much. Or? Some place you had the feeling that you would not have liked to think it through or fantasize any further, for example as I referred to my view that you're looking for more. In the dream you're given an especially good drug. This went on for a long time, and you had the feeling that you don't want to be concerned about it any more.
P: I just had the thought, again in connection with my impatience and possibly with the dream: stay involved for long enough, don't give up early, so that there's nothing left that's only half done.

Consideration. The disappointment triggered dissatisfaction, which was suppressed. This topic was picked up in the next interpretations.

A: Hum. Yes, that's the one side, the disappointment, but your wish is still there. The wish behind it is, well, to get as much as fast as possible, isn't it?
P: Yes, yes, yes, yes.
A: This is presumably one of the wishes you had in your dream.
P: Right.
A: And as much as possible as fast as possible, and something really special . . . .
P: Hum.
A: . . . being able to get something really special.
P: Effectively. [Short pause]
A: It's a younger doctor who gives you something, younger than I am.
P: Yes, that seems to be the case.
A: Hum.

Commentary. The patient did not grasp at the offer, which was relevant to transference. The analyst realized this without commenting on it.

P: This impatience, it's true that I get impatient. Something has to happen fast. There has to be something effective, something I can grasp. Yes, and if this isn't the case, then I get impatient and would like to forget the whole thing. If I conclude everything correctly, then I have a lot more from it.

A: And then you almost force yourself by being patient, don't you? You suppress your natural striving and make an effort not to become impatient.

Commentary. By emphasizing that impatience is something natural, the analyst encouraged him to experience the aggression contained in his impatience.

P: Yes, yes, yes. I don't want to know about it.
A: Hum, hum, hum.
P: Well, when I think of it, then I have the feeling . . .
A: Hum.
P: . . . that I hope you don't drop me.
A: Hum. Yes, perhaps you're making a big effort not to be impatient because of this concern, as if you would be dropped if you got impatient once.

P: I've often had the thought that this might be my last chance, and that I probably won't have another one in my life, to see something like that. And afterwards I have the feeling of being able to make even more out of it, to take . . .
A: Hum.
P: . . . even more out of it and to be creative.
A: Hum. Yes, and perhaps the dream is related to the fact that just today you would like to take as much as you can, because there's going to be an break in treatment.

Commentary. This established the connection to the situative factors possibly precipitating the dream: the break and the distance.

P: Hum, yes, it could be.
A: To get as much as possible.
P: Hum.
A: The subject of distance is still there too, in view of today's session, because of the break.
P: Hum.
A: However, you're the one moving away, away from the injection.
P: Hum.
A: Perhaps symbolically there is a little pain portrayed, yes, somewhere it hurts that there is going to be a break, a distance. [Short pause]
P: Yes, I just had a thought. My wife has asked me a couple of times: "What are you going to do when you can't go to your doctor any more, when you're on your own again?"
A: Hum, hum.
P: [Taking in a deep breath] And I said I hadn't actually thought about it and don't want to either.
A: Yes, for now you're still here, and I am too.
P: Yes.
A: Yes, hum, hum. [Longer pause]

P: Somehow I suddenly feel so protected and have to think of puppets who get to walk around but who are really on strings, I mean who aren't free. Well, I have some room to move but there is somebody there who's leading me.
P: I'm just asking myself, well, room to move, to move, and - without being arrogant - say to myself that I can really try everything, can do everything, because I know that someone is there. [Very long pause] I have to think of this dream from last night over and over again. The doctor is standing there, and I move.
A: Hum, hum.
P: I'm in a certain place and feel my way around.
A: Hum, hum.
P: And this and that come by.
A: Hum.
P: And he stands there watching, watching me. [Breathes very deeply]
A: A while ago you thought about puppets who move, who are led by someone's hand and moved, in other words who aren't merely observed.
P: Hum.
A: That you can feel and can move and turn and move around, can't you?
P: Yes, yes.
A: Hum, yes.
P: Suddenly I have some help. I have somebody who is there. Because of my insecurity I didn't even know whether I was right or wrong. [Long pause]
A: Yes, I have to stop for today. We'll continue on Monday, the 25th.
P: Doctor, I hope you have a good time.
A: Thank you, I hope you do too. Good-bye.
P: Good-bye.

Last not least let me mention that therapists do dream about their patients. Most likely it is a sign of countertransferential involvement that calls for a supervision!

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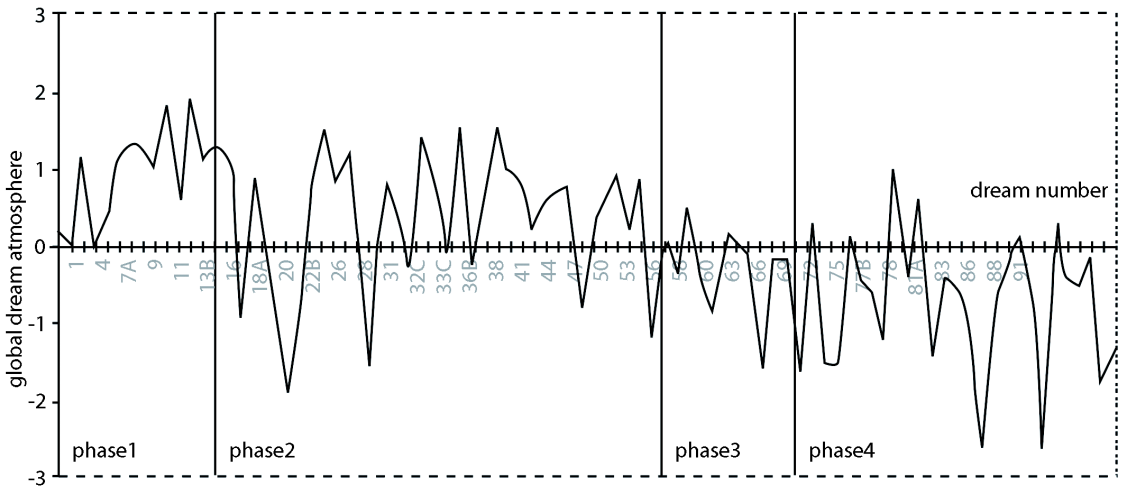
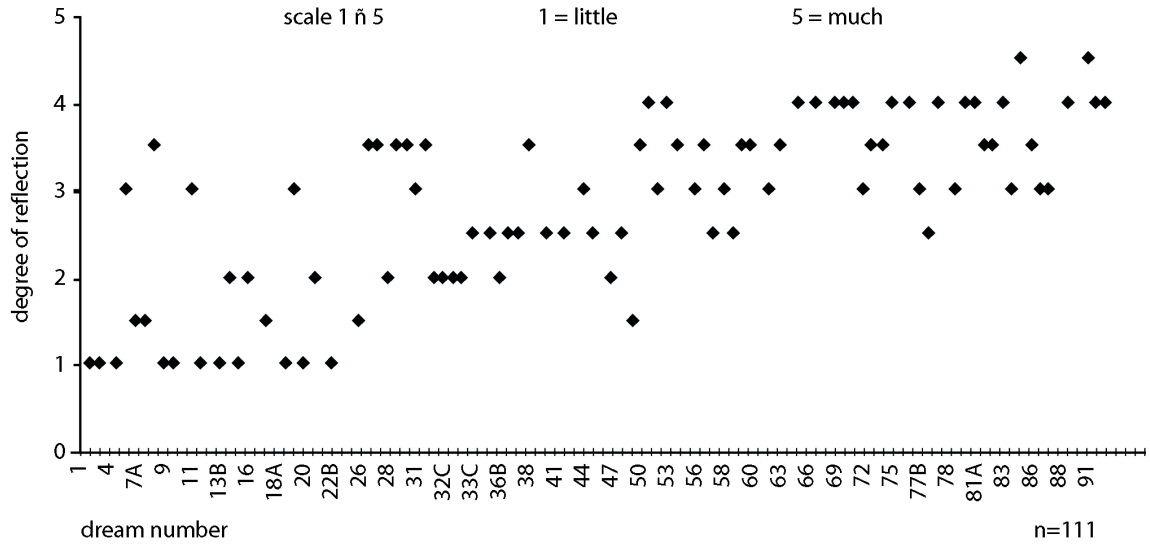

global dream atmosphere
dream number
phase1
phase2
phase3
phase4

Figure 1


scale 1 ñ 5
1 = little
5 = much
degree of reflection
0
1
2
3
4
5
1
4
7A
9
11
13B
16
18A
20
22B
26
28
31
32C
33C
36B
38
41
44
47
50
53
56
58
60
63
66
69
72
75
77B
78
81A
83
86
88
91
dream number
n=111