Seattle Psychoanalytic Society and Institute

THE PSYCHOANALYTIC STUDY OF DREAMS

Year Four Psychoanalytic Training

Instructor: Ron Furedy, M.D.

2nd Trimester 2017-18: February 23, 2018 – March 23, 2018 (5 wks.)

In this course we will explore dreaming from the perspective of different psychoanalytic models of the mind.

To keep our discussions connected to your analytic work, please bring dreams from your clinical work, which you believe illustrate the concepts in our readings and or dreams you find particularly perplexing.

Learning Objectives:

At the end of this course, associates will be able to:

1. Develop and demonstrate approaches to speaking with analysands about their dreams so that analysands become receptive and interested in exploring their dreams as another mode for understanding themselves and their experience in analysis,
2. Utilize their feelings, thoughts and the integrative capacity of their minds in response to their analysands' dreams,
3. Differentiate the conscious, preconscious and unconscious communication of an analysand's dream,
4. Recognize the bodily communication between the analyst and analysand that may be depicted in the emotional, visual imagery of the dream, and
5. Formulate and deliver interpretations of a dream in the clinical setting.

Each of these skills will serve to further and deepen the associates' analytic work, leading to increased patient retention and improved treatment outcomes.

Introduction:

1. Furedy, R. (2018) Summary of Dream Concepts **(Not on PEPWeb)**
2. Furedy, R. (2018) A Guide to Working with Dreams Analytically **(Not on PEPWeb)**

SESSION 1:

1. Freud, S. (1900). *The Interpretation of Dreams, Standard Edition,* Vol. VII, (Chapter 7): 509-631. **PEPWeb**

Dreams are initiated in the unconscious. For subjective awareness to occur, the dream must break through the repression barrier and be modified by: condensation, reversal, displacement, symbolic transformation, (Dream work) to make it acceptable for the preconscious. Secondary revision occurs upon awakening, remembering, and telling the dream as coherent images. Dreams are not logical and are timeless. They are hallucinatory satisfaction of a repressed infantile wish. Freud repeatedly emphasizes that the dream work only processes. It does not think. The manifest dream is literally a collage of sensory impressions, both recent and indifferent, made from the day residues and serving to express what fundamentally was an unconscious, infantile wish that had been stirred up by a current conflict or a preconscious worry. The dream work leads to self-deception. The mind alters ideation to keep itself from being too disturbed.

2. Solms, K., Solms, M. (2000). *Clinical Studies in Neuro-Psychoanalysis*, Karnac Books, 44-69. **(Not on PEPWeb) (OPTIONAL)**

M. Solms interviewed, using a psychoanalytic informed style, patients who had significant damage to specific areas of the brain. With damage to the inferior parietal region of either hemisphere, or the deep ventromesial frontal region, the conscious experience of dreaming stops completely. Therefore, these parts of the brain are capable of initiating the dream process.

The fact that damage in the left parietal lobe stops dreaming, demonstrates that abstraction conceptualization and symbolization are functions in the complex process of dreaming.

Loss of dreaming caused by a right inferior parietal lobe lesions leads to an inability to hold visuospatial information. Thus this region of the brain is necessary for the ability to concretely represent information in the visuospatial mode.

Damage to the ventromesial frontal region results in no dreaming and adynamia (i.e. lack of spontaneous motivational impetus). Therefore, dreams are not motivationally neutral. But, as Freud said, they are meaningful, psychological events.

Damage to the ventromesial occipital temporal region results in the experience of dreaming, but devoid of visual images, or aspects of visual images like color, faces, and movement. Visual pattern activation is lost – an essential function for what Freud called "visual representability."

Damage in the frontal limbic region leads to continual dreaming. These individuals dream excessively, but they lose the ability to distinguish between dreams and real experience—an inability to differentiate between perceptions, thoughts, memories, fantasies, and dreams. Thus the frontal limbic region performs a necessary inhibition or repression of the dreaming process.

Damage to the temporal limbic region leads to recurring stereotyped nightmares and, thus, plays a causal role in the generation of dreams. The factor of affect arousal should be added to the functional matrix of the dream process.

These observations are all compatible with the idea that, motivation (frontal lobe), affect (temporal/limbic) has an initiating role in the genesis of dreaming, as does the complex functions of the parietal lobes. During dreaming the whole process, initiated by different areas of the brain, including the pontine nuclei eventuates in the occipital area of the brain. Patterns activated in the parietal, frontal, and temporal limbic, are projected backwards onto the visual area, resulting in concrete perceptual representations. Again as Freud noted: dreaming is a complex function involving many structures of the brain, multiple functions, with dreaming living between these various functions.

Freud's technique of free association was specifically developed to reach the internal structures of functions that are obscured by resistance. Stated at a meta-psychological level—the emotional resistance conceals the internal structures of personality, motivation, and other complex cognitive/affect structures that the mind deems unacceptable.

Damage to the mesopontine tegmentum severely disrupts the process of REM sleep; but the conscious experience of dreaming persists. This suggests an unexpected dissociation of the physiologic process of REM sleep and the conscious experience of dreams.

Damage to the dorsolateral frontal areas of the brain has no effect on dreaming. This suggests that secondary process (declarative thinking) and volitional motor activity has little to do with the process of dreaming.

3. Mancia, M. (1999). Psychoanalysis and the neurosciences: a topical debate on dreams, *IJP*, 80: 1205-13. **PEPWeb (OPTIONAL)**

Dreams allow old experiences to be reconsidered in the present allowing new meaning to be assigned to past experiences.

SESSION 2:

1. Brenner, C. (1982). *The Mind in Conflict*, International University Press, pp. 180-193. **(Not on PEPWeb)**

Brenner applies the concept of conflict theory to dreams with particular emphasis on the defense mechanisms used to attenuate painful affects: anxiety, guilt, shame, and depression. The dream is a compromise formation.

2. Segal, H. (1983). The function of dreams. In Lansky, M. (Ed.), *Essential Papers on Dreams*, New York University Press, pp.239-248. **(Not on PEPWeb)**

Hana Segal organizes her understanding and interpretations of dreams and interpretation around the action between self and object representations. Affect combined with the use of projection and projective identification results in the splitting of the representation of the object. The ego may identify with this part-object representation. Symbols may be experienced as a "thing" and not symbolic (concrete thinking).

SESSION 3:

1. Molinari, E. (2008). Dreams a transitional area from the body of experience to the body. *The Italian Psychoanalytic Annual*, 2008: 157-169. **PEPWeb**

Dreams occur in a transitional space from the experience of the body to the area of thought. Dreams are shared between the analyst and analysand and are visual, affective experiences of past scenes either imagined or remembered. They can be unconscious memories of primitive sensorial experiences during analytic regression similar to a small child and its mother. The field of the preverbal, relational experience and early proto-affective traces may be in the transference and referenced in dreams.

2. Greenson, R. (1970). The exceptional position of the dream in psychoanalytic practice, *Psychoanalytic Quarterly*: 39:519-49. **PEPWeb**

Working with dreams facilitates free association through a comfort with the unconscious. The immediate visual/affective experience of dreams allows the patient to see the unconscious, thus interpretations are more readily accepted as are the disguised, hidden unconscious affects, wishes, and prohibitions.

SESSION 4:

1. Quinodoz, J.M. (1999). Dreams that turn over a page. Integration dreams with paradoxical regressive content. *IJP*, April 80 (Pt 2) (2): 225-238. **PEPWeb**

Even though disturbing images and affects are experienced in a dream, the dream may still indicate forward movement in the treatment.

2. Grennell, G. (2008). Affect integration in dreams and dreaming, *J. Amer. Psychoanalysis* 56: 223-251. **PEPWeb**

The dream provides a psychological space wherein overwhelming, contradictory or highly complex affects that, under waking conditions, are subject to dissociative splitting or disavowal may be brought together for observation by the dreaming ego. The "me/not me" quality of the dream contributes to the creation of the dream space where play, creativity, and self-analysis can develop. New self and object representations and new relational scenarios may be revealed in dreams, demonstrating the development, integrative, creative aspects of the dreaming process.

3. Grennell, G. (2002). The termination phase as seen through the lens of the dream. *J. Amer. Psychoanal* 50: 779-805. **PEPWeb (OPTIONAL)**

Dreams can reveal an analysand's readiness for termination. Dreams of graduation, funerals, people or objects separating, self-examination (capacity for self analysis) may all be preconscious reference to termination.

4. Watson, R. (1994). The clinical use of the analyst's dreams of the patient. *Contemporary Psychoanalysis* (1999), 30:510-521. **PEPWeb (OPTIONAL)**

The analyst's dream involving the patient can represent (1) neurotic conflict in the analyst; (2) a transient identification with the patient; (3) the mind of the analyst attempting to symbolize and integrate (understand) the patient; (4) a containing function of the projections from the patient with the analyst identifying with the projected disavowed parts of the analysand's mind. Also, the dream may be a representation of the current interpersonal action in the analysis.

SESSION 5:

1. Stolorow, R. Atwood, G. (1992). Dreams and the subjective world. In Lansky, M. (Ed.), *Essential Papers on Dreams*, New York University Press, pp.272-294. **(Not on PEPWeb)**

The concrete perceptual images in the dream can lead to the dreamer's feeling of conviction about the validity of past traumatic experience and the need for dissociation and disguise—perceiving is believing. The dream

affirms and solidifies the nuclear organizing structures of the dreamer's subjective life. Type 1 dream symbols are the customary creation of a neurotic mind with clear configuration of self and other. Type 2 dream symbols are more about maintaining psychological organization, restoring the vulnerable structures to prevent disintegration. At these times the analyst must be experienced as real, not as if. An empathic attunement that serves to maintain the cohesion of the self leads to the experience of the self and analyst as real. Dreams can consolidate and stabilize new structures and subjectivities of the analysand.

2. Kumin, I. (1996). The Container of Sleep. In *Pre-Object Relatedness*, New York, Gilford Press, pp. 118-132. **(Not on PEPWeb)**

If the analyst's containing function fails, dreaming may be troubled, sleep disturbed, and acting out may ensue, in order to obtain contact boundaries with containing receptacles for overwhelming affect states. The dream, instead of action, may indicate the analysand has begun to internalize a neutralizing function of the analyst. The analyst's ability to contain the analysand's overwhelming affects and use interpretation (words, thoughts, symbols) may modify the analysand's inner world and contain his affect.

3. Lansky, M. (1990). The screening function of post-traumatic nightmares. *British Journal of Psychotherapy*, Vol 6: 384-400. **(Not on PEPWeb) (OPTIONAL)**

The compulsion to repeat can be seen as a wish from the ego, originally overwhelmed, as preparing itself in both dreams and repetitive acts to replay and eventually to master overwhelming traumatic experiences. Soldiers, returning from battle, experienced dreams as though they were flashbacks – exact replays. But, on careful examination the nightmares were not exact replicas and some contained material from early family experiences. Viewing the dream as exact replicas of battlefield experience, when they clearly were not, must be seen as an aspect of the disguise function of the dream, a screen to prevent the dream from being too troubling and too connected to ongoing painful and conflicted material, past and present, embedded with guilt and shame. The rationalization that the nightmare has nothing to do with one's life experiences is used to prevent the dream experience from integration into the entire continuity of one's life, childhood, and military experience.

The nightmares clearly have a screening function to conceal from awareness infantile trauma and its residuals. Most of the patients were raised in families where marital strife, physical violence, and alcoholism were rife. The handling of intense shame and rage by placing it on the battlefield is rationalized as coming from the battlefield only and not connected to one's entire life.