Greenson, R. (1970) "The Exceptional position of the Dream in Psychoanalytic Practice" Psychoanalytic Quart, Vol. 39

life. If we hold to the position that the analyst is an impartial observer at a post equidistant to all psychic instances, then it must be assumed that he will also acknowledge and work with ego functions which include reality testing. Recognizing the technical necessity for dealing with nontransference aspects of the patient's productions reduces the danger of a defensive omnipotence and omniscience in the analyst. It leads to a rounded, human experience, divorced from mystic ritual, without losing its essential nature in the building of insight and structure.

We choose to close, however, with an urgent statement of some necessary reservations. There is always the danger of misinterpreting our position to imply overprotective acting out as a teacher, parent, or leader, misusing the "real" as a base for seductive gratifications and unnecessary support. There is no warrant for role playing or for attempting painless or cheerful psychoanalysis. Purist, orthodox analysis in the most extreme sense leaves little room for errors of commission. The principal disasters lie mainly in errors of omission. What we have suggested adds a dimension to analytic interest and concern. In some sense it suggests some blending of restrained humanitarian concern with scientific discipline. In suggesting some enlargement of the arena for analytic interest and activity, we realize that there is always the possibility of introducing new errors of judgment. This seems to us a lesser danger than a persistent neglect of what is "real" and right in our patients.

It has already been suggested that the subject of the "real" relationship might prove "subversive." Perhaps this legitimate warning has tempted us at times to state our position with a somewhat challenging and polemical force. Mainly we hope it will encourage a corresponding investment in critical and thorough discussion. The subject is too important to warrant further silence and neglect.[4]

[4] This paper was discussed at a plenary session of the 26th International Psycho-Analytical Congress, Rome, July 28, 1969. The authors' introductory and closing remarks as well as those of the discussants were published in the *International Journal of Psycho-Analysis*, 51:143-150, 1970. In a few instances I have incorporated some of our discussion remarks in this paper.

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The Exceptional Position of the Dream in Psychoanalytic Practice

(1970)

Freud considered *The Interpretation of Dreams* his major work. He wrote in the third (revised) English edition, published in 1932, "It contains, even according to my present-day judgement, the most valuable of all the discoveries it has been my good fortune to make. Insight such as this falls to one's lot but once in a lifetime" (p. xxxii). At the end of Part E in chapter 7 Freud said: *"The interpretation of dreams is the royal road to a knowledge of the unconscious activities of the mind"* (p. 608). A further indication of how important Freud considered this work to be is that he revised and amplified the book on dreams on eight different occasions, the last time in 1930 (Strachey, 1953, p. xii).[1]

The A. A. Brill Memorial Lecture, November 11, 1969. First published in *Psychoanalytic Quarterly*, 39:519-549, 1970.

I am indebted to Max Schur, Milton Wexler, Alfred Goldberg, and Nathan Leites for many of the ideas in this paper.

[1] It is fitting on the occasion of the Brill Memorial Lecture to note that the first English edition of the book was translated by A. A. Brill in 1913.

You may wonder why I chose to present a paper on the exceptional position of the dream since all this would seem to be common knowledge. A careful reading of the psychoanalytic literature in recent years, however, reveals that a number of psychoanalysts believe either that the dream has declined in clinical importance over the last forty years and is of no special value for psychoanalytic therapy or they use techniques which indicate that they have disregarded Freud's theory and methods of understanding and using the dream in clinical practice. I am also impressed that some influential psychoanalysts contend that this downgrading of the significance of the dream in clinical practice has come about because, (a) the structural theory was introduced, (b) Freud's great work on dreams has discouraged attempts at emulation or elaboration, and (c) Freud's concept of the topographic theory has become useless. These conclusions and more can be found in a monograph titled *The Place of the Dream in Clinical Psychoanalysis*, which is the result of a two-year study of dreams by the Kris Study Group under the Chairmanship of Charles Brenner, with Herbert Waldhorn (1967) serving as reporter. Most of the members of this group appear to have concluded that (1) the dream is, clinically speaking, a communication in the course of analysis similar to all others; (2) it does not provide access to material otherwise unavailable; (3) it is simply one of many types of material useful for analytic inquiry; (4) it is not particularly useful for the recovery of repressed childhood memories; (5) Freud's theory that the dream-work is governed by the interplay between the primary process and the secondary process is not compatible with the structural theory and ought to be discarded.

I disagree with every one of the conclusions stated above. I am happy to point out that I am not alone in my beliefs, for I have discovered that some members of that section of the Kris Study Group, with Leon Altman as their spokesman, opposed many of those opinions. Altman (1969) has published a book, *The Dream in Psychoanalysis*, in which he suggests other reasons for the decline in clinical use of the dream. He expressed the opinion that since the coming of the trend toward ego psychology, many analysts have not had the experience of having their own dreams properly analyzed and the lack of this type of personal experience has deprived the psychoanalyst of the conviction that the interpretation of dreams is of outstanding importance for psychoanalysis.

Besides that section of the Kris Study Group reported in *The Place of the Dream in Clinical Psychoanalysis*, there are prominent analysts of Kleinian persuasion who also work with patients' dreams in ways which are far removed from what Freud, Isakower (1938, 1954), Sharpe (1949), Lewin (1958, 1968), Erikson (1954), and a host of others have described in their writings on this subject. In this paper I shall attempt to contribute some clinical material and formulations which I hope will demonstrate how those analysts who seem to operate from divergent theoretical and technical convictions differ from analysts who believe in the exceptional position of the dream.

It is my belief, after many years of psychoanalytic therapy with private patients and candidates in psychoanalytic training, that one cannot carry out genuine analysis in sufficient depth if one does not understand the structure of dream formation *as well as the patient's and the analyst's contributions to the technique of dream interpretation.*

Some General Formulations

The dream, I believe, is a unique form of mental functioning which is produced during a special phase of sleep. This phase is unlike any other phase of the sleep cycle and differs also from the waking state. The psychophysiological research of Dement and Kleitman (1957), Charles Fisher (1965, 1966), and Ernest Hartmann (1965), among others, has made this emphatically clear. Recent research suggests the likelihood that dream deprivation may be the cause of severe emotional and mental disorders. We may well have to add to Freud's dictum that the dream is the guardian of sleep, that sleep is necessary in order to safeguard our need to dream.

The altered balance of mental forces in the dream is produced by bursts of psychic activity that seek sensory release because sleep diminishes contact with the external world and also cuts off the possibility of voluntary motor action. The dream state allows for a reduction and regression of conscious ego activities and of the censorship function of the superego. It is important to realize, however, that, in a sense, one is never fully awake nor fully asleep. These are relative and not absolute terms. Kubie (1966), Lewin (1955), and Stein (1965) have stressed the merits of keeping in mind the sleep-waking ratio in studying any kind of human behavior. This helps explain the fact that in the dream the perceiving function of the ego, being deprived of the external world during sleep, turns its energy toward internal psychic activity. Freud (1917c) wrote that when people go to sleep they undress their minds and lay aside most of their psychical acquisitions (p. 222). Lewin (1968) added that the dreamer generally sheds his body. The dream usually appears to us as a picture and is recorded only by an indefinite "psychic" eye (p. 86).

If we follow the notion of a variable sleep-waking ratio, we are immediately reminded of phenomena similar to dreams: free association, parapraxes, jokes, symptom formations, and acting out. But there are crucial differences. No production of the patient occurs so regularly and reveals so much so graphically of the unconscious forces of the mind as the dream. Dream interpretation can uncover in more immediate and convincing ways not only what is hidden, but how it is hidden, and why it is hidden. We gain special access to the interplay and the transitions between the unconscious psychic activities governed by the primary process and conscious phenomena, which follow the laws of the secondary process. The proportion between input and output, in terms of reported phenomena and obtained knowledge of unconscious material, is in no other type of psychic phenomena as favorable as it is in dreams (K. R. Eissler, personal communication).

So long as psychoanalytic therapy focuses on the resolution of neurotic conflicts in which the crucial components are unconscious, it makes no sense to consider every production of the patient of equal potential value. Affects, body language, and dreams are all, in most ways, nearer to those almost unreachable depths we search out so persistently in our analytic work. We attempt to present our findings to the patient's conscious and reasonable ego with the hope of providing him with a better understanding of his way of life and an opportunity for change.

These same points can be expressed structurally by stating that the dream reveals with unusual clarity various aspects of the id, the repressed, the unconscious ego and superego, and to a lesser degree certain conscious ego functions, particularly its observing activities. However, limiting the approach to the dream to the structural point of view is an injustice because it neglects the fact that we also have in the dream more open access to dynamic, genetic, and economic data of basic importance. Small wonder, then, that the dream experience itself, often without interpretation, leads more directly and intensely to the patient's affects and drives than any other clinical material. This makes for a sense of conviction about the reality of unconscious mental activity unequaled by any other clinical experience. This is particularly true of transference dreams.

The dream is in closer proximity to childhood memories by dint of the fact that both make use essentially of pictorial representations. Freud (1900, 1923b) and Lewin (1968) have emphasized that primitive mentation takes place in pictures and is closer to unconscious processes than verbal representation. Even after children learn to speak, their thinking is essentially dominated by pictorial representations. Things heard get turned into pictures, as we know from certain screen memories (Lewin, 1968; Helen Schur, 1966). If an event is to become a memory in early childhood, it has eventually to become concretized, a mental representation, a memory trace. Lewin states that then we search for lost memories as if they can be found somewhere. This type of memory, the recall of an objectified experience, is a step which seems to occur at the end of the first or beginning of the second year of life (Spitz, 1965; Waelder, 1937). There are more primitive "imprintings" which are derived from infantile

body and feeling states that are not capable of being remembered but which may give rise to mental images and sensations in dreams. Lewin's ideas on blank dreams and the dream screen and his discussion of related problems are especially worthy of note (1953, 1968, pp. 51-55).

To return briefly to the special importance of the psychic eye for the dreamer and the interpreter of dreams. The dream is essentially a visual experience and most adult recollections of early childhood come to us as pictures or scenes. The analyst interpreting to his patient is often working upon a fragment of historical experience which he hopes will lead to a memory. Such fragments or details may appear in dreams. When the analyst tries to fill in the gaps between single interpretations, he is making a construction, he is trying to re-create a series of interrelated forgotten experiences. Such conjectures may lead to recollections but, even if they do not, they may lead to a sense of probability or conviction that the reconstruction is correct. This may then appear in a dream as an event (Freud, 1937b). Lewin (1968) describes this as trying to re-create a story in pictures of the patient's forgotten past. By doing so we attempt to get the patient to scan his past along with us; we are engaged in conjoint looking (p. 17). The ultraclarity of some dream details also indicates that there is a special relationship between the cathexis of looking and the search for memories. This wish to see what actually took place, to be "in" on it, adds to the special sense of conviction that the correct interpretation of a dream can convey.

Ernst Kris (1956b) decried the one-sided emphasis on analyzing defenses and stressed the importance of reconstructing past historical events so that the patient could "recognize" the pictures drawn as familiar (p. 59). He believed that memory plays a central role in a circular process which, if integrated, makes it possible for the patient to reconstruct his total biographical picture, change his self representation and his perspective of the important persons in his world. In Kris's paper (1956a) on the "good analytic hour," it is remarkable how often he chose examples of hours which contained dreams and recovered memories.

The predominant elements in the psychic activities that occur in dreams are heavily weighted on the side of the id, the repressed memories, the primitive defensive mechanisms of the ego, and the infantile forms and functions of the superego. Occasionally one can observe more mature ego functions, but they are rarely dominant. All this testifies to the high degree of regression that occurs in dreaming, but as in all regressive phenomena, the quality and quantity of regression is uneven and selective in the different psychic structures and functions as Freud pointed out as early as 1917(c), Fenichel in 1945, and Arlow and Brenner in 1964. The clearest and most comprehensive description of the unevenness and selectivity of regression can be found, in my opinion, in Anna Freud's book, *Normality and Pathology in Childhood* (1965, pp. 93-107).

Free association is a similar regressive phenomenon; it is an attempt to approximate something between wakefulness and sleep. The use of the reclining position, the absence of external distractions, the patient's conscious attempt to suspend his ordinary censorship, to abandon strict logic and coherence in his communications, all attest to that. However, real spontaneous free associations are rarely achieved by most patients and are then defended against with far greater sophistication. The point I wish to make is that the dream is the freest of free associations. Slips of the tongue may quickly reveal some deep unconscious insights, but they occur rarely; insight is localized and the old defenses are very readily reinstituted. Acting out is by definition ego-syntonic to the patient and its infantile origins are strongly rationalized away and defended. By contrast, as bizarre and incomprehensible as the dream may appear, the patient recognizes the dream as his; he knows it is his own creation. Although the strange content of the dream may make it seem alien, nevertheless it is irrevocably his, like his symptoms, and he is quite willing to work on his dreams, provided his analyst has demonstrated how working together on dreams is helpful in achieving greater awareness of the patient's unknown self.

A few words before turning to some clinical examples. Freud himself recognized that *some* of his ideas subsumed under

the topographic point of view conflicted with the descriptive and dynamic attributes of unconscious mental activities and he introduced the structural point of view (1923b). This new division of the psychic apparatus into id, ego, and superego clarified the role of the conscious and unconscious ego and the conscious and unconscious superego in its conflicts with the totally unconscious id. I agree with Fenichel (1945), with Rapaport and Gill (1959) as well as with Arlow and Brenner (1964), who stress the superiority of the structural theory in affording a clearer and more logical explanation for the origin and fate of neurotic conflicts. I do not agree with Arlow and Brenner, however, that Freud's hypotheses concerning the primary process, the secondary process, and the preconscious should be discarded or that they are incompatible with the structural point of view. Even Merton Gill (1963), who believes that the topographic point of view is conceptually not on a par with the other metapsychological points of view, agrees that some topographic conceptions have an important place both clinically and theoretically. I find this to be particularly true in working with dream. It is equally important in dealing with patients who suffer from defects and deficiencies in ego formation and the parallel difficulty in building constant internal object representations, problems which go below and beyond the conflict theory of the psychoneuroses. I do not wish to dwell on theory—it is not my strong point, but those interested may turn to the writings of Hartmann (1951), Loewenstein (1954), Benjamin (1959), Eissler (1962), Max Schur (1966), Loewald (1966), Mahler (1968), and Fisher's remarks in the panel on The Psychoanalytic Theory of Thinking (1958), for a more thorough discussion of the subject.

Clinical Examples

Some clinical examples of how different analysts work with dreams illustrate the divergencies in technique and theoretical orientation. I shall begin with clinical material from the publications of psychoanalysts who work with dreams in ways that seem to me to be unproductive, wasteful, and at times even harmful.

A clinical illustration presented in *The Place of the Dream in Clinical Psychoanalysis* (Waldhorn, 1967, pp. 59-67) was that of a thirty-year-old writer in the second year of her analysis. Essentially, she seemed to be an "as if" character, exceedingly immature and dependent. There was a childhood history of social failure in competition with her younger sister because of the patient's ineptitude and gaucheness. The patient had severe acne of the face, neck, and back in adolescence and had occasional recurrent active lesions. She was also thin and flat-chested. She entered treatment because of mild depressions, poor concentration, and inability to sustain an intimate relationship with a man. The patient had several brief affairs accompanied by a dread of losing the man and was always flooded by remorse and loss of self-esteem when the affair ended. In the weeks prior to the dream reported, the patient had had sexual relations with a man named John, whom she had known only a short time. He had left town for several weeks and, in spite of knowing better from past disappointments, she found herself imagining that John loved her and they would be married. During this interval she brought in a dream:

> She began the hour as follows: "I had a very bad dream. I had cancer of the breast. A doctor, a woman, said it would have to be removed. She said that there would be aftereffects which I would feel in my neck. My friend R. had this operation. I was scared and I panicked, and wondered how I could get away, run away and not have to have this done." She continued with the following associations: "I tried to think why I should have such a dream. I thought it must be related to my idea that I am not complete by myself and that I need some sort of union with a remarkable man to make myself complete. This might be related to my worry that John was gone and maybe this was symbolized by my breast being removed. Actually, I am very frightened by

> things like that. Many people do have an obsession about such fears. For example, Paul does. Some people can face these things with great courage and strength, but not me. I am very frightened when I think about the danger of the scorpions in Mexico [she was planning a trip in a few months]" [p. 61].

The patient awoke, fell asleep, and had another dream but I shall omit it because the presenter and the group did not touch upon it. After a few innocuous associations, the analyst finally spoke and I shall quote his first remarks verbatim.

> At this point the analyst intervened, asking "about your dream. What do you associate to the business about the doctor?" The patient responded: "She was a matronly type of woman, stern. She didn't seem to feel sorry for me or anything like that, but just said what would have to be done. I was thinking, how could a man make love to me without one breast? I would be terribly self-conscious. . . ."
>
> After a pause the analyst asked: "What about the part in the dream about the neck?" She responded: "Sometimes I make a wrong movement and my neck muscles can hurt. That area is vulnerable for me because of my complexion problems involving my chin and neck, about which I have always felt so self-conscious. . . ."
>
> The analyst then added: "When you speak of self-consciousness about your skin and neck, does it remind you of the self-consciousness you have recently been describing when you told me about how terrible you felt before you had any breast development?" The patient said: "So, do you think that the fact that John did not call me made me re-experience those feelings of inadequacy? They may still be present" [p. 62].

The analyst then offered a long intellectual interpretation and the patient responded in kind.

The Study Group's discussion of this presentation included the following excerpt:

> The discussion of this report was initiated by the remarks of the analyst presenting the data. He maintained that the clinical material supported the belief that dreams can best be treated in the same way as other associations in the hours, and not necessarily accorded extraordinary or exhaustively detailed procedural attention as some would insist. Here, in the hours described, the analytic work is focussed on the problems highlighted by the repetitive life experience of the patient. . . . Accordingly, some portions of the dream can be neglected in favor of others, and a dream need have no specific attention directed to it if spontaneous associations are meager and the work with the dream (as opposed to other material) seems less likely to be rewarding. The rich amount of symbolically understandable elements in the second half of the first dream was not explored at all, but it was the analyst's clinical judgment that nothing was lost in the process [p. 64f.].

I shall limit myself to a few remarks about the patient's manifest dream, her associations, the analyst's interventions, and the group discussion. In the first dream the patient is terrified upon discovering she has a cancer of the breast. She is told this by a female doctor who warns her there will be aftereffects. The patient's associations sound to me intellectualized and a rote repetition of old interpretations given her by her male analyst. There does not seem to be any attempt on the part of the analyst to point out her intellectualization or to get to her terror of this malignant thing growing inside her. The analyst did not pursue the only spontaneous free association the patient produced, namely, her fear of scorpions in Mexico. After the patient reported the second dream and a few innocuous associations, the analyst asked: "about your dream. What do you associate to the business about the doctor?" To me, the way the question was put gives the impression the analyst is either defensive and hostile or even contemptuous, otherwise he would not use a phrase like "what about the business about the doctor." Furthermore, it is all too intellectual. Words like "what do you associate" push the

patient in the direction of intellectual compliance; not the best way to get into feelings or really free, free associations. In general, there was no sign that the therapist was trying to reach or establish contact with the patient's affects; he shows no signs of being "tuned in" on her feelings; on the contrary, he seems to play right along with her intellectualized defensiveness.

If you read the second dream, it seems to express in obvious symbolic terms the patient's envy of her sister and her aunt, but it was completely ignored. Apparently the analyst and the group did not discern any possible connections between cancer, breast, mother, and envy. There also was no apparent awareness of how frequently heterosexual promiscuity is used as a defense against helpless childhood dependency needs with the resultant urges and fears of fusing or becoming reunited with the pregenital mother. There was also no mention of a hostile transference to her male analyst or a wish to have a female analyst. The analyst and the group seemed content to maintain a highly intellectual contact with the patient, and were reluctant to open up the patient's fantasy life and follow wherever it might lead. Toward the end of this discussion in the monograph, there are a few sentences that deserve special comment.

> Such axiomatic procedures as the desirability of working with transference elements before nontransference material, or affect-laden before nonaffect-laden material, or the necessity of drawing the patient's attention to evident omissions or to an addendum, were all mentioned. The consensus was that these were best considered as tactical maneuvers, subordinated to an overall strategy of the conduct of the analysis, which would, of course, change with the progress of the treatment [p. 66f.].

In my opinion there is no place for "axiomatic procedures" in trying to do psychoanalytic therapy. It is true that some of us follow certain time-tested technical guidelines in beginning the exploration of such oft-recurring clinical constellations as may occur in associating to dreams or in free association in general. These approaches are tools for investigation. I find the concept of an "overall strategy of the conduct of the analysis" an impressive high-sounding phrase but, in reality, with our present state of knowledge, this "overall strategy" is at best loose, subject to frequent changes and revisions, and full of unknowns. Only psychoanalysts with preconceived and rigid theoretical notions are sure of an "overall strategy." And they also have prefabricated interpretations for all types of patients and disregard the fact that each individual human being is unique, as well as the fact that there is still much even the best of us do not know and cannot predict about our patients. Freud (1905a) had the humility to say that we should let the patient determine the subject matter of the hour; he attached great importance to following the patient's free associations. In 1950 Eissler severely criticized Alexander and his followers for making decisions about the definitive strategy for treatment of a case. Eissler felt that Alexander was more interested in validating his own hypotheses than in really analyzing his patients.

This leads to another type of distortion in working with dreams which can be found in the writings of some of the Kleinian analysts. Hans Thorner (1957) in studying the problem of examination anxiety illustrated his ideas by describing a patient, a dream, and his interpretations.

A man of early middle age complained of impotence and that all his love relationships came to a premature end. At times he could begin a relationship, but as soon as he felt the woman was interested in him, he had to break off. He was impotent in other spheres of life as well. Although he had reached a high standard of proficiency in music, he was unable to play in public or before his friends. It became clear that all these situations approximated an examination situation. When he applied for a new job, he was terrified of being interviewed because of what he considered to be his "black record," although realistically there was little black in his record. During one of these intervals he reported a dream which shed new light upon the nature of his black record. In the dream red spiders were crawling in and out of the patient's anus. A doctor examined him and told the patient that he was unable to see anything wrong with him. The

patient replied, "Doctor, you may not see anything, but they are there just the same." Thorner reports his interpretations to the patient as follows:

> Here the patient expresses his conviction that he harbours bad objects (red spiders) and even the doctor's opinion cannot shake this conviction. The associative link between "black record" and "red spiders" shows the anal significance of his "black record." He himself is afraid of these objects against which he, like the man in the dream, asks for help. This help must be based on a recognition of these objects and not on their denial; in other words, he should be helped to control them. It is clear that we are here dealing with a feeling of persecution by bad internal objects [p. 286].

I believe this is a prime example of interpreting the manifest content of a dream according to the analyst's theoretical convictions. The patient's associations are interpreted in a narrow preconceived way. The patient's reproach to the examining physician, "Doctor, you may not see anything, but they are there all the same," is not recognized as a hostile transference, nor is it acknowledged as a possible justifiable reproach to the analyst that he really may be missing something. I wonder if the red spiders crawling in and out of the patient's anus are not the patient's reaction to his analyst's intrusive and painful interpretations. But now I, too, am guilty of interpreting without associations.

Another example of a similar type can be found in Hanna Segal's book (1964). She describes a patient, his dream, and her interventions as follows.

> Powerful unconscious envy often lies at the root of negative therapeutic reactions and interminable treatments; one can observe this in patients who have a long history of failed previous treatments. It appeared clearly in a patient who came to analysis after many years of varied psychiatric and psychotherapeutic treatments. Each course of treatment

> would bring about an improvement, but deterioration would set in after its termination. When he began his analysis, it soon appeared that the main problem was the strength of his negative therapeutic reaction. I represented mainly a successful and potent father, and his hatred of and rivalry with this figure was so intense that the analysis, representing my potency as an analyst, was unconsciously attacked and destroyed over and over again. . . . In the first year of his analysis, he dreamt that he put into the boot of his little car tools belonging to my car (bigger than his), but when he arrived at his destination and opened the boot, all the tools were shattered.
>
> [Segal interprets:] This dream symbolized his type of homosexuality; he wanted to take the paternal penis into his anus and steal it, but in the process of doing so, his hatred of the penis, even when introjected, was such that he would shatter it and be unable to make use of it. In the same way, interpretations which he felt as complete and helpful were immediately torn to pieces and disintegrated, so that it was particularly following good sessions which brought relief that he would start to feel confused and persecuted as the fragmented, distorted, half-remembered interpretations confused and attacked him internally [p. 29f.].

Here, too, I believe one can see how the analyst's conviction about the correctness of her insights and interpretations tempts her to make detailed interpretations without any of the patient's associations for confirmatory clinical evidence. Once again I do not see in this case presentation any evidence of an analyst and patient working together on a dream. I see instead an analyst forcing a patient to submit to her interpretation. By doing so this analyst is acting in a way which proves she is really like the patient's hated and envied potent father. No wonder he dreams that all his tools are shattered. To quote Freud (1925a): "But dream-interpretation of such a kind, without reference to the dreamer's associations, would in the most favourable case remain a piece of unscientific virtuosity of very doubtful value"

(p. 128). I must add that many analysts of non-Kleinian affiliation also disregard the patient's associations.

I shall now present some work with dreams that I believe exemplifies how an analyst who appreciates the exceptional position of the dream utilizes it in his practice. For the sake of clarity and demonstrability, the dreams I have chosen for illustrations are those from my recent clinical experience with which I was able to work fruitfully. They are not everyday examples of my work with dreams. There are many dreams I can understand only vaguely and partially and some I can hardly understand at all. There are also occasions when the dream is not the most productive material of the hour, but this has been rare in my experience. Freud wrote as far back as 1911(b) that dream interpretation should not be pursued for its own sake, it must be fitted into the treatment, and all of us agree on this obvious point.

I realize that no clinical demonstration of the value of dream interpretation will change the opinions of those who are predominantly devoted to theory conservation or theoretical innovations. Their theories seem to be more real to them than the memories and reconstructions of their patient's life history. Working with dreams is not only an enlightening experience for the patient, but it may be a source of new clinical and theoretical insights for the analyst, if he has an open mind. Furthermore, there are some analysts who have no ear or eye for dreams, like people who find it hard to hear and visualize the beauty of poetry, or like the tone-deaf who cannot appreciate the special imagery and language of music, or those who have no facility for wit and humor. Such analysts will lower the importance of dream interpretation, no matter what evidence one presents. Finally, there are analysts who, for some other reasons, have never had the opportunity to learn how to listen to, understand, and work with dreams.

The two dreams I shall present are from the analysis of a thirty-year-old writer, Mr. M.,[2] who came for analytic treatment because of a constant sense of underlying depressiveness,

[2] See also chapter 22.

frequent anxiety in social and sexual relations, and a feeling of being a failure despite considerable success in his profession and what appeared to be a good relationship to his wife and children. He had a great fear that he would not be able to do free association at all, and that if he did I would find him empty or loathsome and send him away. We worked on these resistances for several weeks and he was then able on occasion to do some relatively spontaneous free association on the couch. One of the major sources of his resistances in the beginning was his experience with several friends who were also currently in psychoanalytic treatment. They talked freely and often in social situations about their oedipus complexes, their positive and negative transference reactions, their castration anxiety, their superegos, their incestuous desires, etc., all of which my patient felt was "textbooky," "artificial," and "a load of crap." Mr. M. was afraid that he would not be able genuinely to accept such interpretations, and yet also dreaded that unknowingly he too might turn out to be a "junior psychoanalyst" socially. I want to present the highlights from an hour in the sixth week of his analysis in which he reported his first dream. He had often had the feeling of having dreamed, but until this point could never remember any of his dreams.

One day he began the hour by stating: "I had a dream, but it seems unrelated to anything we have been talking about."

> I was making a phone call to some guy in a men's clothing store. I had ordered some clothes made to order and they didn't fit. I asked the guy to take them back, but he said I had to come in myself. I told him I was not going to pay for the clothes until they fit. I said, "It seems like you just took them off the rack." I repeated, "I won't pay for the clothes until they fit." As I said that I began to vomit, so I dropped the phone and ran into the bathroom to wash out my mouth. I left the receiver dangling and I could hear the guy saying, "What did you say, what? What?"

I remained silent and the patient spontaneously began to speak: "The most striking thing to me is the vomiting. I just can't

vomit, I never, never vomit. I can't even remember the last time I did, probably as a child sometime. It is like a biological thing, it's so strong. Like in yesterday's hour, I couldn't get myself to talk [Pause]. Free association is like vomiting." I intervened at this point and said, "Yes, free association becomes like vomiting when things are trying to come up in your mind that you would rather keep inside yourself and away from me. The dream says it has to do with something not fitting you properly." The patient quickly replied, "Yes, it's about clothes, but that is too silly. Why clothes? Clothes not fitting? [Pause] Oh my God, this can't have anything to do with the analysis. The man saying, what is it, what, what, what, that could be you. [Pause] I leave you talking and go to vomit in the bathroom—but why, why do I do that?" I answered, "When I give you an interpretation that doesn't seem to fit you, you must resent it and feel that I just took it off my 'psychoanalytic rack,' like the other 'textbooky' analysts you have heard about." The patient: "Oh Jesus, I can't believe it, I thought things like this only happened in books. How funny!"

At this point, the patient began to roar with laughter and tears streamed down his face. He gathered himself together and said: "I never thought things like this would happen to me. You are right. When you say things that don't seem to fit me, sometimes I do get annoyed, but I keep it in. [Pause] I get scared here when I feel angry. It's like being afraid of my father when I was a kid. [Pause] I now suddenly see a vague picture of me vomiting when I was about three or four years old. [Pause] It was my mother, right on her, she must have been holding me. She was so nice about it, too, she took me to the bathroom and cleaned me up and herself too. Amazing this whole thing." I answered: "Yes, apparently you were not afraid to vomit up things in front of your mother, but you must have been very scared of doing that with your father and now you feel the same way here with me. But you see these kinds of things do tend to come out in dreams or in such things like your forgetting to pay me this month." The patient was startled and blurted out: "This is too much. I had your check in my wallet, but in the last minute I decided to change my jacket and left my wallet at home. And I never even

thought of it when I was telling you the dream, all about not wanting to pay that man. Something must really be cooking inside of me." The patient paused, sighed, and after a while I asked him just to try to say what was going on. His associations then drifted to his shame about revealing his toilet activities, masturbation, his hemorrhoids, a history of an anal fistula, and other matters.

I believe this clinical example demonstrates how it is possible to work productively with a first dream, which is contrary to the opinions expressed in the monograph *The Place of the Dream in Clinical Psychoanalysis*. Avoidance of dream interpretation by the analyst can frighten the patient, because the patient may sense the analyst's fear of the dream contents. An analyst's timid approach to a dream may add to a patient's suspicion that he, the patient, is especially full of internal evils or may convince him that he has a frightened analyst. On the other hand, deep interpretations given too early will either frighten the patient into leaving the analysis or it will persuade him that the analyst is omniscient and convert the patient into a devout follower and not a working ally. One has to assess carefully with each patient how much and how little one can do with early dreams and early material in general.[3]

Let us scrutinize more carefully what I tried to do with that first dream. Once the patient was spontaneously able to connect his fear of vomiting with his fear of free association, I first confirmed this representation of his resistance by saying out loud what he had already become conscious of—his dread of losing control over the horrible things inside of himself: vomiting is equated to free association and he vomits into the sink and not into the phone, the analysis. I then felt I could lead him in the direction of trying to discover what was making him vomit. The obvious symbolism of the ill-fitting clothes delivered to him ready-made and not made to order, symbols which he himself could grasp, encouraged me to point out his suppressed anger at

[3] See Berta Bornstein (1949) and Loewenstein (1951) for examples of their method of dealing with this delicate problem. See also Greenson (1967a).

me for my ill-fitting, ready-made interpretations, taken off my psychoanalytic rack. His laughter was a relief from the fear that he lacked an unconscious mind and was a freak, and also that I might be harsh with him for such thoughts. It was confirmation of the correctness of my interpretation and also an early sign of conviction that there is an active but unconscious part of his mind which does contain specific and personal meanings and they are not as terrible as he had imagined.

My referring to myself as the "textbooky guy" who is unable to tailor his interpretations to suit the patient must have given Mr. M. enough trust in my motherliness so that he could recall an early childhood memory of vomiting on his mother. Here vomiting is loving and not hating. He was then able to contrast this with his dread of vomiting up things in the presence of his father. His later association to the toilet, masturbation, and so forth, indicated an increase in his ability to let things come up in free association in my presence, a lessening of his resistances. Apparently my way of communicating to him helped me establish a working alliance with his reasonable, observing ego.

There are many elements in this dream which I did not point out to Mr. M., but which are of interest to us as examples of the function of the dreamwork and of the interaction of the primary process and the secondary process as well as of the interaction of the id, ego, and superego. The patient's very first sentence before telling the dream: "I had a dream, but it seems unrelated to anything we have been talking about," is an attempt to contradict and deny the very essence of the dream, namely, that it concerns his feelings about me and the analysis. The psychoanalytic situation is depicted as a telephone conversation, only a verbal exchange, and even that is held at a distance. The man he speaks to is referred to as a "guy working in a store," not the awesome or flattering representation of a psychoanalyst. The insights and interpretations I gave him were represented by clothes, and clothes conceal rather than reveal, an example of reversal and the use of opposites. Psychoanalysis does not strip you, it is supposed to clothe you, a reassurance, a wish fulfillment. His fear of close emotional contact with the analyst is demonstrated by his refusal to come in person to the store. His leaving the phone dangling and hearing the "guy's voice" saying, "What is it, what, what?" is a beautiful and hostile caricature of my analytic technique. It also is his revenge against me for leaving him dangling hour after hour; it is not he who keeps asking desperately, but I. The vomiting is not only an expression of his forbidden instinctual impulses, but it is also a self-punishment for his hostility. It is, furthermore, a rejection of the interpretations I have been forcing him to swallow and his spiteful obedience: "You want me to bring things up. Okay, here it is." This is an example of the coexistence of opposites in the primary process.

One can see that the vomiting is derived from both the id and the superego. It also serves the resistances, a defensive function of the ego, by breaking off our line of communication. All this and more is in the dream *and* in the patient's associations, facilitated by the interpretations. Only a fraction of this material can be meaningfully conveyed to the patient in a single hour, but it serves a valuable service for the analyst as source material for clues that will be of use in the future.

Mr. M. continued with the theme of clothes and concealment in the next several hours. As a child of impoverished parents he was embarrassed by his shabby, dirty clothing. He was also ashamed of being skinny and had tried to hide this by wearing several sweatshirts and sweaters on top of each other when he was young. When he later became affluent, he bought bulky tweed sport coats and often wore turtleneck sweaters with a leather jacket and boots. During the postdream interval he recalled stealing money from his father to buy a zoot suit, which was fashionable in his youth, because he wanted to make a good impression at a school dance. He also recalled having severe acne which he attributed to masturbation and which he attempted to cover with various facial creams and lotions. He tried to rationalize his stealing from his father by recalling that his father cheated his customers at times. All this material had the meaning: "I have to hide my true self. If anyone sees beneath my surface he will find me ugly and unlovable. I am a fraud, but so

is most of the world. How do I know you are genuine and sincere in your treatment of me and will it change once I am stripped of all my superficial disguises?" (I was not merely working with the manifest dream in the following days, but with the latent dream thoughts which the patient's associations and my interventions had uncovered.)

Another dream of Mr. M. occurred about two and one half years later. The patient had to interrupt his analysis for six months because of a professional assignment abroad and returned some three months before the dream. During this three-month interval of analytic work Mr. M. was in a chronic state of quiet, passive depression. I had interpreted this as a reaction to his wife's fourth pregnancy, which must have stirred up memories and feelings in regard to his mother's three pregnancies after his birth. It seemed clear to me that he was his mother's favorite, the only child and the favorite child. The patient accepted my interpretations submissively and conceded they had merit, but he could recall nothing about the birth of his three siblings or his reactions, although he was over six when the youngest was born. My interpretations had no appreciable influence on his mood.

Mr. M. came to the hour I shall now present, sadly and quietly, and in a somewhat mournful tone recounted the following dream:

> I am in a huge store, a department store. There are lots of shiny orange and green plastic raincoats on display. A middle-aged Jewish mother is arranging other articles of clothing. Nearby is a female manikin dressed in a gray flannel dress. I go outside and see a woman who looks very familiar, but I can't say specifically who she is. She is waiting expectantly and eagerly for me near a small surrey, putting clothes in it. I feel sorry for the poor horse and then realize the surrey is detached from the horse. I lift up the surrey to connect it and I am surprised how light the surrey is, but I don't know how to hitch it up to the horse. I also realize then that I was silly to feel sorry for the horse.

Mr. M.'s associations were as follows: "The three women in the dream were so different from one another. The older Jewish woman was a motherly type, working, doing, arranging, like my own mother used to be before she became bedridden. The manikin reminds me of how I used to think of gentile girls when I was a kid; beautiful, pure, and cold, like my wife. But they taught me different. The best sex I have ever experienced was only with gentile girls. Jewish women just don't turn me on. They never did. Since my wife's pregnancy our sex life is practically nil. She isn't feeling well and I must say I'm in no mood for sex. I would like to be close to her in bed, but I don't want her to think it is a sexual demand so there is no talking even. I'd like to just be close and cuddle. My wife is so quiet of late. I feel she is getting revenge on me for all my past wrongs. I never realized before I had had such a bad temper and that she had been and still is so afraid of me. [Pause] I feel so alone in that big house of ours. I work like a horse to pay for it. Maybe I am the horse in the dream that I felt sorry for."

I intervened, "It might be so. You think he had such a big load to carry, but then you lift up the buggy and you are surprised to discover how light it is." The patient interrupted me. "That buggy it was so light, it was so tiny, and the woman was putting clothes on it, like diapers." [Pause] I interrupted, "A baby buggy is very heavy for a little boy, he has to work like a horse to push it." Mr. M. burst in with, "I can remember trying to push my baby sister in her buggy, but it was too heavy for me. Now I see my father carrying the baby carriage downstairs as if it were a toy. I can even remember my brother and me together trying to push it." I interpreted and reconstructed: "I believe you have been depressed ever since your wife got pregnant because it stirred up memories of how you reacted when you were a small boy and your mother got pregnant and delivered your brother and sisters. You didn't want to face the fact that your father was hitched up to the coming of babies. You wished you could have been the father of the babies. But you weren't—you didn't know how to do it as a little boy and you felt left out in the cold, detached. You have been depressed about this ever since." After

a pause, Mr. M. said, "I've always felt I'm not a real man. I act like one, but inside I still feel a real man should be like my father; strong physically, tough, and unafraid. I can fly airplanes, but my hands sweat whenever I want to screw my own wife."

In the next hour the meaning of the green and orange raincoats became clear. The patient spontaneously recalled some dirty jokes about puberty in which the terms "raincoat" and "rubbers" were used to refer to condoms. He then remembered condoms in his father's chest of drawers and later stealing some for his own use, just in case an opportunity presented itself, which, he wistfully said, "didn't occur for several years." By that time the "rubbers," the raincoats, had disintegrated in his wallet. It is worth noting how the hidden old shreds of "rubbers" in the patient's associations were changed into the shiny new raincoats on display in the dream. Here one can see the attempt at wish fulfillment in the manifest content of the dream: "I can buy conspicuous sexual potency in a store or in analysis." Later it also became clear that I too was the poor horse who had him as a big load to carry and also I was the "horse's ass" who could not help him make proper sexual connections with his wife or any other woman.

To me the outstanding element in the manifest dream was the surrey which turned out to be so tiny and light. My translation of the word "surrey" into "buggy" was the crucial technical point. I got from surrey to buggy by visualizing a surrey, which I have never seen in actual life but which brought to mind a popular song, *A Surrey with a Fringe on Top*. This led me to baby buggies with fringes on top. Not wanting to push the patient into *my* association of baby buggy, I dropped the baby part and said just buggy, to see where it would lead him. (All this flashed through my mind quickly and was not as carefully thought out as it sounds here.) But I believe I was on the right track as it helped the patient pictorialize a baby buggy. And this enabled him to recall early childhood memories that had been repressed. Once his associations became freer, I could see how the dreamwork had condensed, reversed, and disguised the

agony of feeling abandoned, unloved, inept, and depressed, by pictorializing an attractive woman waiting eagerly for him to join her. The tininess and lightness transform the surrey into a baby buggy and change the adult Mr. M. into a jealous, rivalrous small boy who cannot make babies as his big father can. The dreamwork tries to negate the fact that the father is connected with the mother's pregnancies; the surrey and horse are not hitched together—the patient is unable to hitch a male and female together. The familiar but unrecognizable woman is the mother of his childhood years, whom he has tried to ward off in his memories, in his sexual life, and in the analysis. The hugeness of the department store is a plastic representation of him as a little boy in a situation too big for him, as his present big house makes him feel like a tired old horse. He is full of jealousy, envy, and depression, and sorry for himself.

It was not possible to work on all these points in one hour; but the surrey-baby-buggy dream led in the next hours to the conviction that his present depression and the old underlying depression from childhood, which had brought him into the analysis, were directly connected, hitched up, to his mother's pregnancies and deliveries. The repression, isolation, and denial were temporarily broken through by our work with this dream, and there were several tearful and angry hours, in contrast to the quiet sadness of the previous months. By making available to the patient's conscious ego the memories and affects related to trying to push the baby carriage I could reconstruct a crucial phase of this man's conflicts in early childhood, which were emotionally inaccessible to him until our work on the dream.

I believe this clinical vignette demonstrates the exceptional position of the dream. Months of what I believe to have been good psychoanalytic work on the patient's acting out or reenactment of the childhood depression provided insight and some understanding but no emotional or behavioral change, although I am fairly sure that it prepared the way for the surrey-buggy dream. It was the dream, however, plus the patient's and the analyst's work on it, that made possible the breakthrough to the hidden memories and affects. Only then did the patient develop