

*A Dream Workshop Experience  
from 1965 to 1970*

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On December 3, 1965, the dream workshop of the American Academy of Psychoanalysis came into existence. Dr. Montague Ullman, its initiator and chairman, noted that new developments in dream research necessitated a greater clarity regarding the use of dreams in the psychoanalytic situation. He recognized also that the workshop could be a unique opportunity for analysts of different theoretic persuasions to share their experience and thinking.

It has been a unique opportunity indeed. Alone in our offices, we rarely had reason to question our psychoanalytic use of dreams. Together, our astounding problems in communicating about differences in approach and concept forced us to examine our ways of working with dreams and our inference-making processes along with the usual issues related to dreaming. Confusion, sharp conflict, and feelings of anger and hopelessness often characterized our workshop exchanges creating a sometimes painful, always struggling, and sometimes exciting involvement of considerable intensity.

This report thus has to be about our group's efforts to communicate about our work with dreams as well as about our ideas. As

Dr. Ullman writes, "I think the real task we set for ourselves was to learn to talk to and listen to each other about what we do in response to the dreams of patients. It is comparatively easy to get analysts to talk to each other. It is much more difficult to get them to listen to each other."

We cannot report conclusions or a consensus. In Dr. Ullman's words: "We experienced greatest difficulty in conceptualizing the limits of our task. The subject of dreaming covers a spectrum of events that includes the phenomenology of dreaming, the therapeutic use of dreams, and dreams as a vehicle for studying the inference-making processes of different analysts. There is some artificiality to these separations and perhaps this accounts for the enormous difficulty we had in maintaining our focus on our inference-making processes."

As we launched into our work, the spectrum of events and also of individual interests became increasingly apparent. The chairman, favoring an open-ended process, expressed his belief that a focus and format should gradually evolve itself.

Dr. Shainess spoke about dream metaphors being no strangers to us in waking life. Poetry, novels, the theater of the absurd, and surrealistic art also employ the same medium. She offered slides demonstrating the appearance of dreamlike metaphors in art.

In the second workshop, brief reports were presented in the morning. Then, in the afternoon, dreams in clinical context were discussed in small groups thrusting us into the chaos of unrestrained interpretive ingenuity. Some structure was clearly needed. In the third session, Dr. Shainess presented a manifest dream by itself and asked the participants to guess about such data as the dreamer's sex, age, education, and life problem. Later, she added the clinical context. No trend could be discerned among our speculations. Most of the participants became involved in the analyst's mode of treatment. Following a suggestion of Dr. Enelow we made our first attempt to trace our steps of inference making. We tried to identify the referents in the present, the past, the future, and the analytic situation for our responses. It was a totally unsuccessful attempt. Opposition to the task of making a step-by-step analysis of our inferences was very evident. Some felt strongly that they needed to see each detail in its total context including the therapeutic flow and felt constricted by our objective.

Our very frustration, however, gave rise to an important innovation in the workshop. Dr. Ullman provided us with the means of

corresponding between meetings. Letters sent to him were copied and circulated among a core steering committee, formed from those who were most active in the correspondence. This interim correspondence among a dozen or so members thenceforth constituted a vital part of the workshop. This allowed us to air our dissatisfactions, state our propositions, challenge each other, and prepare a solid foundation for the actual workshop meetings.

Our passion for speculative interpretation, our emotional investment in these hunches, our inability to listen to each other, and our insistence on persuading each other gave rise to the first volley of letters. Dr. Zane summarized this distress: "Participants inferred meaning by relating the dream elements to any frame of reference that seemed right at the moment, e.g., to the manifest dream, to the patient's current life, his past, his future, his family relationships, the analytic situation, and to the analyst's favored psychodynamics."

An important question arose: Was it profitable to study a dream alone without clinical context? Dr. Enelow felt that the study of the manifest dream alone could lead only to a maze of guessing games. He also resented his being confined to the "detached, isolated, dehumanized manifest reported dream." It is, he maintained, the clinical context that suggests meaning. "Many associations," he wrote, "are possible to any dream. As therapists we have to order and select according to what we establish as relevant and this depends wholly upon our conception of the person and his dream as an inseparable unit, not an isolated, mimeographed manifest dream." Dr. Zane replied, "I am fully aware that associative and historical data greatly enrich our understanding of the dreamer and may be essential for therapeutic use of dreams. However, our task of finding the referential basis for our interpretations becomes far more complex and confusing when associative and historical data are included. Hence I suggest we work with the manifest dream alone. As I see it, the manifest dream — as a product of a person's mental operation while asleep — is as typical of the individual as any other aspect of his behavior. By simplifying what we work with we improve our chances of understanding how each of us works." However, the group decided to include the history and the clinical context along with the manifest in the material presented to the workshop.

Our growing interest in inference making gave focus to our fourth workshop, in Detroit. An edited tape recording made Dr. Zane's presentation exceptionally valuable. After listening to the dream as it

was actually reported in the session, each member noted down the questions he would like to ask of and about the patient. Later, in small groups, the participants were to seek the frame of reference that determined their questions. Instead of pursuing the task again the pull was toward individual interpretation and criticism of the presenter's therapeutic utilization of the dream.

In spite of our usual, uncritical indulgence in interpretative activity, this workshop emerged with the first vision of a constructive approach. Drs. Barnett and Eckardt analyzed, for their respective subgroups, the conceptual approach of each participant as reflected in the recorded questions, in their recorded interpretations of the dream as well as in their comments in discussion. Dr. Barnett, whose interest in the cognitive styles of analysts predated the workshop, summarized his sophisticated impressions in the following way: "Concerning initial inference making, therapists seem to fall into three groupings in terms of their attention and reaction to the manifest: atomistic-essential, holistic-essential, and experiential styles can be differentiated. These styles seem to determine much of the immediate response to the dream. The atomistic-essential style attends to and translates discrete elements of the dream imagery as reported and gives a point-for-point translation of the dream. The holistic-essential style is characterized by an almost immediate tendency to transform dream elements into global generalizations which are used as inferences from the manifest. The experiential style is one which concerns itself prominently with the relationship of the dream elements, the action of the dream, or the contrast between the dream and reality." To Dr. Barnett each of these styles seemed to lead to consistent operations on the part of each participant in terms of his responses to the material, the way in which he made inferences, and his choice of mode of intervening with the patient. Dr. Barnett hoped we could explore these stylistic systems as a key to understanding our bewildering and conflicting reactions.

The Detroit workshop was experienced by many as the best up to then. It had structure and method. It focused upon a single important clinical aspect in the use of the material, namely the comparative approaches of the analysts to the same material.

However, Dr. Zane, the presenter, felt disappointed and very little understood. He had hoped to demonstrate his method of inference making. Apparently each of us was still too involved in his own ideas and approach to be interested in the opportunity of hearing the presenter illustrate and explain the bases for his work with a dream.

More workshops passed before we again confronted and learned this vital lesson.

The next two workshops, with Dr. Enelow presenting the fifth and Dr. Bonime the sixth, failed again to provide a structure that would make a meaningful exchange possible. The remarkable difficulties encountered by our group in focusing on and creating a procedure to explore a common problem are probably not unique to our psychoanalytic group. As Dr. Ullman observed, "What goes into the interpretive process seems to be easier to think about than to put into practice because of the tremendous pull in the direction of clinical interpretive activity rather than analytic examination of the interpretive process."

Our most meaningful exchanges occurred in our interim correspondence. Dr. Enelow, echoing Dr. Zane's fate, protested his experience as a presenter. "We got off onto the dream and our passion for interpretation trying to discern latent meaning rather than trying to discuss the ideas that I was presenting along with the dream." He stressed the need for better communication of ideas. He had hoped to talk about the problem-solving function of dreams for tensions experienced currently in the here and now. All dream exploration, he maintained, should elicit the emotions (or thoughts, feelings, and mental life generally, of the previous day or days) that initiated this inner activity in the patient. The current problems may or may not relate to problems from an earlier period. Dr. Enelow summarized his statement thus, "We need to explore the emotional day residue, and then clarify the day residue with the help of the dream, rather than the dream with the help of the day residue." Dr. Ullman joined Dr. Enelow in stressing the importance of the day residue and said that apart from helping the therapist to cue into what is troubling the patient, it also provides a much-needed discipline to prevent wild speculation by psychoanalysts. He further stated, "Dreams have a specific as well as a general component. It is tempting as well as safer to dwell on the latter at the expense of the former. It is also a mistake. If the true originality, struggle, and dilemma of the patient are to be appreciated, then we must understand why this particular dream containing these specific dream elements was dreamed at this particular time. Otherwise any therapeutic gain achieved will lack the weight of an active confrontation around a current issue." He also stressed the importance of having our interpretation fit the structure of the manifest dream. "Specific meaning not only has ultimately to link up with specific

elements, but must also be congruent with the specific way in which they are put together."

This latter theme was restated emphatically by Dr. Zane and led to an important controversy. "My theoretical position requires," stated Dr. Zane, "that every idea I have about the dream be harmonious with the concrete spatial and temporal relationships of the manifest dream's elements, their movement and their structure. In my opinion such a position is the bedrock essential for creating a commonly acceptable method of dream interpretation or utilization while preserving and benefiting from our individual styles."

The clarity and challenge of this statement elicited this response from Dr. Bonime. "I believe," he wrote, "it is very difficult to make accurate inferences about dreams. To some degree all communication is only an approximation. . . . We never say completely and accurately what we feel or think. . . . Our words are makeshift expressions of these inner experiences; our symbols including dreams are richer, more inclusive, more complex manifestations of the subjective processes. Dream interpretation is never more than an approximation and requires, therefore, the greatest flexibility of the processes involved. I believe this is what Dr. Eckardt has been saying in such comments as, 'I do not think that in actual practice we interpret dreams. We use whatever a patient's dream suggests to us for further exploration and dialogue.'"

In workshop 6 in Boston tempers became quite frayed as our tolerance for diffuse, diverging, and tangential dialogue reached its limits. We responded to the dream of Dr. Bonime's patient as it was presented in its clinical and therapeutic context. In the frustrating plenum discussion Dr. Barnett noted and Dr. Eckardt affirmed, "No one of us has changed. . . . Our ideas remain separate over the years." At this crisis we agreed upon a structure for our next workshop less for the sake of its research value than as a desperate means of bringing some organization to our responses and order to our work.

The format chosen was to have each member write down his responses in two stages: (1) to the manifest dream alone, and then (2) to the manifest dream plus the clinical context.

We also decided to keep together in the workshop for continuing group discussion those who participated in active correspondence. Drs. Barnett and Enelow volunteered to lead new and transient participants in the workshop through the same two-stage program.

For workshop 7 in New Orleans Dr. Eckardt provided the clinical

material which was also used as the basis for workshop 8 in Miami. After she had received each member's response to the manifest dream alone of her patient, Dr. Eckardt sent out the manifest with its expanded clinical context. Our aim was to explore how the clinical context modified our responses to the manifest, to note differences among the respondents and the extent to which interpretative comments can be validated by the data provided. In responding to our new format, a very active correspondence developed characterized by many dialogues. Many of the reports and analyses were detailed and documented. In the steering committee's group discussion we tried in a systematic way to get a statement from each member regarding his response to a few of the same dream elements. Even this limited exercise led to a confusing diversity of response. However, there was satisfaction in attempting the same task. The ensuing correspondence continued to be brisk and enlightening.

Dr. Eckardt, reading the many responses, became more clearly aware of her own mental steps during the reported therapeutic hour. These included her questions to herself, the reason for her interventions, and her particular focus. At workshop 8 in Miami, where she was questioned by the members of the steering committee about her way of working with the reported dream, she realized and stated that she had pursued a particular metaphor because it seemed to be saying something new about the patient's place. She emphasized repeatedly that she was interested not in interpreting the dream, but in exploring the patient's experiences in life — past and present — that seemed reflected in this particular imagery.

Dr. Ullman, appreciating her approach, commented: "I thought your further explication of the hour was great as it clearly put together experiential data with the elements of the dream. To my mind this is the single most important aspect of dream work, namely establishing the immediate congruence of manifest content and life experience."

The addition of the therapist's mental steps to the reported material gave more meaning to the reported events and provided a more stimulating base for discussion. It also helped the group to focus on the therapist's activity as well as on the patient's production. Dr. Bonime, who chaired the Miami workshop, remarked, "Here we actually talked about what we had come to talk about: the processes that are involved in a particular analyst as she works with a dream."

Dr. Eckardt's approach was characterized as "dream appreciation" as opposed to "dream interpretation." Dr. Ullman said,

"I like the word appreciation because the dream is a work of art and its primary response is a felt response, and we cannot limit the dimensions of that felt response." Dr. Enelow commented, "I think Dr. Eckardt's point is that we are not really looking for meaning. We are trying to stimulate dialogue." Dr. Bonime added, "in the resonance between the two, the relevant material will come out which contains implicitly the meaning without the formulation."

Apparently, we had learned a lesson. Workshop 9 in New York City proved even more satisfactory. The presenter, Dr. Bonime, wishing to focus on the role of affect in dreams, devised a three-stage procedure. First, he submitted a manifest dream isolated from its clinical context and, to the extent possible, divested of any indications of its accompanying affect.

Second, the same dream, still without its clinical context, was submitted with the reported affective data. Third, the full, reported dream was presented with its clinical context.

The ensuing debate by letters and at the workshop was launched by Dr. Ullman's challenging procedure itself. "Affect," he said, "is embedded in the metaphor and therefore it is artificial to deal with it as a separate thing." Dr. Bonime replied, "The exercise suggested does not oppose the concept of feeling being embedded in metaphor. Nevertheless, the question remains whether separate attention to affect is a legitimate, useful part of the clinical process. I make a point of separating out feeling for two reasons: The first is that it is neglected so much of the time. It is neglected by the therapist, the patient, or both. And often it is assumed without being defined. The patient may, for example, say he felt 'peculiar' or 'funny' or 'upset' and assume he communicated affect, although such terms do not clearly designate what kind of affect, and the therapist may assume that a significant message about emotion has been included though it does not become further elaborated. . . . My second reason for giving separate attention to feeling in dreams in spite of its being embedded is that it is not always obvious or discernible within the imagery. . . . We often assume a feeling, without exploring its accuracy. We thereby insinuate it into the other person's metaphor and may change its connotation. . . . An important aspect of our goal with a patient is to help him become aware of the nature of his emotions and the role they play in his life."

A novel feature of the ninth workshop was our having Drs. Bonime and Zane, confront each other in the group and ask questions



about the other's views and treatment of affect in the dream. Then both submitted to questioning by the other committee members.

The workshop once more was a rewarding experience. The focus was maintained. Dr. Zane felt he had been heard and partly understood. Dr. Bonime had the opportunity to lead the group in the exploration of this vital issue of affect in dreams, a long-standing interest of his. He acknowledged that most of the respondents had guessed the affect which had been edited out but he cautioned against generalizing on the basis of a single dream, particularly from an obsessional patient, that the "analyst can derive the feelings from the metaphor without being told them."

Concomitantly, as part of workshops 7, 8, and 9, Dr. Barnett, with impressive ingenuity, led other groups consisting largely of one-time registrants in parallel exercises. After this experience in workshop 7 in New Orleans, he concluded, "Perhaps most fascinating was the fact that adding the clinical material evoked almost no change in the interpretative efforts of the group. Clinical material was used primarily to substantiate or fill in the interpretation." "This," he stated, "raised some interesting questions about dream interpretation in the therapeutic situation. Is dream interpretation a "royal road" to the unconscious and therefore new and inaccessible material or is it primarily a teaching device, in which the therapist trains the patient in ways of structuring relatively personal data in accord with the therapist's personal and theoretical style? If it is the latter, as I rather suspect it is, then how does the issue of conviction and belief get played out between the patient and the therapist?"

Dr. Barnett also found that these one-time participants reacted to separate elements comprising the manifest dream with openness and flexibility; they used referents from their personal life as well as from their theoretical orientation and training. When they proceeded to construct an interpretation from these inferences and impressions there was heavier reliance upon theoretical constructs. Their views congealed quickly. They then exhibited little or no uncertainty. Conflicts, criticisms, competitiveness, and even hostility and condescension occurred between members of the group. When clinical material was added, in the second stage, it led to almost no change in their interpretative efforts.

In workshop 8 in Miami the transient group worked with a dream that had been presented in workshop 5 by Dr. Enelow. The dream report was: "A male and a female dinosaur were having intercourse.

We were studying the reproductive physiology involved. After it was over, we peeled the male off — just empty skin. The female was fatter and had a penis. She had consumed the male. She had sucked him in and swallowed him up." Having obtained everyone's impressions, it occurred to Dr. Barnett to ask whether their impression of the dream would be any different if the main actors were Schnauzers rather than dinosaurs. To his surprise, most members thought that the meaning and impact of the dream would remain the same. "The impact of the dream was thus less dependent on the metaphor of the striking dinosaurs but inherent in the structure and drama of the dream." Dr. Barnett continued, "In our workshop experience, the structure of the dream and the relationship of the dream elements to each other were seen to have a considerable importance. The structure of the dream imagery has a distinct referential value that cannot be ignored. Although the images of the dream and their symbolic translation are important, there is no doubt that the structure of the dream conveys much implicit meaning."

In workshop 10 in San Francisco each member of the steering committee discussed his own experience in the workshop's history. The exchanges often were heated but the communication was more effective than ever.

Those discussions contributed greatly to this present report because in them each participant had expressed more clearly his own ideas, his disagreements, and his experiences with the issues raised by the workshop. Haunting questions that have been with us since the beginning of the workshop echoed again in the discussion. Are we brainwashing the patient with our interpretations? What are our criteria for validity when we connect a dream and life? Why is it that our agreement is greatest when we respond to the manifest dream alone and drops precipitously the more clinical data we are given? What is the basis for regarding a dream as a metaphor? Yet there was no doubt that our ability to listen, to ask questions, to communicate, to understand, and to disagree had improved immeasurably. In a limited, well-defined, highly significant sector of psychoanalysis, we have confronted and begun to cope with the astounding difficulties and complexities that emerge when psychoanalysts leave their private offices and attempt to work together on a clinical event.

Basically each participant is still opting for the interest closest to his heart. Early in our experience these discordant, individualist pressures threatened the survival of the workshop. However, we

persevered and today we are more optimistic about the workshop than ever. We ascribe this constructive development to the evolution of a format which permitted each of us to express himself freely about a dream and to learn more about the relationship to the dream of our ideas about the patient.

The format evolved for our workshops on dreams includes these elements:

1. Organization of each workshop around a single focus (e.g., affect in dreams, "dream appreciation," referential bases for the analysts' questions, selection of ideas).
2. Distribution of the dream and clinical material in stages prior to the workshop to evoke responses to the manifest dream alone and then to the dream in clinical context.
3. Encouragement of interim group correspondence around shared, specific clinical data, offering criticisms and ideas, sharpening differences, etc.
4. Integration of the activities of our one-day participants at each workshop with those of the ongoing group.

As Dr. Bonime stated concerning the present mode of structuring the workshop: "There is no limit to the problems regarding dreams which can emerge and be tackled in this way as time goes on."

The workshop will go on. We have defined some of the problems that arise when psychoanalysts join to study and work with dreams. We are able to listen and speak more easily and freely with each other. As a consequence our individual efforts are now complementing each other in a most salutary way. Our present format should enable us to design experiments that will reveal more of what occurs in dream analytic work. We look forward with eagerness and confidence to future workshop experience.