Dream Frequency in Psychoanalysis and Psychoanalytic Psychotherapy

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DREAM FREQUENCY IN PSYCHOANALYSIS AND PSYCHOANALYTIC PSYCHOTHERAPY

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The authors examine data on dream frequency from 50 patients, half of whom were seen in psychoanalysis and half in psychoanalytic psychotherapy. Frequency, defined as the proportion of sessions where at least one dream is related, is analyzed statistically as a function of sex, age, and type of treatment. Also, treatment outcome is examined as a function of sex, type of treatment, diagnosis, and dream frequency. Psychoanalytic patients are found to have higher dream frequency than the patients in the psychotherapy group. Higher average dream frequency is correlated with a better treatment outcome in both patient groups.

IN THIS PAPER, DATA DEALING WITH frequency of dream presentation in psychoanalysis and in psychoanalytic psychotherapy will be presented. The data come from the last 25 patients in psychoanalysis and the last 25 patients in psychoanalytic psychotherapy who completed treatment with one of us (WAM). This information has been accumulated over a considerable period of time by systematically writing down the dreams of the analytic patients as they were presented from the couch and by noting down the dreams of psychotherapy patients after their sessions had ended.

Unfortunately, the work to be presented here was not originally designed as a scientific study, but rather developed out of the inadvertent accumulation of the dream frequency data. As such, it has certain inherent methodological difficulties. The

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most important of these, is that the therapist (WAM) served in the dual capacities of therapist and retrospective rater of outcome.

In addition, while the outcome ratings were all completed at the same time for the purpose of this study, varying intervals—from weeks to years—had elapsed after the end of each treatment. These problems aside, it is our belief that the results of this study, approximate as they are, are of heuristic value inasmuch as they point out the direction to take in future prospective studies of this area. In such studies, different individuals would be enlisted to serve in the capacities of therapists and raters, thereby eliminating the issue of treater-rater bias.

The statistical analyses of the data (by Statistical Package SPSS/PC) will examine the frequency of dream presentation as a function of age, sex and the type of treatment. The outcome of treatment will also be examined as a function of sex, type of treatment, diagnosis, and dream frequency. Dream frequency is defined here as the proportion of sessions with at least one dream.

Patient Population

The patient population (see Table 1) consists of a total of 50 subjects, half-of whom were in psychoanalysis and the other half in psychoanalytic psychotherapy. Male and female patients were almost equally divided within each treatment group. The mean age was approximately 40 (range 24–65 in the analytic group and 24–75 in the psychotherapy group) and did not differ significantly among the various treatment-sex categories.

Data Analysis

Patients seen in psychoanalysis (four times per week) had considerably more treatment sessions on the average (848) than did those seen two times per week in psychoanalytic psychotherapy (255), because the analyses lasted an average of five

TABLE 1
AGE, NO. OF SESSIONS, AND DREAM FREQUENCY BY TREATMENT TYPE AND SEX

	Psychoanalysis			Psychotherapy		
	Total	*Male*	*Female*	*Total*	*Male*	*Female*
Number	25	14	11	25	12	13
Age						
Mean	39.5	39.1	40.0	41.3	41.8	40.8
SD	11.8	11.3	12.9	12.0	11.2	13.1
No. Sessions						
Mean	848.2	847.1	849.6	254.9	255	254.8
SD	125.4	128.9	126.9	91.4	101.7	84.8
Dream Freq.						
Mean	39.2	38.7	39.9	21.4	20.5	22.2
SD	14.3	11.3	18.0	6.0	6.3	5.7

years, while the psychotherapies lasted an average of three years. The psychoanalytic patients had a higher average dream frequency (39%) than did those in psychoanalytic psychotherapy (21%).

A stepwise multiple regression analysis examined dream frequency as a function of sex and treatment group and showed a significant relation between dream frequency and treatment group ($p < .001$) but not with sex. A stepwise multiple regression analysis examination of dream frequency as a function of age revealed a significant relation between dream frequency and age ($p < .001$), with dream frequency decreasing with age within both treatment groups.

Table 2 shows that male and female analytic patients and female psychotherapy patients generally had good treatment outcomes (> 60%), whereas only 41.7% of the males in therapy had good treatment outcomes. In addition, analytic patients tended to have higher-level diagnoses than did those in psychotherapy.

Ratings of outcome in psychoanalysis and in psychoanalytic

TABLE 2

OUTCOME AND DIAGNOSIS BY TREATMENT TYPE AND SEX

	Psychoanalysis			Psychotherapy		
	Total	*Male*	*Female*	*Total*	*Male*	*Female*
Outcome						
Excell.	1 (4%)	0	1 (9.1%)	0	0	0
Good	16 (64%)	9 (64.3%)	7 (63.6%)	13 (52%)	5 (41.7%)	8 (61.5%)
Fair	6 (24%)	4 (28.6%)	2 (18.2%)	8 (32%)	5 (41.7%)	3 (23.1%)
Poor	2 (8%)	1 (7.1%)	1 (9.1%)	4 (16%)	2 (16.7%)	2 (15.4%)
Diagnosis						
High	16 (64%)	9 (64.3%)	7 (63.6%)	9 (36%)	3 (25%)	6 (46.2%)
Low	9 (36%)	5 (35.7%)	4 (36.4%)	16 (64%)	9 (75%)	7 (53.8%)

psychotherapy were made by the analyst-therapist who treated the patients. As noted earlier, while the outcome ratings were all completed simultaneously for inclusion in this study, variable lengths of time had elapsed after the end of each treatment, with the intervals varying from weeks to years.

Outcome Criteria

Analytic treatment outcome was decided on the basis of several criteria. Specifically, an analysis was thought to have had a good (or excellent) outcome when there was a good (or excellent) resolution of a transference neurosis or of strong transference elements and when there were considerable symptomatic and characterologic changes in the patient (especially in the spheres of sexual and occupational functioning and interpersonal relations). The outcome result was evaluated retrospectively by the analyst. Corroboration was sought from notes of the patient's verbalizations during the latter phases of the treatment. In good or excellent outcomes, there was a very high degree of agreement between the analyst's retrospective ratings and the patients' statements during the latter phases of their treatment.

An analysis was determined to have had a fair outcome

when there was a less than optimal resolution of a strong transference or transference neurosis and some symptomatic but little characterologic change (again, particularly in the sexual, occupational, and interpersonal spheres). In such analyses, there was generally agreement between analyst and patient as to the treatment's having helped the patient to a considerable degree. A poor outcome was judged to have occurred when either a transference psychosis or a poorly acknowledged transference neurosis developed and there was minimal symptomatic and no real characterologic change in the patient. A poor agreement was found in these cases between the evaluations of the analyst and the patient as to the extent of change which had occurred.

In the selection of patients for analysis, as opposed to psychoanalytic psychotherapy, the most frequently utilized criteria were related to the patients' capacity for higher-level object relations, their psychological mindedness, the accessibility to them of unconscious material (such as dreams and fantasies) and the intensity of their motivation for change.

With the psychotherapy patients, a good treatment outcome was determined by the occurrence of some resolution of strong, nonpsychotic transference manifestations and by the presence of good symptomatic and modest characterologic change (particularly in the sexual, occupational, and interpersonal areas). In these treatments, there was inevitably a high degree of agreement between patient and therapist as to the amount of change that had resulted from the treatment.

A fair treatment outcome was decided on the basis of the presence of little resolution of moderate to strong transference manifestations and modest symptomatic and minimal characterologic change. Agreement as to the extent of change between patient and therapist was more variable in this group. A poor treatment outcome was deemed to be present when there was practically no resolution of transference manifestations (which varied in degree from minimal to psychotically intense) and little to no symptomatic or characterologic change. In this latter

group, there was often considerable disharmony between the patient's assessment of the treatment outcome and the therapist's. The patient group, in general, tended to see the outcomes as more positive than the therapist did.

The psychotherapy patients were most often chosen on the basis of exclusion, as the degree of their psychopathology was deemed to be too intense or their motivation for characterologic change too weak to suggest analysis for them. Other factors, such as the presence of frequent business travel, financial considerations, and intervening life variables (such as marital and situational crises) also occasionally precluded recommendation of psychoanalysis, as opposed to psychotherapy, for some patients.

Diagnostic Groups

With respect to diagnostic ratings, the following diagnoses (in accordance with *DSM III*) were included in the higher-level group for both the psychoanalytic and psychotherapy patients: histrionic personality (301.50); ego-dystonic homosexuality (302.00) in an underlying dependent personality (301.60); dependent personality (301.60); atypical personality (301.89); compulsive personality (301.40); obsessive-compulsive neurosis (300.30); passive-aggressive personality (301.84).

Lower-level diagnostic categories included: borderline personality (301.83); narcissistic personality (301.81); hypochondriasis (300.70); major depression, recurrent (296.3x); major depression, single (296.2x); major depression and alcoholism (303.9x). While arguments could be made one way or another for modifications of the high-low categories, the separation into these groups was made on the basis of clinical experience of one of us (WAM) in treating such patients.

In Tables 3 and 4, the relations between mean dream frequency, sex of the patient, treatment outcome, and diagnostic levels are examined. Better outcomes are associated with higher

mean dream frequencies and within outcome categories, lower dream frequencies are associated with lower-level diagnoses.

TABLE 3
MEAN DREAM FREQUENCY BY SEX, TREATMENT TYPE, AND OUTCOME

Psychoanalysis

	Male: Dream Freq.			*Female: Dream Freq.*		
Outcome	*Mean*	*SD*	*No.*	*Mean*	*SD*	*No.*
Excell.	0.0	0.0	0	85.0	0.0	1
Good	44.6	8.7	9	38.0	11.2	7
Fair	30.0	6.4	4	30.5	9.2	2
Poor	21.0	0.0	1	27.0	0.0	1
Overall	38.7	11.3	14	39.9	18.0	11

Psychotherapy

	Male: Dream Freq.			*Female: Dream Freq.*		
Outcome	*Mean*	*SD*	*No.*	*Mean*	*SD*	*No.*
Excell.	0.0	0.0	0	0.0	0.0	0
Good	25.2	7.1	5	24.7	5.8	8
Fair	17.9	3.2	5	20.2	1.5	3
Poor	15.5	0.0	2	15.3	2.0	2
Overall	20.5	6.3	12	22.2	5.7	13

TABLE 4
MEAN DREAM FREQUENCY BY DIAGNOSIS, TREATMENT TYPE, AND OUTCOME

Psychoanalysis—Outcome Diagnosis

	Good: Dream Freq.			*Bad: Dream Freq.*		
	Mean	*SD*	*No.*	*Mean*	*SD*	*No.*
High	44.6	14.7	16	0	0	0
Low	38.9	0	1	28.6	6.3	8

Psychotherapy—Outcome Diagnosis

	Good: Dream Freq.			*Bad: Dream Freq.*		
	Mean	*SD*	*No.*	*Mean*	*SD*	*No.*
High	28.0	4.4	9	0	0	0
Low	17.9	1.3	4	17.7	2.9	12

Discussion

The data indicate that the psychoanalytic patient group had a higher average dream frequency (39%) than the psychotherapy patient group (21%). However, a major part of the difference can be ascribed to the different attributes of the individual patients selected for each group, rather than to any differences between the two types of treatment. Specifically, one of the key factors in the selection of the analytic patient group was the availability to them of unconsciously derived material, such as dreams. It is also probable that the nature of the psychoanalytic situation itself, with its greater attention to the state of the transference and the recumbent position of the patient on the couch, may stimulate either the production or the recall of dream material with a higher degree of frequency than in other modalities of therapy.

It also is likely that the analyst's (WAM's) strong interest in dreams must readily have been communicated to the patients. The patients' capacity to gratify this desire for dream material is likely a function of their adaptational potential and is probably related to their index of overall psychological functioning.

While most patients were relatively consistent in their dream frequency levels throughout the course of their analyses, others showed considerable variation. Intercurrent life situations, such as the birth of a baby and accompanying lack of sleep, often contributed to a transient decrease in dream frequency level. At other times, increased resistance to acknowledgment of transference manifestations led to temporary decrease in dream frequency levels, whereas diminished resistance to acknowledgment of transference manifestations was often accompanied by increase in dream frequency levels. However, variations in dream frequency levels during the course of the treatment were less profound in the psychoanalytic psychotherapy patient group.

Why dream frequency should decrease in older individuals is not clear to us, inasmuch as the capacity to form intense

transference relationships with the analyst-therapist seems undiminished by age. Further data are needed to elucidate this finding.

That most of the male psychotherapy patients had poorer treatment outcomes and lower-level diagnoses seems to be a function of the "luck of the patient draw" at that time. This would likely not hold up over a greater length of time, though these data should be expanded and studied further.

Bad treatment outcome was associated with a low-level *DSM-III* diagnosis, while higher-level diagnoses were associated with good treatment outcomes in the male and female analytic patients and were generally accompanied by good treatment outcomes in the female and male (less so) psychotherapy patients.

A decrease in average dream frequency was associated with a lower-level diagnosis and a less felicitous treatment outcome. Psychotherapy patients had a lower mean dream frequency than psychoanalytic patients, regardless of diagnosis or outcome.

As noted before, the accessibility of unconsciously derived material, such as dreams, and the capacity to adapt to the therapist's desire for the patient to produce dreams, are both qualities most commonly associated with higher-level psychological functioning. Consequently, a greater degree of mental health, as assessed initially in selecting patients for psychoanalysis (as opposed to psychoanalytic psychotherapy) and the observation of a greater capacity for adaptation during the treatment, are associated with higher-level diagnoses and better treatment outcomes.

Exceptions to the rule are not easy to explain. A number of patients who had good treatment outcomes and yet had low dream frequencies initially, were found to have higher dream frequencies over the remainder of their analyses or therapies. In such instances, difficult induction phases, based on ambivalence about the treatment (or other factors) may have been responsible for the initially low dream frequency.

In addition, psychotherapy patients with the diagnosis of major depression tended to have good treatment outcomes, unless their problems were compounded by the presence of alcoholism. They did not, however, have mean dream frequencies as high as many other therapy patients, whose treatment outcomes were less felicitous. The actual dream frequencies in patients with depressions are undoubtedly influenced by their affective disorders. It would be necessary to compare the data from these patients with dream frequencies taken in the same individuals in periods free of affective disturbance, in order to obtain a better picture of their overall indices of mental health.

Instances where patients had high dream frequencies and still had poor or fair treatment outcomes are harder to explain. This was generally seen in narcissistic personalities, who may have tuned in to the therapist's wish to have them produce dreams, and who utilized this method as a means of exhibiting their grandiose selves to the therapist.

As noted, there are certain methodological problems inherent in this study. The results, however, seem to point to a direction for future prospective studies involving the relation between dream frequency and the outcome of treatment. It is our hope that a further examination of the initial data, now in progress, will enable us to offer a firmer empirical basis for making early predictions as to which analyses and therapies will have a good (or a poor) treatment outcome. Such findings would not only be of value in determining which treatments are unpromising and should be terminated at an early time, but would also be of heuristic value in helping to design future studies.

REFERENCE

AMERICAN PSYCHIATRIC ASSOCIATION (1982). *Diagnostic and Statistical Manual of Mental Disorders* (*DSM III*). Washington, D.C.: Amer. Psychiat. Assn.

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