Dreaming and a Depressive Patient's Condition in Psychoanalysis

Paula Regina Peron

Pontifical Catholic University of Sao Paulo, Sao Paulo, Brazil

This paper examines a diminished capacity for dreaming and communicating one's dreams in a psychoanalysis therapy. This diminished capacity is related to depression and to one of its possible causes—traumatic experiences. In order to give theoretical support to these ideas, Sigmund Freud's concepts on the interpretation of dreams are presented, together with contemporary review of his contributions. The discussion reveals that traumas can cause impoverishment of one's ability to construct mental representations of one's experiences and also produce a condition that appears as a depressive state, which includes therefore a diminished ability to dream, showing that the function of dreaming as elaboration of intense psychical excitation is paralysed. All this is addressed in a clinical vignette from a psychoanalytical treatment.

Keywords: psychoanalysis, dreams, trauma, elaboration, depression

Introduction

In my psychoanalytical practice, I work with a myriad of different people. Some of them are able to associate freely, which used to be a requirement to an analytical treatment. Some others have a hard time expressing their thoughts and feelings, due to psychological resistances. And others don't express themselves because of some psychical conditions in which a lot of elaboration is required beforehand.

This paper will examine this latter diminished capacity for communicating and expressing oneself in a psychoanalysis therapy. I will address an even more specific issue: When this impoverished condition is accompanied by an absence of dreams. The patient says he or she doesn't dream, and dreams are usually a much useful way for psychical elaboration in a psychoanalytical treatment.

My researches point to a connection between this diminished capacity and depression. This later condition can be understood through one of its possible causes—traumatic experiences. A traumatized patient can therefore present a deficient capacity of dreaming and of exploring his or her inner world. In order to give theoretical support to these ideas, Sigmund Freud's concepts on the interpretation of dreams and on trauma will be presented below, together with contemporary review of his contributions.

My theoretical discussion reveals that traumas can cause impoverishment of one's ability to construct mental representations of one's experiences. Traumatic experiences also produce a condition that appears as a depressive state, which includes therefore a reduced ability to dream, showing that the function of dreaming as

elaboration of intense psychical excitation is paralyzed. I will address all these points in a clinical vignette from a psychoanalytical treatment.

Considerations on Freud's Theories About Dreams and Trauma

Over a hundred years ago, Freud published "The Interpretation of Dreams", a text in which he proposes his important theory about the interpretation of dreams as disguised fulfillment of repressed unconscious wishes. His ideas continue to produce much reflection and debate in the psychoanalytic field.

In the mentioned text, Freud gives us details on how and why we dream and provides us with a model of the psychic apparatus. Its mechanisms try to block access of childhood wishes to consciousness, transforming them to produce dreams, in a compromise with our internal censorship. The displacement and condensation work compose the final dream images, which will bring traits of latent wishes in their manifest contents. Freud proposed to work therapeutically in a regressive way from the description of the dream, brought by the patient, to the hidden wishes, through the interpretation of free associations of the patient about his dreams. In the interpretation of dreams, he provides us with the amazing number of 223 dreams to exemplify his dream theories (Roudinesco & Plon, 1998, p. 392). This model of functioning of our mind gave him basis for his analytical work with the symptoms. Freud also interpreted symptoms as replacing blocked infantile wishes, so they could reach free flow to the patient's ego. In this model, the pleasure principle tries to subdue the mind, but has to deal with opposing forces, such as the need for preservation of the ego.

Based on new evidence brought by colleagues who worked with traumatized patients who had experienced the terrors of the First World War, and also based on his clinical experiences and his informal observations of children's play, Freud wrote "Beyond the Pleasure Principle" (1920). In this important paper, he discusses the domination of the psychic apparatus by the pleasure principle, and concludes that there are processes whose origins are not the forces of pleasure. On children's play, using the example of his grandson and his playing with a wooden reel, which he threw and then pulled by a string, with a joyful expression, Freud notes, "It is clear that in their play children repeat everything that has made a great impression on them in real life, and that in doing so they abreact the strength of the impression and, as one might put it, make themselves master of the situation" (1920, p. 16).

To explain his speculations, Freud presents a description of the mental apparatus as being surrounded by a protection filter to excitations. These can come from the internal or external world. A trauma would then be the result of sufficiently strong external excitations, with the power to cross this excitatory filter and create an economic disturbance in the psychic apparatus, since, as Freud had stated in "On Narcissism: An Introduction" (1914), our mental apparatus is "a device designed to control excitations that would otherwise be felt as overwhelming or would have pathogenic effects" (p. 85).

In the text "Beyond the Pleasure Principle" (1920), Freud uses the figure of a vesicle, a simple organism with its receptive cortical layer. This vesicle develops a shield against stimuli—a membrane or envelope, which weakens the stimuli from the outside. This "protection against stimuli is an almost more important function for the living organism than reception of stimuli" (p. 27), since the energies working in the external world could destroy the organism, given their intensity.

The system also receives excitations coming from within the psychic apparatus. This excitement is felt as pleasant or unpleasant, and if it is too intense, it is treated as a stimulus from outside. This projection is "destined to occupy an important part in the causation of pathological processes" (p. 29). Freud then

characterizes this intense excitement:

We describe as "traumatic" any excitement from outside which is powerful enough to break through the protective shield. It seems to me that the concept of trauma necessarily implies a connection of this kind with a breach in an otherwise efficacious barrier against stimuli. Such an event as an external trauma is bound to provoke a disturbance on a large scale in the functioning of the organism's energy and to set in motion every possible defensive measure. (p. 29)

The principle of pleasure is put temporarily out of action due to the flooding of large amounts of stimulus. Then the problem becomes the domination and binding of invasive energies, so that they can be used inside the apparatus. How is this done? First, a countermeasure is performed by a counter investment on a large scale, with energy drawn from other systems. But this action consumes energy from other systems, depleting them, so that other mental functions are extensively drained.

In this scenario of unbalance, the pleasure principle becomes useless, and the mind tries to dominate the energy invasion, mobilizing energies available and jeopardizing the functioning of the other systems. Such traumatic effect is also produced due to the unpreparedness of the psychic apparatus at the time of the shock. Without warnings, our mind is not able to produce anxiety, which in general can work as preparation to face external excitations. With these concepts in mind, Freud tries to explain the different category of traumatic dreams and symptoms, which repeat not pleasure, but unpleasant experiences. With this repetition, our minds try to

master the stimulus retrospectively, by developing the anxiety whose omission was cause of the traumatic neurosis. They thus afford us a view of a function of the mental apparatus which, though it does not contradict the pleasure principle, is nevertheless independent of it and seems to be more primitive than the purpose of gaining pleasure and avoiding displeasure. (p. 32)

Therefore, a traumatic situation produces mnemonic marks that cannot be transformed and absorbed until they have been dominated by the connections of the secondary processes of the psychic apparatus: "The marks left there are not convertible in memory traces, they are voices, noises, actions of others on subject that haunt by their massiveness and omnipresence, without any chance of being worked by the dream and find places/times in the mind" (Menezes, 2005, p. 98).

From the theoretical considerations presented above and also through clinical experience, I can assume that dreams concerning traumatic situations tend to repetition as a way of connecting psychic energies in a free state. My doubts and concerns arose in clinical cases where there is a predominance of a depressive state, which tends to neutralize the functioning of the dreaming processes. Based on some situations from my practice, I explore the idea that a depressive state can influence the dream production of the patient, in the sense of lowering this production and its condition to translate wishes and also of connecting traumatic psychic excesses. I will examine excerpts from a clinical case in which the dream production of the depressed state showed peculiar characteristics.

I am based on the notion that we do not need to derive generalizations from a single case, but that it can clarify some aspects of other cases as well. In this way, we produce a reciprocal and continuous path between our analytical practice and its theoretical basis, trying to improve both. I also point out to the fact that the clinical case shown below is amply modified in its contents. Only relevant information concerning the aspects explored here is presented, in order to protect my patient, according to the ethical guidelines prescribed by our field of study.

On the other hand, the problem of depression requires clarification. It has been the focus of many debates in psychoanalysis and unfortunately it is sometimes regarded as foreign to our territory and should therefore be reserved for the psychiatric work. In this sense, I will use Freud as basis, who states that depression is a symptom that may affect various psychopathological conditions. This symptom presents itself as a global inhibition of ego activities, remarkable psychic paralysis and lack of will to carry out the analytical work (Freud, 1926, p. 90). It is not my goal in this paper to discuss the diagnosis of the presented case, or discuss whether depression is a psychoanalytic diagnosis. I believe, however, that the discussion about depression is relevant and extensive and can be taken in other directions, different from my proposal. Moreover, there is no doubt that this is a relevant discussion to our time, which is easily verifiable through recent publications of psychoanalytic colleagues and also other areas of our interest—philosophy or sociology, for example. Depression is at the center of many clinical discussions because it has become so widespread. HWO has stated it as being present in 121 million people worldwide.

Description—The Clinical Case and Some Theoretical Elaborations

Ana is a middle-aged patient, who showed typical features of a depressive condition. She had difficulties in expressing herself in general: aggression, fantasy, thought, and memory. These difficulties drew a scenario of excessive passivity and paralysis, with a globally lowered psychic activity. The general condition was dominated by poverty of speech—with no lack of abilities or cognitive conditions—and extensive monotony of a psychic life in a painful stillness. In Fédida's words: "The depressive condition is a bit like a non-performing and inactive body, whether hidden in an inert immobility, whether dragging the feeling of prostration and exhaustion" (2002, p. 186). Ana showed a marked inhibition of the work of thought, of remembering and fantasizing and also of affective expressions. All these caused constant silence during sessions and little flow of free association. I also could see her great emotional anesthesia when she had to confront experiences.

Ana was analyzed over a long period of time and did not use the couch during the first year. She defined it since our first interview, when she also said she wouldn't tolerate a cold environment in the analysis: "It was very difficult to come up here, but I think it will be harder to tolerate your silence". However, the silence was hers. I realized that she asked me not to make her think, since it evoked suffering and anguish, sometimes catastrophically hard to bear. This phrase she pronounced in her arrival foreshadowed the tone of several issues that appeared during the treatment. There was an insistent silence in many ways—of words, of investments, of affection, of involvement, and also of dreams.

About her history, she is the youngest daughter of three siblings, raised almost exclusively by her mother, who lost her husband early and continued to battle for life, without ever getting involved with another man and proving to be strong, self-sufficient and independent, yet rigid and very indifferent to life. The absence of Ana's father was always denied, and never talked about. She barely remembered her father, though she was over eight years old when he died. The whole family has never talked to Ana about her father's death, nothing was explained to her about the event. She was present at the funeral, although nobody told her who had died and why, and who was that dead man. It was only after analytical work that she could access the content relating to his death and its psychological consequences, as if this part of her life was separated from her other memories.

This patient showed great inability to maintain loving relationships or deepen her very few stable social relationships. She dated some men without showing true involvement or love, while maintaining a very similar attitude to her mother's—a sentence they shared: "I do not need a man"—a defensive aspect that also related to

the death of her father. Her school life showed the same characteristic of volatility, and she did not attach to the people and the institutions. She seemed to have developed a kind of shell that gives her the image of being extremely independent and disconnected from everyone, which also shows her identification with her mother. However, her shell was filled with a sense of loneliness and abandonment.

During the first month of analysis, Ana said she did not dream. Gradually she remembered a persistent dream, present occasionally since childhood, and that had now returned, accompanied by a lot of anxiety. She could not at first say when it had started or come back. And described it: "I dream of a large, shapeless mass, with a strange color, and it seems to be made of clay, and it is under the table. I know that it is alive, but not moving much. There is another person on the scene, but I do not see this person directly". When she first told me, I remembered a passage from "The Interpretation of Dreams", where Freud speaks of remote past wishes that take part in dreams, comparable to shadows in Homer's *Odyssey*, which awoke to some sort of life as soon as they had tasted blood (p. 249). What would have awakened these shadows? This dream was the subject of many sessions, and gradually it took a more distinct shape. It took quite some time and analytical work so that Ana could bring associations about the dream. She said she felt like the shapeless mass under the table, hidden and alone, afraid of the silent adult world, reacting sadly to her father's death. She also spoke of how attached she felt to her mother, like an amorphous mass, in a negative way.

For years, this one dream was brought to me in some rare sessions, and she often repeated she had no other dreams. I relate this to her depressive condition, where even the basic psychical work of trying to diminish excitement by putting it into words and images is not flowing. Depression can affect the most basic mechanisms and resources our psychical world has. But after much time and analytical work, Ana's speech became more colored by emotions and externalized conflicts, accessible memories, and also dreams.

Gradually, with the psychical elaboration brought by our treatment, Ana left her condition of isolation and terrifying emptiness, and a second dream appeared: "I'm in a very beautiful room with my father and my mother. The dream had clear colors and I felt really good with them". From this dream, we could re-signify the first one. It seems to me that this dream was triggered by the awakening of her possibility to put her wishes into images and words, giving her internal figures more defined shapes, making it possible for her to name her feelings and desire more freely and intensely.

In a text called "From Dream to Trauma: Psychosomatics and Addictions", Gurfinkel (2001) points to some clinical situations, involving drug addictions and psychosomatic manifestations, in which the onirical expression of the patient may be dysfunctional. He says: "The dream is the fulfillment of a wish; but what if the ability to wish was not sufficiently built, or was dismantled? I propose we call these situations 'collapse of dreaming'" (Introduction). Joyce McDougall proposes similar ideas referring to terrifying childhood experiences when they cannot be put into words, as they relate to early life, prior to the acquisition of language, and she suggests that the collapse of the dream function can produce somatic manifestations—"the psyche evacuates its tensions" (1989, p. 73) in the body.

Fédida (2002) also brings us interesting ideas regarding depression, and proposes a difference between depressivity, as something inherent to psychic life, in the sense that through it we can protect, balance and regulate our minds, and on the other hand, the depressive state, which is a kind of identification with death or the dead. What he calls depressivity enables us to open and close the contact with the world, rhythm and regulate it. The depressive condition nullifies depressivity, as if our eyes—to internal and external world—were always closed or always opened—exposing us excessively. If our ability to think, our potential of using words

and our wishes are inhibited as psychic manifestations, as a consequence of intensive traumas, the dream will also suffer the influences of this, thus collapsing. In this condition, it cannot be used as a way of elaboration. For my patient Ana, the return of the ability to dream, even if she had the same dream over and over for quite some time, represented a revival of her inner life.

Conclusion—Final Thoughts

As we have seen, Freud founded a new version of the psychic apparatus that produces dreams as a way out of its tensions, with the publication of the text “The Interpretation of Dreams”. The description of the primary processes and of the dream work, which includes condensation, displacement, representability and the tendency to regression, also allowed Freud's exploration of a model for psychoneurosis and its symptoms.

Later, in 1920, he completed his theory of dreams, talking about the traumatic collapse of the condition and function of wishful dreaming. He demonstrated that the dream function of representing wishes may fail if there are excessive stimuli to be processed, to be connected in the world of representational subject. The predominant pleasure principle is canceled and the psychical unit seeks to neutralize the action of energy excess, producing repeated and poorly constructed dreaming, that indicate traumatic elaboration. I think the chronicity of depressive condition can even affect this basic elaboration function.

From the theoretical and clinical considerations presented above, I could show that dreams concerning traumatic situations tend to repetition as a way of connecting psychic energies in a free state. But a depressive state can influence the dream production of the patient, in the sense of lowering this production and its conditions to translate wishes and also of connecting traumatic psychic excesses. My patient Ana brought no dreams to her analytical treatment for some years, she said she couldn't dream. In her first described dream, one sees the stagnant dreaming processes starting to function, which must be considered structurally by the analyst.

It is precisely through dreams and its contents that we can interrogate the shadows of the repressed unconscious mind and the mysteries of it. But beyond it, the very function of dreaming may be at stake, and that should also be recognized by the analyst. A patient's depressive state can present a diminished capacity to dream and it can be related to a traumatic family background that produced alteration in the processes of symbolization and representation. All of the three topics explored in this paper—depression, dreams and consequences of traumas—are relevant research fields for a psychologist. Psychoanalysis is an important clinical and psychological science and must present its contributions to this important debate. Considering that, I showed briefly how it theorizes about depression and how psychoanalysis works therapeutically with a depressive patient.

References

- Fédida, P. (2002). *The benefits of depression—Appraisal to psychotherapy*. São Paulo: Ed. Escuta. (in French)
- Freud, S. (1995). *The standard edition of the complete psychological works of Sigmund Freud*. London: The Hogarth Press.
- Freud, S. (1900). *The interpretation of dreams*. op.cit. vols. IV and V.
- Freud, S. (1914). *On narcissism: An introduction*. op. cit. vol. XIV.
- Freud, S. (1926 (1925)). *Inhibitions, symptoms and anxiety*. op. cit. vol. XX.
- Freud, S. (1920). *Beyond the pleasure principle*. op. cit. vol. XVIII.
- Gurfinkel, D. (2001). *From dream to trauma: Psychosomatics and addictions*. São Paulo: Casa do Psicólogo. (in Portuguese)
- Gurfinkel, D. (2003/2004). Dreaming and travelling: On the vertical of strangeness. *Percorso Journal of Psychoanalysis of Sedes Sapientiae Institute*, 31/32, 79-92. (in Portuguese).

- Mcdougall, J. (1989). *Theaters of the body: A psychoanalytic approach to psychosomatic illness*. New York: Norton Publishers.
- Menezes, L. C. (2005). Considerations on the trauma notion from a freudian perspective. In: M. O. A. F. FRANÇA (Ed.), *Psychical trauma: A psychoanalytical and philosophical view on modern culture* (pp. 93-108). São Paulo: Casa do Psicólogo. (in Portuguese)
- Peron, P. R. (2007). Contributions to the psychanalytical clinic of trauma (Ph.D. thesis in Clinical Psychology, Sao Paulo: Pontifical Catholic University of Sao Paulo). (in Portuguese).
- Roudinesco, E., & Plon, M. (1998). *Dictionary of psychoanalysis*. Rio de Janeiro: Jorge Zahar. (in Portuguese)