The Healing Dream
The Therapeutic Use of Dreams in Hypnosis

Giuseppe De Benedittis

The dreams of patients in therapy deal with conflicts mainly with unresolved childhood conflicts, but they are also reactions to, and expressions of, a current, focal conflict, that is one in which the dreamer is involved in his present life situation. Sometimes therapeutic solutions are tested and often the sucession of dreams may represent small but continuous steps in the therapeutic process.

Furthermore, as dreams can be easily induced and/or utilized in the pyschotherapeutic process, in this respect we may conceive of the dream as the „healer within us". If dream is the royal road to the unconscious, hypnosis is another. Not only interpreting dreams may be useful for the hypnotherapeutic process but inducing and manipulating hypnotic and nocturnal dreams are for some patients the most important diagnostic and therapeutic tool. The author reports the most effective dream utilization techniques in hypnosis and an illustrative case.

Ideas about sleep and dreaming have been central to man's concepts of mind and consciousness. Thinking about sleep has followed two lines. One characterizes sleep as an analog of death during which mental function ceases - Hesiod called sleep "brother of death." The other view holds that sleep, like wakefulness, is a special form of mental activity. Like Shakespeare's Hamlet, many have viewed sleep as a suspension of life than as a chance to dream, a chance to engage in a special form of mental activity.

In 1900, Sigmund Freud significantly expanded the latter view. In *The Interpretation of Dreams*, Freud proposed that dreams might represent "the royal road to the unconscious," a unique avenue by which unconscious motivations and fantasies could be explored.

Dreams continue to occupy a major position in psychoanalytic practice and theory, and have been extensively studied along physiological and psychodynamic lines. Much has been learned about the physiology of sleep cycle and sleep disorders, though the understanding of the role and functions of sleep and dreams is still uncertain. The psy-

choanalytic view of the dream process and the dream experience continues to draw heavily from Freud's discoveries.

The dreams of patients in therapy deal with conflicts - mainly, in Freud's view, with unresolved childhood conflicts and represent a "primary wish-fulfilling process," which is interfered with by the "dream censor," that is the ego.

More recently, French and Fromm (1986) placed more emphasis on ego processes in the dream and on its cognitive structure. They conceive of the dream as an ego function, a problem-solving attempt of the unconscious and the preconscious ego. French and Fromm have also demonstrated that dreams are reactions to, and expressions of, a current conflict, a "focal conflict," that is, one in which the dreamer is involved in his present life situation. Every dream contains one or more successful or unsuccessful attempts to solve the conflict (Brown & Fromm, 1986).

For these reasons, the therapeutic use of dreams may go far beyond the psychoanalytic paradigm, as each new dream or part of a dream may represent a free association to general meanings, current conflicts, or to elements of a previous dream. Sometimes therapeutic solutions are tested and often the succession of dreams may represent small but continuous steps in the therapeutic process.

Furthermore, as dreams can be easily induced and/or utilized in the pyschotherapeutic process, in this respect we may conceive of the dream as the "healer within us."

Hypnotic and nocturnal dreams: analogies and differences

First of all, it is necessary to give an operational definition of "hypnotic dreams," as opposed to natural "nocturnal dreams." For many clinicians and experimenters, any kind of imagined or visualized scene or activity in the course of induced hypnosis or self-hypnosis is called "dreaming."

For the purpose of definition, dreams during or under hypnosis are hallucinated visual and multisensory experiences which occur after sleep-suggestions given during hetero-hypnosis have been executed within the period of suggested sleep (Sacerdote, 1982).

"Natural dreaming" appears to be a necessary physiological activity which occupies a significant part of our sleeping hours. This does not exclude that dreaming serves important psychodynamic functions. Freud himself, while postulating that "dreams are the protectors of sleep," also implied that they represent a particular attempt by individuals to deal with problems, to communicate with themselves and (in analysis) with the therapist. Within this frame of reference, individuals who deny dreaming may either have an overwhelming need to repress insights achieved during dreaming or their dreamwork is so directly effective that there is little need for communication of the results from the dreaming state to the awake state. When not recollected, dreams can be conceived as internalized communications (Sacerdote, 1982).

Dreams provide specific communication from patient to therapist during psychoanalytic or hypnoanalytic therapy. The purpose of analytical interpretation of dreams is to clarify for the patient those observations and discoveries that he has been struggling

to achieve during dreaming, but which he does not yet clearly understand or accept in his awake state.

Orthodox analytical therapy purports to utilize "natural dreams," although these also are, in reality, "induced dreams" since the patient is unconsciously or consciously aware that the analyst expects and needs meaningful dreams for productive therapy. On the basis of a positive transference, the patient feels compelled to bring his therapist the gift of a daily dream (Haley, 1963; Sacerdote, 1982).

If we accept that dreams reported during analytical therapy are essentially induced dreams, it then becomes very natural to use hypnosis as a powerful tool for suggesting dreams, their possible contents, and desirable goals.

A large proportion of patients are able to produce successions of nocturnal dreams by post-hypnotic suggestion. Patients capable of deep hypnosis have little difficulty in producing successive dreams during hetero-hypnosis and even during self-hypnosis.

Although the psychophysiology of hypnotic dreams is not like that of nocturnal dreaming, as it is more like that in the hypnagogic state (Domhoff, 1964), in exceptionally hypnotizable subjects the structure and content of hypnotic dreams are like those of nocturnal dreams. In less hypnotizable subjects, the structure and content resemble daydreams (Barrett, 1979). But it is irrelevant from a clinical point of view whether induced dreams are genuine nocturnal dreams or pseudo-dreams, as they may be psychodynamically equivalent (Sacerdote, 1982).

The therapeutic dream in hypnosis: rationale

If dream is the royal road to the unconscious, hypnosis is another (Brown & Fromm, 1986). From a neuropsychological point of view, there is a considerable evidence supporting the notion of increased right hemispheric activation in hypnosis, imagery and dreaming, although studies are somehow contradictory and unconclusive, so to make it difficult to draw conclusions at this time (Gabel, 1988).

On a psychodynamic basis, hypnotic dreams enable the patient to gain access in a symbolic manner to his inner life, to unconscious conflicts and to self- and object representations. Hypnotic dreams are a convenient type of "forced fantasy" (Ferenczi, 1926) by which the clinician can directly inquire into unconscious processes.

Thus, historically, the first rationale in the therapeutic use of dreams deals with its diagnostic functions. The interpretation of dreams, associated with the free association technique, is still the major focus of the psychoanalytical and hypnoanalytical process.

In interpreting the dream, the hypnoanalyst should not just decode "symbols," but "like the good translator of poetry from a foreign language and culture, who faithfully and artistically tries to recreate in the language of translation the specific poetic atmosphere and quality of the original poem, so the dream interpreter must also recreate the dream's elusive atmosphere in order to make the dream meaningful to the patient's conscious mind" (Brown & Fromm, 1986).

In dream interpretation, the hypnoanalyst enjoys a distinct advantage over the psy-

choanalyst, who must wait, often for weeks, for the dream reports the patient brings in. And psychoanalysts are always faced with the fact that much of the content of dreams has been repressed, forgotten or distorted. Hypnosis provides a number of tools to facilitate and improve working with dreams:

1. The hypnoanalyst can hypnotically induce dreams during the hypnotic session, dreams that the patient reports immediately after they are dreamt.
2. The hypnoanalyst can suggest that the patient dream out a particular conflict or problem the therapist is trying to help him solve.
3. If the patient has not come to a solution by means of the dream, the hypnoanalyst can ask him to dream it again - perhaps with a different manifest content - and to try again to cope with the same problem, either in a different manner or on a different level.
4. The hypnoanalyst can suggest that the patient will be better able to understand the symbolism and meaning of his dreams as time goes on.
5. The hypnoanalyst can give the patient a post-hypnotic suggestion that during the following days he will dream some important dreams at night, which, even if he should forget them, will rise into consciousness and be remembered by him as soon as he steps into therapist's office next time.
6. It happens not infrequently that the patient asked to dream during the current hypnotic session, will hypermnestically remember an old nocturnal dream he had repressed before.

Induced dreams are for some patients the most important diagnostic and therapeutic tool. They are really the *healing dreams*. For others they are but a part in the overall therapy. It can be useful to combine the diagnostic and therapeutic possibilities of induced dreams with hypnoanalytical techniques. Hypnotic dreaming often represents a kind of "monitoring" about the ongoing therapeutic process. Once it is established that the patient has the ability to produce hypnotic dreams, he can be told to dream about a particular problem. The patient can also be told to dream abouth the therapeutic relationship, as dreams are useful indicators of the status of transference at any given moment in the therapy. Profound changes are often "forecast" in a series of dreams weeks or months before the changes become recognizable to the therapist and patient. It is often countertherapeutic to interpret such dreams to the patient, and it is wise to use the information immediately, allowing patient's unconscious to gradually convey the understanding to his conscious, rational mind.

Inducing hypnotic dreams

Erickson (1952) first introduced the induction of dreams as a useful variant of the "rehearsal technique" in inducing deep trances and studies of motivation, association of ideas, regression, symbol analysis, repression and development of insight. This technique consists primarily in suggesting the subject to repeat over and over a dream, or, less preferably, a fantasy, in constantly differing guises. That is, the patient repeats a spontaneous dream or an induced dream with a different cast of characters, perhaps in a different setting, but with the same meaning. After the second dreaming, the same instructions are given and this continues until the purposes to be served are accomplished.

Erickson warned that the therapist should use dreams of a pleasant character. If this were not possible, he should implant an artificial complex to limit the range of unpleasant emotions.

Many patients with low hypnotic talent or extreme resistance to deepening become amenable to hypnotherapy after suggestions that they may have a succession of dreams in the course of one or more nights. In fact, many patients start to recollect more and more of their dreams and to understand them as the symbolic expression of important conflicts. Often, the successive dreams comprise a testing of possible solutions. The response often involves subjects' gradually learning to remember entire dreams or parts of them, when they had previously stated, "I never dream" or "I seldom dream" or "I never remember any of my dreams."

Generally, after inducing a trance, suggestions are given to prepare the patient for dreaming during the hypnotic session or at home. To avoid the onset of unnecessary or countertherapeutic defenses, the therapist implies that dreams are pleasant, relaxing , interesting and instructive. The patient is also allowed to forget part or all of his dream experiences if they are too disturbing for his awake ego to handle.

Hypnotically induced dreams and post-hypnotically nocturnal dreams can at times permit age regression (Fromm, 1965) which the patient had been unable to experience during hypnosis.

Series of successive dreams may begin with an apparently insignificant one or with one that appears completely nonsensical to the patient as well as to the therapist. As the second suggested dream develops, one or more of the themes that were not previously recognizable in the first dream make an appearance. By the third or fourth dream, actions, images, metaphors and symbols direct our attention to problems or conflicts and to tentative solutions.

Schematically, the induction of dreams during hetero-hypnosis is as follows (Sacerdote, 1978; 1982; Brown & Fromm, 1986):

1. Induction and deepening of trance.
2. Induction of easy natural sleep.
3. While asleep, the patient will continue to be in contact with the therapist and will be instructed to have a pleasant, interesting dream.
4. Ideo-motor signalling will communicate to the therapist the end of the dream. After few minutes of silence, the subject will wake up and will clearly remember the dream and be ready to report it to the therapist as soon as possible.
5. If the patient fails to produce a real dream, the suggestion is repeated over a number of sessions. Each time the suggestion is modified slightly so as to evoke mental products progressively more like nocturnal dreams, along a continuum from secondary to primary process manifestations.

6. Sometimes, the patient is asked to report his dream to the hypnotist while still in deep trance in order to by-pass censorship of the secondary processes which are active in the waking state. Dream contents may be also worked through covertly in the hypnotic condition until the patient is overtly ready to analyze the dream work and to face the inner conflicts often related to it (De Benedittis, 1994).
7. Generally, alternating periods of sleeping, dreaming and awakening have the effect of deepening the trance. At the same time, dreams gradually change in character, at times becoming more realistic, at other times assuming all the characteristics of a naturally occurring dream, including symbolization, displacement, metaphors, and so forth. By this time, the patient may start to recognize the meanings of his dreams.
8. At the end of the third or fourth dream, the patient can be instructed to fall asleep, to dream and to describe the dream while it is occurring, with additional suggestions for remembering, understanding, and utilizing parts or all of the dreams.
9. With less responsive subjects, the patient is invited to talk about recent nocturnal dreams and then, after hypnosis has been established, to redream details of nocturnal dreams that have been forgotten. He may also redream or refantasize his nocturnal dreams in different guises, different settings, and/or with different actors. Conflicts, motives and concerns usually become more easily recognizable. A good part of this new information is continuously fed back to the patient while in hypnosis, then discussed again when he is awake.

Illustrative case report

A 31-year-old married woman, school teacher, presented herself at our Pain Center with a history of persistent, disabling headache which had been going on since the age of 16. The headache became extremely severe eight years later following parturition. The patient was overtly anxious, but denied any psychological problem and lacked entirely by emotional insight. Psychometric evaluation (Minnesota Multiphasic Personality Inventory, MMPI) showed highly significant neurotic patterns associated with a considerable degree of introversion. MMPI profile indicated somatization reaction, reactive depression, denial of emotional problems and high levels of free-floating anxiety.

The overall diagnostic impression was the following: 1. Mixed headache (combined histaminic vascular headache and tension-type headache). 2. Conversion reaction with depressive neurosis.

The patient was an attractive young woman, who, on her first visit, stated that if it were not for the headache she would be entirely problem-free. It soon became evident that this was not the case. Although the patient complained of an almost complete amnesia for significant events of her infancy and childhood, she could describe herself unhappy during that period, as she was entirely devoid of any love or affection by her parents. As a little girl, she tried to get close to her father, who would never permit this because of his domineering, uncommunicative character. She described her mother as anxious, overprotective and completely submitted to her husband.

She suffered from competition and rivalry with her siblings (particularly her older brother) for the attention, affection and esteem of her parents. She felt somehow rejected by her parents, for giving preference to her brother and later on to her younger sister, however she never actively expressed any anger or resentment toward them. The patient rationalized parents' attitudes as a consequence of her insufferable and bizarre behaviour. She described herself as a difficult child

to take care of, nasty and disobedient, repeatedly devising situations to provoke or exasperate her parents.

The patient could recall only two significant episodes of her early childhood, both somehow related with physical pain involving her face and head. Once her mother hit her with a belt's buckle on the face, which was stained with blood. She could not remember the reason for being hit, but argued: "At that time I was a naughty girl!" At the age of 5 she compulsory slipped into her parents' bedroom almost every night for a long time, silently waiting at her father's bedside, without apparent reasons. Whenever her father realized her presence there, he got angry with her and repeatedly struck her on the face and the head.

The headache began at the age of 16, when her father was reduced to bankruptcy and the family was forced to move from Milan to a small, isolated, province town. She felt angry, humiliated, making her father responsible for all that, but unable to overtly express those feelings.

The patient got married when she was 23. A few months later, she became pregnant. Despite a refusal attitude toward motherhood, she accepted to carry the child to term. Shortly after her daughter's birth, she had frequent quarrels with her mother-in-law. On one occasion, she recalled to have been violently slapped on the face and head by her. "I was so angry that I could kill her - she confessed - but I just went out slamming the door." A severe exacerbation of her headache occurred as a result of this traumatic event.

Disappointed by the husband's attitude, who pleaded his mother's cause, she rushed headlong into her teaching profession, without much satisfaction. She became meticoulous, perfectionistic, workaholic. Despite the efforts, she eventually realized that she had all failed to make successful life adjustments since she was a "never do well" person. Two years before examination, she engaged in an extramarital relationship but gave it up soon because of guilt feelings. Also on this occasion the headache became more severe and intolerable.

A short training period preceded the beginning of the therapy. Hypnosis was induced and the patient turned out to be an excellent subject, reaching sonnambulistic state with a spontaneous, self-protective, posthypnotic amnesia.

Following the training period, during which the patient was taught the technique of self-hypnosis in line with developing her own resources and activating an unconscious search, the analytical phase was instituted. Free associations and age regression techniques were used in order to explore and uncover repressed memories and/or traumatic events. The patient was induced into an extremely deep trance and slowly disoriented for time and place. She was then reoriented to earlier periods by appropriate suggestions. Each time regression spontaneously occurred at the age of 5, presumably because this was a significant period to her. During the first attempts, the patient was encouraged to recall happy episodes of that period, such as Christmas Eve, her birthday, etc. Following successful recall of those neutral episodes, a cautious open-ended exploration of the traumatic aspects of memory was carried out.

Although in deep hypnosis, the patient could elicit only a confused and vague flash-back of a forgotten episode and was unable to verbalize her thoughts and visualizations. Moreover she appeared very anxious and was displaying the same type of aggressiveness to the hypnoanalyst that she used to display at home with her family. In order to work through and to overcome these strong transference resistances, the patient was taught to dream and redream during hypnosis and during sleep, focusing on issues related with her inner conflicts. During one of these attempts, the hypnotic dreaming facilitated a true age regression (revivification), actually returning to the previous epoch with a reliving of the same traumatic experience that existed originally. She revivified being raped by a 16-year-old boy, who was working at that time in her grandfather's farm, and whom she adored as a father-substitute. Following a forced oro-genital intercourse, the boy sneered at her saying: "Well, that's what your mother and father like best!" She ran away from the boy, horrified and disgusted, harboring death wishes toward him.

Once the repressed, traumatic material had been divulged during hypnosis, the patient was slowly prepared to face the exhumed material at non-hypnotic levels. Even though the patient could consciously master the repressed material, her symptoms did not subside but shifted their patterns. Headache became nocturnal in onset, although less severe, and more somatizations appeared, while she became more anxious and depressed. Despite this, the relationships with her daughter and her husband unexpectedly began to improve. It was apparent that some inner conflicts were still uncovered.

These further resistances were worked through, requiring quite a long period of time. Eventually the patient, during a self-hypnotically induced dream, revivified the crucial episode which occurred a few months after having been raped. One night, she awoke from sleep and compulsively walked softly to her parents' bedroom. She needed to know the "truth" about what that boy told her concerning her parents. She hid behind the door that was ajar. It was mere chance that she witnessed a sexual intercourse between her parents (the "primal scene"). Thereafter, she heard her father saying, while talking with her mother, that he did not love his daughter (i.e. the patient) and would prefer to have another daughter. From then onwards, the little girl slipped every night into her parents's bedroom, as she believed it was the only chance she had for asserting her presence and her right to be loved by them. At the same time, by interposing herself between father and mother, she attempted to prevent the birth of a new, undesired sister. She was also prepared to pay dearly for that: whenever the father realized her presence he got angry and would struck her on the face and the head. Despite the efforts, all her plans failed and a few months later a new sister was born. She eventually desisted in trying to regain the affection of her parents and repressed the intolerable and painful feeling of rejection into her unconscious mind.

This dream material was worked through and flown carefully into awareness, allowing the patient a great deal of emotional relief as a result of this discovery. The "healing dream" anticipated the termination of the hypnotherapeutic process and represented a significant contribution of the patient's unconscious search to achieve the therapeutic goal. She realized that she had been suffering during all her life for feeling rejected by her father and that her rebellious behaviour might have been an unconscious reaction for that. In the following sessions, the patient could elaborate at a conscious level the ambivalent relationship with her father, entangled of death wishes toward him blended with feelings of guilt. She recognized the fact that her headaches have constituted for her a smoke screen behind which she hid her feelings of death wishes, rejection and self-devaluation. She could also recall, however, the unique chance she had of having eventually reconciled to her father, when he was dying for cancer many years later.

During the last sessions, the patient became symptom-free. Headache and multiple somatizations had completely disappeared. A long-term follow-up confirmed that the patient has been permanently cured.

References

Barrett D. (1979). The hypnotic dream: its relation to nocturnal dreams and waking fantasies. Journal of Abnormal Psychology, 88, 584-591.

Brown, D.P. & Fromm, E. (1986). Hypnotherapy and Hypnoanalysis. Hillside, N.J.: Lawrence Erlbaum Publisher.

De Benedittis, G. (1994). The poisoned gift: hypnoanalytical treatment of severe chronic headache. Paper presented at the XIII International Congress of Hypnosis, Melbourne.

Domhoff, B. (1964). Night dream and hypnotic dreams: is there evidence that they are different, International Journal of Clinical and Experimental Hypnosis, 12, 159-168.

Erickson, M.H. (1952). Deep hypnosis and its induction. In L.M. Le Cron (Ed.), Experimental hypnosis (pp. 70-114). New York: MacMillan.

Ferenczi, S. (1926). On forced fantasies. In Further contributions to the theory and techniques of psychoanalysis (pp. 68-77). London: Hogarth Press.

French, T.H. & Fromm, E. (1986). Dream interpretation - A new approach. Classics in Psychoanalysis. Monograph Series #5. New York International University Press.

Freud, S. (1953). The interpretation of dreams. In J. Strachey (Ed. and Trans.), The standard edition of the psychological works of Sigmund Freud (Vols. 4 & 5). London: Hogarth Press (Original work published 1900).

Fromm, E. (1965). Spontaneous autohypnotic age-regression in a nocturnal dream. International Journal of Clinical and Experimental Hypnosis, 13, 119-131.

Gabel, S. (1988). The Right Hemisphere in imagery, hypnosis, rapid eye movement, sleep and dreaming. Empirical studies and tentative conclusions. Journal of Nervous and Mental Diseases, 176. 323-331.

Haley, J. (1963). Strategies of psychotherapy. New York: Grune & Stratton.

Sacerdote, P. (1978). Induced dreams: about the theory and therapeutic applications of dreams hypnotically induces. New York: Theo Gaus.

Sacerdote, P. (1982). Hypnotically induced dreams: theory and practice. In J.K. Zeig (Ed.), Ericksonian approaches to hypnosis and psychotherapy (pp. 228-238). New York: Brunner/Mazel.