



**Utilization of  
Awake Dreams  
for Therapeutic  
Intervention**

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**Dreaming (& Waking) Lucidity and Healing  
Utilization of Awake Dreams for Therapeutic Intervention**

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As a nurse-psychotherapist working in outpatient psychiatry office I have been able to view the process of awake dreaming and harness it's therapeutic potential. I use three biofeedback procedures, temperature training, voluntary muscle training and palm sweat reduction to teach Autogenic Therapy (Schultz & Luthe, 1969).

The majority of my patients have various types of atypical depressions (Kernberg, 1984). The self-hypnotic aspect of the autogenic phrases combine with the biofeedback skills to allow the patient to experience a new psychophysiological state of "low" arousal. This different state, the "mezzanine of the mind" connects the patients to their emotional life in a markedly different way. A fascinating paradox of this newly mastered "deep relaxation" can be the spontaneous intrusion of symbolic hallucinatory phenomena classified by W. Luthe as Ideational Autogenic Discharges. However, the autogenic discharges, or biofeedback side effects, can occur in any organ systems and as a physical discharge. Another aspect of these side effects is that with frequent regularity there occurs a physical manifestation accompanying the most highly charged visual symbolism. These physical disturbances can range from mildly annoying to frightening and/or painful. Luthe had considered all these ideational and physical phenomena or autogenic discharges to indicate an unhappy brain needing to unload (personal communication from Luthe, 1969).

The awake dream can be harnessed by the patient and therapist and can offer a new journey to the inner world of emotional imagery. The harnessing process is accomplished as follow:

1) a few weeks home practice of biofeedback and autogenic phrases with supervision.

[if !supportLists]2) [endif]patient brings to session two 90 minute tapes.

- 3) instructions to assume same posture as has been used in office and at home with biofeedback and autogenic phrases, in recliner, with eyes closed, legs and arms uncrossed, covered by a blanket, microphone in place.
- 4) their task is to simply report what they get-
  - a. what they see
  - b. what they think
  - c. report all physical sensations
  - d. report in a continuous fashion
  - e. resist censoring or organizing the material
  - f. to resist moving - to keep it at a minimum
- 5) the tape is taken home and transcribed by the patient and brought to the next session where it is read out loud and reviewed.
- 6) the process then repeats with taping session followed by review session (Luthe, 1972).

About 50% of all patients will experience spontaneous visual imagery. The sessions are weekly but may be more often if the pain or anxiety levels become too great. With only two "dreams" per month therapy often will continue for a two year period. W. Luthe has tried to bring some order to the process by describing the differentiation of the visual phenomena into seven states (Luthe, 1970).

### **Stages Of Brain-Directed Visual Elaboration During Autogenic Training And Autogenic Abreaction**

#### Stage I. Static Uniform Colors

Elementary stage characterized by one-tone color filling the entire visual field (mostly dark shades). Frequently described as "just nothing", a "blank", or "as if my eyes are closed". Less frequently are lighter shades (e.g., silvery gray, yellow, pink, or light blue).

#### Stage II. Dynamic Polymorphic Colors

Elementary stage with more differentiated elaboration of chromatic, structural (e.g., cloud-like, shadows, vague forms), and dynamic features (e.g., various simple movements).

#### Stage III. Polychromatic Patterns and Simple Forms

Elementary stage with more differentiated and specific elaborations of forms (e.g., discs, ovals, rings, dots, lines, textile patterns), colors (e.g., purple, brown, blue, green), and dynamic features (e.g., turning, coming close, getting bigger, undulating, "flying" or "falling").

#### Stage IV. Objects

Further structural and chromatic differentiation of mostly static objects (e.g., utilitarian, ornamental, symbolic, faces, masks, monsters) which appear on a background of mostly dark shades or colors. Realistic or unrealistic dynamic features (e.g., "a turning coffee pot", and "a moving candle") may occur.

#### Stage V. Transformation of Objects and Progressive Differentiation of Images

Development of differentiated images (e.g., interiors, outdoor) of progressively increasing complexity with gradual transformations, displacements and polychromatic features. Realistic components may be distinguished. "Self-participation" rare.

#### State VI. Filmstrips

Highly differentiated and complex elaborations of structural, dynamic and chromatic elements. During advanced phases of this stage the trainee may occasionally change from the role of a "passive observer" into an "active participant" (e.g., "Now I am looking out the window"). Realistic and unrealistic features are distinguished.

#### Stage VII. Multichromatic Cinerama

Highest level of elaboration with prolonged periods of "self-participation" (e.g., "I am choking my father", "I am being eaten up by a huge monster", "I am driving along a road"). Realistic and unrealistic developments may alternate. Luthé, (1970) notes regarding this stage:

The highest level of differentiation of visual elaborations is usually associated with correspondingly high degrees of functional flexibility, providing optimal conditions for differentiated and multithematic processes of brain-directed neutralization. Spontaneous age regressions and spontaneous age progressions, transsexual transformation, engagement in violent dynamics of aggression or all imaginable activities of a sexual nature occur at this level of differentiation. Material of experiential nature (e.g., fight with a teacher) and disturbing material of non-experiential origin (e.g., suffering in hell, dying) may participate in highly complex and variable cinerama productions. Initially, cinerama patterns are of shorter duration, and functional regressions to state VI tend to occur easily. Later these cinerama elaborations may continue for one or two hours or even longer.

Brain-antagonizing and brain-facilitating forms of resistance may participate in bringing about temporary functional regressions to stage IV, to intermediary or even elementary stages.

As with Ullman's main premise for night dream appreciation, the transfer of the private intrapsychic communication of the night dream into a spoken social communication in a structured protective group (Ullman & Zimmerman, 1985), the "awake dream" shows the same potential. It is not until the patients observing self,

working at home, transcribing the dream tape for the next session's review, that the impact of the actual experiencing of the themes are realized. Childhood memories, emotions and traumas are all laid out over and over again. A wide range of critical issues appear on the program. Life threatening accidents come alive and demand appropriate emotional catharsis. The major theme that begs to unload deals with the emotional trauma of parental failures to provide a climate for development of inner structures of "self" support, giving a picture of 1) disintegration anxiety (Kohut, 1984), and 2) "abandonment depression" (Masterson, 1976). This fact makes the management of awake dreams a very specialized and sensitive task to work through for the patient and therapist and sometimes requires hospitalization.

A copy of a patient's awake dream follows. The bold lettering marks the patient's conflict/resistance and serve as exclamation points around the material presented. The "red threads" and "red arrows" that unlock and point to major "unfinished business" are the resistances-announcing physical sensations that accompany the symbolic metaphorical productions. An example of the extreme importance of these physical discharges for therapeutic intervention follows:

Leg itches. My right eye hurts a little. I see a roller coaster with rails on the sides and the rails are bent backward and I'm walking along the rails. OH my right eye itches. it really itches. (You're walking along the of the roller coaster where are you?) Just going up and down. And then I fall and I bounce back up. It didn't hurt. I'm just bouncing up and down. Seems to be something dark, a man's body with a monster head. It seems to be lurking underneath the roller coaster. He's spreading out his arms. It doesn't scare me though. It makes him mad that I'm not scared. And then It's like I'm patting him on the head and he has sharp things all over his head and I'm patting him with the palm of my hand and I can just feel the tips hit my palm. MMMMMM it just feels like he took his fist and hit me in the nose. Oh I just got a funny sensation at the end of my breast bone. And I get up and I look at him. Whack; ooooo I hit him in the face. I hit him again, hit him again, whack, oooo it makes me feel good to hit him. He just stands there. I just keep hitting him. Whack, oh it feels so good to hit him, whack. Oh! I just love it. (That's fine) I can't tell you how good it makes me feel. I love to hit him. Puts up his fist. I just hit him, whack, then I take my fist and hit him on top of the head, just punch him right down into the ground, whack, whack, whack, whack, whack. Nothing sticks out of the ground but his head. Oh that felt good.

Sounds like a steam shovel. Steam---shovel comes and puts dirt all over the head. I wan. I'm absolutely delighted with myself. I love it. Oooooooo I feel like I want to cry and I feel just for an instant that I was spinning around. It stopped.

The patient's mastery of her victimization by becoming the aggressor gave rise

to tears and dizziness. Could it be that by letting go of her rage at this point it left her temporarily without her favorite way of "connecting and belonging?" Could it be she then began to experience the overwhelming nothingness and void with dizziness that precedes new growth around developmental arrests? The "butterflies" she reports are her gut fear response. Her major use of that emotion and her suffer/punish cycle were the "gifts" from the awake dream. The patient brings both the problem and solution to the session.

Otto Fenichel (1945), summarizing Freud, Ferenizi and Hahn, makes a very accurate plea for the need to invite the "dreamer", patient, both his experiencing self and observing self and the therapist to work toward "gradual summation of such discharges and derivatives."



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