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The Use of Presleep Instructions and Dreams in Psychosomatic Disorders

Loma K. Flowers

Department of Psychiatry,
University of California,
San Francisco, Medical Center,
San Francisco, Calif., USA

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Abstract
Economic restrictions in health care delivery encourage the development and use of efficacious, inexpensive, and brief psychiatric interventions in the treatment of psychosomatic illness that can by employed by generalists as well as psychiatrists. This article reports on the successful new application of recently developed techniques in dream interpretation in three cases of varying psychosomatic symptomatology. The improvements noted suggest that this approach may provide a rapid, low-cost diagnostic and treatment method appropriate for a range of psychosomatic patients.

Recent economic restrictions in US health care delivery have challenged psychiatrists who treat psychosomatic illnesses to develop new diagnostic and treatment approaches that are inexpensive and that can be made available to consultation-liaison and primary-care physicians [1]. Any new approaches must continue to delineate and treat complicated psychiatric (psychodynamic) components of psychosomatic illnesses as effectively as traditional approaches, such as Freudian [2–5] and Jungian dream interpretation [6].

Two factors limit the use of dreams in patients with such illnesses. Many psychosomatic patients have poor dream recall [7], and traditional techniques of dream interpretation require substantial costly psychiatric expertise and, often, considerable time to effect change [8].

However, a new application of a recently developed approach to dream interpretation may offer an inexpensive alternative. This approach is a presleep instruction process, 'dream incubation,' followed by a descriptive interpretive process known as 'dream interviewing' [9]. Such intervention has been observed to result in rapid improvement in a range of patients indicating the potential of this method for reducing overall treatment time and, therefore, costs. Also, these meth-

Loma K. Flowers, MD
1670 Plymouth Avenue
San Francisco, CA 94127–2143 (USA)

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Table 1. Steps in dream incubation and recall and physician's explanatory instructions to patients

Steps	Physician's instructions to patient
Dream journal	Begin a dream journal in a notebook, such as a spiral binder in which you will write the following notes.
Day note	Just before you go to sleep, write the date and title, 'Day Note'; then, write a brief paragraph about the major events and *feelings* of your day.
Incubation question	Now write a subtitle, 'Incubation Question,' followed by a few lines about your understanding of the emotional aspects of your illness; next write the specific question or issue you would like your dream to answer or clarify; do not ask for magic; be as precise as you can about your wording; ask only what you would *really* like to know.
Recall preparation	Leave the dream journal, pen, and a light by the bedside within easy reach.
Actual incubation	Repeat your question to yourself as you fall asleep; if your mind wanders, bring it back to focus on your specific question or request; if you awake without a dream, try again.
Dream recall and recording	Upon awakening, immediately think back, and write down any dream, dream fragment, thought, or feeling; then give each dream a title for easy reference; be sure to distinguish waking ideas from dream ideas.

ods are available to practitioners with varied training, obviating the necessity for more specialized treatment in certain cases.

In this method, dream incubation, as it was called by the ancient Greeks, is presleep instruction designed to influence the latent content (meaning) of a dream [10]. Such instruction can address precise questions about individual cases of psychosomatic illness and can direct and enhance the process of dream recall. Dream interviewing is based on the assumption that the meaning of each dream image is known best to the individual patient.

This article describes the use of presleep instruction and dream interviewing to diagnose and treat the psychiatric components of psychosomatic disorders in 3 patients with widely differing pathology: hypertension, persistent tension headaches, and psychosomatic vomiting. The cases are presented in order of increasing complexity of psychiatric components. In all 3 cases, the use of this method resulted in rapid alleviation of symptoms.

Method

In introducing this method, patients were briefly educated about the clinical use of dreams and reminded of the influence of psychological factors on physical health. They were informed that work with one dream a week could help improve their health. To enhance dream recall, they were encouraged to avoid excessive fatigue, drugs, alcohol, and noise.

Following this introduction, patients were instructed in the steps of dream incubation and recall. These steps are summarized in table 1. After reporting a dream, patients received an explanation of the dream interview method of interpretation [11, 12]. Interested patients were given references to read [11, 12, 19].

The dream interview process began with the physician asking a series of questions about each major image in turn. These questions were designed to obtain a full and distinct description of each major image (a descriptive definition) [13] necessary for the interpretive step. Then, to construct the actual interpretation, the physician sequentially substituted these definitions into the plot of the dream and asked the patient a series of 'bridge' questions. These bridge questions were designed to match the dream metaphor to reality by determining where each descriptive definition was mirrored in the patient's waking life. A bridge question about the *setting* was the usual starting point because it often localized the area of the patient's life to which the dream referred. A key factor in this phase of the inter-

pretation was to retain the dynamic structure and chronology of the dream; the interpreted details then provided verification of the most specific interpretation. Identification of the most specific interpretation seemed to increase the patient's speed of change. The following cases illustrate the method.

Case Reports

Case 1. A 58-year-old divorced African-American woman had an uncomplicated partial bowel resection for cancer, and developed severe vomiting about 5 days postoperatively that persisted for 2 weeks. No organic cause was found for the vomiting, but obstruction was possible. Work on a spontaneous dream [6] revealed the dynamic of unresolved grief for a lost son. The grief had been somaticized and expressed as retching and vomiting. When the vomiting began converting to anguished sobs, she was encouraged to continue crying and instructed to incubate: 'I need a dream to help grieve my son.' Next day, in a chair, eating for the first time in 2 weeks, she related 'a wonderful dream':

We were in the house we lived in when he was small. We were playing Old Maid. He was the same age he was when we did play Old Maid. He was winning the way he always did, and laughing the way he always laughed, and cheating the way he always cheated!

The patient experienced 'real joy' in the memories and relished the power of the dream incubation – in contrast to her powerlessness during his psychosis and her vomiting. This dream reframed her relationship with her son and restored the balance of positive and negative feelings necessary for grieving. She went home in 3 days.

Case 2. A 29-year-old British-American woman in outpatient psychiatric treatment for depression developed severe tension headaches, which she self-medicated with narcotics.

The patient reported that the headaches began during a seminar at work where the style of teaching confronted students with the limitations of their knowledge and then criticized them for errors. Concurrently, she noticed that she was having recurrent, spontaneous, and 'endless war dreams'. She described her dreams 'I was in a little hovel, in a war zone, periodically creeping out to steal bread'. The patient did not understand these dreams but assumed that they were related to the headaches, and, therefore, she incubated the following question: 'what are these war dreams about':

I am having a huge argument with my mother. She is so apologetic and self-deprecating, like 'beat me!' and I am yelling at her to 'stop doing that! You're tall and attractive, and you act like a hunchback! Why do you have to *be* like that?'

The patient recognized this dream as a metaphor for an internal conflict about her own unconscious imitation of her mother's perfectionism and style of seeking emotional support. This style, although effective in their family, was especially maladaptive in the work seminars where it elicited critical attacks. In addition, she felt the war zone setting accurately depicted her feeling of being continuously under fire at work. She equated her view of her trainee status in her field with the hovel; and she recognized her episodes of periodic public self-deprecation in her dream as dashing out, risking greater exposure to attack, in order to get some basic support (represented by bread).

The patient's dislike of self-deprecation immediately motivated her to use these metaphors to identify individuals at work who might be emotionally available to her to provide emotional support, and to plan how to elicit such support regularly and appropriately. In addition, she designed strategies to confidently declare the limit of her knowledge rather than be tempted into further self-deprecation. These insights and plans occurred in one 50-min session in which her headache faded. Since she acted on this knowledge, her symptoms have not recurred.

Case 3. A 39-year-old African-American man hospitalized for hypertension (BP 260/150) refused psychotherapy, but agreed to his internist's referral for dream work. Instructed in dream recall and incubation over the phone prior to his first psychiatric outpatient visit, he presented this dream on the second visit after incubating: 'How can I be healthier and make my blood pressure go down?:

My wife was having a meeting with graduate students on an on-ramp (to a freeway). No one had a car. They were discussing the difficulty getting jobs and what to do with careers and school. The tone was congenial; she was advising. I was present but also I knew that I was home in the bed. I was worried enough that I wanted to get out of there; it's not a good place to have a meeting because it poses a danger to them, but nobody else seemed concerned.

The patient gradually recognized that this dream referred to his complex career concerns. He was stationary in his current position which was often used by others as a stepping stone (on-ramp) to the fast track. Concurrently, he was redefining his professional identity (represented by the meeting). The recent impact of fatherhood had made financial success a primary consideration ('today's' graduate students) and he despised such values. In addition, his moderate interest in

career success was associated with a previously unrecognized stubborness (his wife). This internal process was passively observed by his former identity as an unambitious, community minded-bachelor (I). This part of himself was both aware of the life threat in his current psychological position (present and worried) and simultaneously uninvolved and unconscious (home asleep). This new conceptualization facilitated his gradual integration of all three attitudes into a coherent identity and career plan.

During a 17 visit course of brief psychotherapy guided by this psychodynamic formulation, his blood pressure remained under control (130/88–137/90) while his medication dosage was reduced by half, despite his return to work and family responsibilities.

Discussion

Since 1911, a number of studies have focused on the use of presleep suggestions to manipulate the manifest content and affect of dreams [14, 15], and have noted that the wording and phrasing of the presleep suggestion may play a significant role in the outcome. Published work has described clinical experience with dream incubation [13], but few studies have described attempts to influence the meaning (latent content) of dreams [16]. One study manipulated dreams for manifest content and collected subjects' associations to those dreams but produced no useful data pertaining to meaning [10]. Case reports of dream interpretation in psychosomatic illness have generally used the traditional associative methods of dream interpretation – Freudian [2, 13] and Jungian [5, 14] – on spontaneous dreams. Investigators are also studying multiple aspects of dream recall [17] and one study has reported successful prompting of memory with dream titles [18]. Our experience confirms this finding.

In my experience, any medical patient who is cognitively intact and capable of speech can use dream incubation. Patients have responded well to the increased conceptual balance of physical and emotional issues and shared treatment responsibility fostered by these techniques. The very act of incubation instruction encourages a patient's role to develop from passive to active and the interview process models a collaborative approach to treatment. The connection between recurrent dreams and physical symptom development (case 2) has been noted elsewhere [4] and suggests broad opportunities for dream work. Furthermore, some women with eating disorders [3] and medical patients like case 1 and 2 who resist psychiatry, may accept dream work, indicating additional potential for use of this technique in this population.

A striking aspect of this approach is the swift integration of new psychodynamic insights leading to effective emotional and behavioral change and a prompt response in the psychosomatic illness. Several possible mechanisms might explain this response. The self-designed phrasing of the incubation may tailor the insight to accomodate the patient's defenses. The patient's own metaphoric language may also facilitate a straightforward acceptance of complicated, consciously new concepts. Discovery dreams [19] are common in psychosomatic patients and the level of insight generated by this method may be close to consciousness and therefore more easily integrated. Furthermore, visual presentation of complex conceptualizations facilitates understanding and mastery. Finally, the face-saving inherent in self discovery and the enjoyment of that power (case 1) may also contribute to patient receptivity. More clinical experience and studies are needed to confirm the efficacy of this approach.

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References

1 Eisendrath SJ: Brief psychotherapy in medical practice – keys to success. West J Med 1993;158:376–378.
2 Potamianou A: Somatization and dream work. Psychoanal Study Child 1990;45:273–292.
3 Brink SG, Allan JAB: Dreams of anorexic and bulimic women. A research study. J Anal Psychol 1992; 37:275–297.
4 Levitan HL: Dreams which culminate in migraine headaches. Psychother Psychosom 1984;41:161–166.
5 Levitan HL: Implications of certain dreams reported by patients in a bulimic phase of anorexia nervosa. Can J Psychiatry 1981;26:228–230.
6 Welman M, Faber PA: The dream in terminal illness: A Jungian formulation. J Anal Psychol 1992;37: 61–81.
7 Monday J, Montplaisir J, Malo J: Dream process in asthmatic subjects with nocturnal attacks. Am J Psychiatry 1987;144:638–640.
8 Sabini M: Dreams as an aid in determining diagnosis, prognosis, and attitude towards treatment. Psychother Psyehosom 1981;36:24–36.
9 Delaney G (ed): New Directions in Dream Interpretation. Albany, SUNY Press, 1993.
10 Delaney G: A proposed dream experiment: Phase-focussing dream incubation. Sundance Community Dream J 1977;1:71–83.
11 Delaney G: Living Your Dreams. San Francisco, Harper & Row, 1988.
12 Delaney G: Breakthrough Dreaming. New York, Bantam Books, 1991.
13 Flowers LK: Dream Interview method in a private outpatient psychotherapy practice; in Delaney G (ed): New Directions in Dream Interpretation. Albany, SUNY Press, 1993, pp 275–277.
14 de Koninck J, Brunette R: Presleep suggestion related to a phobic object: Successful manipulation of reported dream affect. J Gen Psychol 1991;118:185–199.
15 Barber TX, Walker PC, Hahn KW: Effects of hypnotic induction and suggestions on nocturnal dreaming and thinking. J Abnorm Psychol 1973;82:414–427.
16 Barrett D: The 'Committee of Sleep': A study of dream incubation for problem solving. Dreaming 1993;3:115–122.
17 Moffitt A, Hoffmann R, Galloway S: Dream recall: Imagination, illusion and tough-mindedness. Psychiatr J Univ Ottawa 1990;15:66–72.
18 Cipolli C, Fagioli I, Baroncini P, Fumai A, Marchio B, Sancini M, Tuozzi G: Recall of mental sleep experience with or without prior verbalization. Am J Psychol 1992;105:385–407.
19 Flowers LK: The morning after: A pragmatist's approach to dreams. Psychiatr J Univ Ottawa 1988;13: 66–71.