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Subject: Desoille's Rêve Éveillé Dirigé

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Participants:

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Editor's Note:

1. Parts of Dr. Haronian's talk on Desoille's technique have been omitted because the points have been covered more adequately in three lectures given by M. Desoille at the Sorbonne, Paris, in January 1965. With the author's permission, mimeographed copies of Dr. Haronian's translation of these talks have been made available for limited circulation. A copy is attached.

2. Dr. Weber's talk to follow.

PSYCHOSYNTHESIS RESEARCH FOUNDATION
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Dr. Frank Haronian:

My discussion tonight will be based primarily on Desoille's most recent book, The Theory and Practice of the Directed Daydream. I have made notes of those issues which appear to comprise the most salient differences between Desoille's technique and the more familiar forms of psychotherapy.

Here first are some procedural aspects of Desoille's technique. He says that he generally sees his patients about once a week for sessions which last from 1½ to 2 hours. He prefers to use a form of multiple therapy, and for this purpose, he often uses his wife or a student therapist as a passive observer of the treatment session. He believes that it is better if therapist and patient are of opposite sexes. This means that the co-therapist who does not take an active part in the treatment should be of the same sex as the patient.

Each session generally has three parts:

1. A discussion of what happened to the patient during the past week.

2. A review of the previous directed daydream and any nocturnal dreams which the patient experienced.

3. The development of a new directed daydream, which takes from half an hour to an hour.

Subsequent to the session, the patient is expected to write a detailed account of his daydream. He is asked to recount it as completely as possible and to mention in his account all ideas which are spontaneously associated with the contents of the daydream as he writes it out. The patient is also expected to write out his night dreams. These reports are either to be mailed to the therapist or brought to the next session. At that time, therapist and patient together consider the meanings of these productions.

Now, as to the daydream session itself: The patient is invited to lie down in a quiet room in which the lights are dim. Suggestions are used to help him to relax, to close his eyes, and to slip into a state which encourages reverie. The therapist reminds the patient that in a dream, anything can happen, that he will be expected to remember these events, and that he should not be surprised if he experiences unusual and intense feelings during the course of the daydream.

The psychotherapist then suggests an image of specific symbolic significanc in order to give the patient a starting theme. Desoille uses six standard images. For a man, the first is a weapon, such as a sword. In the past, he has also used a key. He believes the phallic symbols evoke a man's image of his own masculinity. For a woman, the first image is a receptacle of any kind, such as a vase or box. The patient is encouraged to visualize and describe the image in detail. The image and his account of it induces a flow of fantasy which gradually replaces the structure and content of conventional thought with a dream-like flow of images. This spontaneous change can be noted as the patient talks more slowly, monotonously, and with less force. This process induces strong affective reactions in the patient much more rapidly than would occur in a direct therapeutic interview. (Parenthetically, my impression is that these affective eruptions represent the single most essential aspect of the

treatment process.) The patient's physical passivity and hypnoidal state will often mask from the therapist the intensity of the emotions which the patient is feeling. It is therefore essential that the therapist constantly keep asking the patient what he is feeling, and that he observe the patient minutely for small changes in facial expression, breathing, and other bodily movements which may indicate changes in feelings.

There are several ways in which the therapist may intervene in the process of the patient's daydream and offer it direction:

1. Reminders that in a dream, anything is possible.

2. Encouraging the client to face and cope with challenging and difficult situations.

3. Intervening so as to prevent the development of too intense a feeling of anxiety by the client if and when the imagery becomes too threatening.

It may take quite a bit of practice for a patient to get into the spirit of this technique. Some achieve it more rapidly than others, but this is not something that you can expect to occur automatically. The patient must be relaxed and must be free from preoccupations and worries. The use of a starting image is helpful for getting the patient going. Later, one may permit the patient to choose his own starting image, or one may propose starting images which are taken from the patient's own night dreams. If the patient has had a dream which provoked so much anxiety as to awaken him before he finished it, the imagery from this dream might fruitfully be used as the seed for a directed daydream.

According to Desoille, the initial results of using directed daydreams with a new patient show little difference between them and ordinary night dreams. At this stage, the directed daydreams provide very useful diagnostic signs of much the same sort that Leuner gets through the use of his twelve starting themes in Initiated Symbol Projection. But subsequent imagery draws increasingly on the kinds of concepts which Jung has called archetypes. And eventually, there may appear images which are almost entirely abstract representations of light. Desoille calls these "mystical" images.

According to Desoille, for a patient to imagine a danger or experience a fear in a directed daydream is only possible in reference to a danger or a fear that once was experienced. But even a weak memory of a painful experience can arouse an intense reaction in the directed daydream. When painful imagery arises in a daydream, the therapist can help the patient to recognize just what people and situations gave rise to those fears. The therapist then directs the patient toward a symbolic resolution of the painful situation in such a way that affirms his own legitimate interests. This symbolic solution, achieved on the level of imagery, and often without any conscious insight by the patient into its meaning, can provide the patient with a decided feeling of relief. It can desensitize him from the noxious effects of subsequent experiences which may otherwise have the effect of reinstating the old anxieties.

Patients often state with considerable surprise that they were overwhelmed by the intensity of the feelings which they experienced in the course of the directed daydream. But how is it that such surprisingly strong feelings are

aroused? Desoille relates this fact to Pavlovian theory, according to which the directed daydream situation releases the normal inhibitory effect of the cortex over sub-cortical brain functions, and this weakening of cortical inhibition allows feelings to develop to an extent not otherwise possible.

But how is it possible for the imaginary and symbolic resolutions of conflicts which have been directed by the therapist to have a corrective effect on maladaptive patterns in the patient's daily life, especially in view of the absence of any "insight" on the patient's part as to what his daydream and its resolution means? Desoille explains the healthful results of the procedure by first describing Pavlov's theory of two separate "signal systems". The first signal system is comprised of sensory impressions and imagery; with what we supposedly share with the lower animals. The second signal system is concerned with the symbol-making function, and particularly with language. Desoille claims that the communication between these two systems is so intimate that whenever anything occurs within one system, it is accurately reflected in the other system. The directed daydream makes it possible to resolve conflicts on the non-insightful (hence, less painful and less resistance-provoking) level of the first-signal system. Once this is done, at least a partial desensitization of the patient to his painful feelings has occurred. Along with desensitization there is less need to repress. And if the therapist has directed the daydream effectively, the patient may be ready to find a new and productive way of dealing with the old and painful conflict. The net effect should, in theory, be the gradual emergence of the original conflict into the patient's awareness along with a practicable solution to it.

By now, the patient has replaced the originally noxious and painful feelings associated with the conflict by more pleasant feelings of success. These new and happier feelings emerge from the imagined experiences of accomplishment and success which the patient had in his directed daydreams.

It is an extremely important part of the directed daydream process that the patient experience success and accomplishment. You don't simply threaten the patient by pushing him into imagining a situation in which he has to struggle with an octopus at the bottom of the ocean or go kill a dragon in a cave. Desoille very often helps a patient by such tactics as offering him a talisman which will protect him from the dangers through which he must pass.

Desoille's method seems to depend on the patient's development of a narrative in which there is a sequence of events and which eventuates successfully. The patient does not have to understand the symbols for them to be effective; it is only necessary that he develop the narrative and that he carry it through to a successful conclusion. But if I understand Leuner correctly, even that much is not necessary within the context of his method. I think that Leuner would say that as long as the client develops an image, focusses intently on it, and allows it to develop as it will, appropriate feelings will be aroused and therapy will take place. It may be that some patients respond better to Desoille's more active kind of imagery while others prefer the more gradual and static approach of Leuner.

I think that there are similarities between Desoille's technique and Wolpe's form of behavior therapy. Both help their patients to face painful feelings in graduated steps so as to desensitize them from the situations which evoke these negative feelings. Both depend on the extensive use of imagery for this purpose. Both recognize that desensitization is not enough, and that in order to overcome the noxious effects of faulty conditioning, the patient must develop an alternative

and healthy response to the stimulus which has in the past brought on the painful feelings and/or disturbed behavior. Despite these similarities and their common reliance on Pavlovian theory, Desoille's approach seems highly artistic and intuitive while Wolpe's technique sounds almost tediously routine and methodical.

So far, I have tried to give you an overview of the theory and the procedures. Now I would like to go into some more of the details of Desoille's suggestions about the relationship between therapist and patient.

One of the first tasks of the therapist is to give the patient a sense of personal responsibility for dealing with his difficulty. But he must manage to do this without developing any sense of guilt in the patient for his neurosis. The relationship should be that of man to man, and with the greatest possible frankness. Desoille decries the Olympian attitude of the classical psychoanalyst and says that it should be avoided at all cost.

Next, a detailed anamnesis is appropriate. This is especially important for the uncovering of all kinds of habits of daily life. It surprised me to learn that Desoille is interested not only in the sexual behavior of his patients but also in their eating habits, sleeping habits, and especially in the way a person handles his job, how well he deals with the ordinary problems of living, the most prosaic everyday situations. He seems to believe that people who routinize well, who systematize their lives and work efficiently are healthier to begin with and are better prospects for therapy than others. One part of treatment, if not an essential one, is often to encourage patients to practice the development of will power by systematically organizing their lives, by getting up at a regular time, by being reasonably efficient about the ordinary routines of life. This was a bit surprising to me. I don't recall any psychoanalytically oriented therapist who is so concerned about these relatively minor details of living. Yet when you think of the considerable amount of time and effort that we put into them, they do seem rather important.

Desoille feels that a client should be helped to criticize his own behavior, but in such a way as to reinforce his sense of responsibility and his self-confidence. The therapist tells the client that his troubles are only a pack of maladapted habits which are not inevitably his fate. The process of the establishment of the conditional response is explained to the patient. In this procedure there is definitely a quality of indoctrination into the theory; the patient is told what a conditional response is, the basic principles of treatment are explained and the patient is told what he can expect will happen at different times. This certainly sounds quite different from what occurs in conventional psychoanalysis.

Regarding the question of prognosis and the likelihood of cure, Desoille will not treat psychotics. He insists on sending them to psychiatrists. He feels that a cure depends on the ability of a client to <u>want</u> and to <u>will</u> a new orientation of his personal interests and to establish a meaningful personal goal which is accessible, not unrealistic. He says that the technique is effective with hysterics, anxiety neurotics, phobics and homosexuals; also with cases of impotence and frigidity, and with some obsessives. However, he has not been successful with hypochondriacs and paranoids, nor with psychasthenics who are incurably thin.

Desoille points out that the standard psychoanalytic procedure leads to the development of transference neurosis which he interprets as an understandable

regressive reaction by the patient to the frustrations which he is experiencing in the treatment at the hands of the analyst. This results in the compulsive repetition of a maladaptive stereotype, or of several such behavioral stereotypes, which have been determined in part by constitutional factors and in part by life events. When these stereotypes crop up in the patient-therapist relationship, the therapist is dealt with by the patient as a person who is similar to pre-existing prototypes: mother, father, or the significant figure.

Desoille thinks that the fact that regressive inappropriate habits are evoked in psychoanalytic treatment sessions is simply an understandable response of the patient to the frustration and the confusion which is brought on by the character of the treatment situation. To paraphrase him, the analyst intentionally frustrates a patient and this frustration provokes a regression which is manifested by recourse to stereotyped behavior. This behavior is often very archaic in origin partly because the patient is facing a situation which is analogous to that of a child being frustrated by an authority figure. Desoille sympathizes with the patient, and says that much of what is called transference is an understandable evocation of old patterns of behavior in trying to cope with a frustrating situation.

It seems to me that the situation boils down to this: Psychoanalysis says that to cure a neurosis, one must frustrate a patient and provoke him into a transference neurosis, and then proceed to treat <u>that</u>. But Desoille claims that this is unnecessary and that it is a waste of time and effort. Transference is merely the evidence of a pack of inappropriate habits which can be diagnosed and extricated by the directed daydream much more quickly than by the usual analytic procedures. The directed daydream is quicker and less painful than psychoanalysis partly because it does not require the induction of a transference neurosis. Further, Desoille claims that Freud himself said that the cure is not complete without the use of an auto-suggestion procedure. Desoille quotes approvingly the remarks of a Freudian analyst to the effect that old, obnoxious habits are only destroyed by substituting other habits, i.e., by setting up new patterns of behavior which interfere with the old ones which one seeks to eradicate. This seems also to fit nicely with those of Wolpe's ideas which go under the rubric of "reciprocal inhibition."

Obnoxious habits are resistant to elimination in the same way that conditional responses are; after being out of action for a while, they may suddenly crop up again. Because of this tendency for extinguished conditional responses to recuperate spontaneously, the patient should be advised that if and when the symptoms recur, they will do so with less strength than before, and if they are resisted, they will eventually lose practically all force.

Desoille claims that orthodox psyhoanalysis fails to offer any specific technique for helping the patient to acquire new and more effective habits. It leaves the patient to his own devices, to his intuition. The analysts <u>talk</u> about the importance of habits but they forget that habits are only established by the repetition of a planned pattern of behavior. (I question this point but will not take issue with it now.) This can be done in either of two ways, either starting strictly on the level of imagination, as in the directed daydream, or by getting the patient actually to practice different behavior in daily situations. On this point, the similarity between Desoille's ideas and Moreno's sociodrama is evident. Kelly's "role repertory therapy" sounds very much like this. After he has diagnosed the difficulties of his patient, he writes a new role for him, a personality sketch, and he gives him a new name. He then asks the patient to live out this

role, with this new name, over a period of time. If the patient tends to have trouble in certain kinds of social relationships, Kelly describes the new personality as one that can deal effectively with at least some of the patient's problems. Of course, the very act of going through this procedure amounts to a strong suggestion to the patient that he will be able to carry out the instructions.

Desoille claims that in his approach, the transference presents fewer difficulties than in psychoanalysis because it comes through in a weaker form and because it is elaborated and worked through in the directed daydream instead of in relation to the therapist. It seems possible that the passive presence of a third person in the room during the treatment sessions may be sufficient to inhibit the direction of transference reactions onto the therapist, thereby channeling them into the content of the daydream itself.

In the usual therapist-patient interchange, the therapist's reactions to the patient's remarks serve either to reinforce or to extinguish the patient's habitual reactions. Desoille believes that in the usual psychotherapeutic situation, there are sharp limitations on the characters of the situations and the intensity of the feelings that are brought up. He believes that by using directed daydreams, both the content of the interchange and the intensity of feelings are enhanced. As a result, the therapist can apply greater leverage for either reinforcing or extinguishing behavior. This may be another reason why Desoille prefers to use two therapists, one of each sex. He also suggests that sessions could be conducted alternately by a male and a female therapist. In any event, he believes that for treatment to be effective, the patient must have confidence in the therapist. This requires a direct, "man to man" relationship between therapist and patient. If the therapist were to remain a neutral reflecting mirror forever, Desoille feels that there is the risk that the transference will never be resolved because the patient may eventually learn to derive neurotic gratifications from the treatment process itself.

DISCUSSION

Swartley: I have a clarification that might help: Desoille wrote five books to my knowledge; and as far as I know this one, "Theory and Practice" (1961), is the last one, which is probably a second edition of the one originally out in the early 1940s. As you said, he started with a combination of hypnosis, Freudian, Jungian and Pavlovian ideas; and his books are almost in that order. The first book in 1938 was "The Exploration of the Subconscious Affects in the Methods of the Directed Daydream." He was sparked to start all this with some sort of contact with a medium - that is where the hypnosis part of it comes from. The first book is rather straight forwardly Freudian, with hardly a mention of Jung and no mention of Pavlov. The second book is almost totally Jungian; Freud is still there but in the background and no mention of Pavlov yet - and that was written during the war and came out in 1945. Then a third book is only partly his - just a chapter or two - and the rest is case histories of other therapists; that one is partly Jungian but Pavlov starts to appear. And then this last book is very strongly Pavlovian; conditioning theory is added as a sort of foundation to the earlier work.

Regarding the role the therapist plays in this technique, I frequently say something like "Don't be surprised if you get very excited." I give them license to feel very intensely.

Taylor: In terms of Jung's typology where the intuitive faculty is highly developed probably the feelings will be relatively undeveloped.

Swartley: Yes, he said that; and I think you will find in people who take to this readily - who are normally intuitive people according to Jungian typology (Haronian: Patients or therapists?) Both! - their emotional reactions will be all on a rather primitive level. These same people, the intuitives, who abreact violently are, in a normal state of mind, unemotional and undemonstrative; but when they do emote it is on a level that is quite childish.

Haronian: One of the last statements in Desoille's book is that psychotherapy by directed daydreams is far too dependent on the intuitive and imaginative gifts of the therapist. It is the kind of thing that is congenial to some people and not to others, whether as therapists or as patients.

Gross: Can you tell me if this is all he does in psychotherapy? Is it his only method?

Haronian: As far as I know, this is his only technique. From my description, I don't think that you got the flavor of intuitive responsiveness that this man shows to the productions of his patients. He is "all there" with his sensitivity for Freudian symbolism and Jungian archetypes. He is apparently quick to make all kinds of suggestions which are intuitively designed to enhance the therapeutic impact of the patient's daydream.

I have neglected to mention that although in this book, Desoille does not say much about the spiritual side of what he does or of what can be done by directed daydreams, he is sensitive to the fact that some patients produce images which transcend the usual character and which manifest what he thinks is a mystical content. He does not expect this to happen with all patients, but he does sometimes get reactions which he describes as mystical or spiritual. I think that he believes that the people who produce these images could proceed to unusual heights in the development of their personalities. This is probably one of the important connections between Desoille's thinking and psychosynthesis.

Swartley: The second book which was published after the war - I do not know when it was written - was much more systematic. This last book presumes you have read the first ones and is really an attempt to underwrite with Pavlovian theory all else he has written. Then the war apparently had a big effect on his thinking - the humiliation of the French defeat and the subsequent turmoil and instability in France; so you find a playing down or ignoring of the religious type of development, and instead there is emphasis on the will. I think this was a reaction to the war and the post-war period in France. It was not in any of the earlier books.

Haronian: Do you know how this compares with Hanscarl Leuner? His approach seems similar to Desoille in many ways.

Swartley: I would say this: more of Leuner's method comes from Desoille than from any other single source. As far as we are able to determine Leuner does not read French and he learned what he did about Desoille from German rehashes. Desoille's and Leuner's early work are in a sense identical; which means that Leuner played as active a role as Desoille does - if a patient was having trouble

getting over a wall he would say, "Here is a ladder!"; or if a patient was afraid, he would draw a magic circle around him, etc. But in recent years, Leuner has moved away from that to more of an encouraging of the patient to do more; and he, Leuner, is now playing a more - I do not want to say "passive" role - but his activity has changed from this obviously active intervention to a gentler "herding" of the patient to deal with issues. If the patient runs away from a situation he tries to bring him back to it; he encourages him to confront it, but is less likely to offer him help.

Gross: Have you compared Desoille with Perls and his gestalt therapy?

Swartley: As far as I know, Fritz Perls came along alone in his development. He moved away from dreams and came to this gestalt kind of thinking, which you find in his book. He has since moved back to much more interest in dreams; and when he learned of Leuner and Desoille it fitted in with an already strong current in his own development and reinforced it. So that when I last saw Perls he had a blend of his own thinking plus Leuner and Desoille.

END OF DISCUSSION