

PSEUDO NEAR-DEATH EXPERIENCES IN WAKING DREAMS

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The Benefits of Working With a “Dead” Patient:  
Hypnotically Facilitated Pseudo Near-death Experiences  
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Abstract

The literature on near-death experiences is consistent in describing how such events are typically transformative. Utilizing standard hypnotic techniques, therapists can approximate many of the therapeutic aspects of such experiences, without the life-or-death crisis, to facilitate both first and second order change in psychotherapy. This article explores the use of hypnotically facilitated waking dreams as an interactive projective technique. The focus is on the varied ways that the dream components which correlate with near-death experiences can evoke durable change.

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The literature on near-death experiences (NDE's) is consistent in describing how such events are typically quite transformative (Moody, 1991; Ring, 1980, 1984; Sabom, 1982). A variety of psychotherapy models seek to foster therapeutic experiences for their patients which can facilitate similarly transformative, second order change, albeit more slowly (Haley, 1984; Watzlawick, 1983, 1988; Watzlawick, Weakland & Fisch, 1974). The attractiveness of a single event growth experience such as an NDE was the basis of the 1990 movie Flatliners. In the movie, a group of curious medical students use technology to artificially induce near-death experiences in each other. Unlike the medical students in Flatliners, of course, psychotherapists are not free to induce literal NDE's. However, hypnosis provides a tool that allows them to come much closer than might seem obvious.

This article explores the use of hypnotically facilitated waking dreams to approximate many of the therapeutic aspects of NDE's without the patient being in a life-threatening situation. Researchers have long reported the therapeutic potential for both first and second order change associated with altered states (Borysenko, 1987; Rossi & Cheek, 1988; Rossi, 1986; Borysenko, 1987). Waking dreams define another way in which hypnotic techniques can be applied towards these ends. For more than a decade I have helped patients utilize trance phenomena in a variation of Sacerdote's induced dreams (Sacerdote, 1967). Instead of discussing the patient's recall of night time dreams, these dreams are understood as being generated by the patient's unconscious while in trance during the therapy session.

#### Some theoretical origins of waking dreams

The role of dreams as a significant source of information about the patient's inner life has been richly studied by many theorists/therapists including Freud, Jung, Perls and others. Thirty years ago Paul Sacerdote, M.D., Ph.D., wrote about a different approach which utilizes dream material (Sacerdote, 1967). In the introduction to Sacerdote's book, Induced Dreams, Erika Fromm noted:

Dr. Sacerdote's innovation is the mildly directed induction of a series of consecutive dreams dealing with the same problem. Permissive hypnosis is the tool by means of which this is accomplished. Step by fast step, through inducing dreams in which the hypnotized patient tests symbolically his growing ability to master his own fate, Dr. Sacerdote guides them towards health and maturity.

This form of psychotherapy is based on the sincere and deep conviction that, with some supportive directing from the therapist, the patient can gain inner strength and solve his problems through a dialogue between his Unconscious and his Preconscious — a dialogue that is carried on while he dreams. The hypnotherapist progressively helps the patient to use more and better coping mechanisms, replacing pathological defenses and freeing energy so that it can be used

constructively. Hypnotically programmed dream induction thus provides a corrective emotional experience in the Unconscious. (p. vii)

In this way Sacerdote was able to deal with the emotions generated by the dream during the session, rather than hours or days later. His permissive use of hypnosis, as opposed to a directive use, fit the classical psychoanalytical model of requiring the patient to generate his or her own material. His treatment goal remained consistent with those of earlier analysts: replacing unhealthy defense mechanisms with more effective strategies for dealing with current problems.

In this regard, induced dreams can be considered to be a virtual reality<sup>1</sup> version of a technique George Kelly (1963) first proposed in the 1950's. He had patients find and study a real or fictional person (e.g., from literature) whose qualities the patient admired and wished he or she possessed. Kelly then had patients act as if they were that person. Since the patient was only acting, Kelly could often bypass the person's belief system which held that he or she wasn't really assertive or confident or some other missing personality trait. Just as a good actress becomes her character during a play, Kelly's patients found that their acting eventually evolved into a different, durable, self-perception:

The composition and playing out of artificial roles, as elements upon which to create new constructs which in turn are later to have more vital meanings, is another example of the use of fresh elements to develop new constructs. The patent artificiality of the role is the very feature which prevents the tender shoots of new ideas from being trampled in the frantic rush to maintain oneself in his previous role. (p. 162)

#### Waking dreams

In waking dreams, as in Sacerdote's induced dreams, the hypnotized patient can be said to be dreaming while conscious. He or she actually experiences being someone else in the dream, with all of that person's values, beliefs, emotions, and self-perceptions. The differences in these aspects of personality from the patient's everyday personality can be striking. Sometimes the dream functions as a virtual reality in which the patient possesses the wished for competencies. Because these are experienced as emotionally congruent in the dream imagery, the patient not only sees the desired behavior being performed, but feels what it is like to act that way successfully. This is analogous to how sports psychologists use imagery rehearsals of desired events to enhance performance. The patient's prior conviction that he or she could never act in such a confident or assertive or effective manner begins to crumble with the in vivo experiences in the waking dreams.

At other times the dream content functions as a vehicle to illustrate a different view of a presenting problem. The patient may experiment with a different solution, or experience the problem from an alternative perspective. A patient who feels victimized may have a waking dream in which he or she is the aggressor. A patient with control issues in relationships may have a dream in which he or she is in the counterbalancing role. Someone who struggles with ending a dying relationship may experience a dream life in which he or she successfully grieves a major loss and is able to move on with life.

Initiating a waking dream in trance is straightforward. After induction<sup>2</sup> has been accomplished, the patient is asked to imagine being in a movie or story whose main character's life will contain experiences which the patient will find clinically relevant. For example, the therapist might say, "As you continue to relax and go even more deeply within, you might find yourself beginning to imagine being someone in a movie; a person whose story will contain experiences that will be *constructive, timely, and useful* for you in your own life." While more specific suggestions can be offered, the risks of biasing or confounding the process are minimized when the therapist is as non-specific as possible. The technique retains more of its projective qualities in this manner, analogous to using the Rorschach ink blots rather than TAT story cards. One way of phrasing this opening suggestion is to ask the patient's unconscious or higher self "to generate a story [perhaps from another time and place] in which the events will provide you with greater understanding [of the presenting problem] that will be constructive, timely and useful in helping to resolve [the presenting problem.]"

In practice, the movie/dream is almost always experienced in the first person rather than the third person, so the dream is richly emotional and not just a cognitive experience. In fact, when the patient does experience the dream in the third person as an observer, it seems to serve a protective function analogous to the screening room dissociative technique sometimes used when dealing with traumatic memories<sup>3</sup>. Note that waking dreams are not used to access real memories from childhood. Indeed, if a history of childhood trauma is suspected, any use of hypnosis must be done with considerable caution (Brown, et.al., 1997).

For some, the dream begins with an experience of being a child. For others, the person is already an adult. The entry point is not critical. Because the dream content is defined as fictional, it is even workable to have the patient intentionally make up an initial scene. For example:

One patient kept rejecting images he was having because he thought he was consciously making them up, and thought they should somehow feel different if his unconscious was generating them. I suggested he simply make up a scene. The patient immediately saw himself – as a different person – approaching a fork on a dirt road at which stood a large, dead tree. As he studied the image he had a sense the area had suffered a severe drought for several years. Turning down the left fork he came to an abandoned house which triggered profound sadness (in the man he was in the dream). As the waking dream continued, its theme and mood had clear parallels to the long-standing emotional drought in the patient's marriage and the "fork in the road" he had come to in his life.

Most waking dreams follow a chronological progression over the life of the main character, though sometimes events are experienced out of sequence. Some patients will describe considerable contextual details regarding the person's life. Others offer only minimal details like a theater stage with very few props. Sometimes the dreams include the names of people, cities, or even specific years. If asked about such information, however, the patient typically reports that it is unimportant.

If the patient is having trouble obtaining sufficient imagery, it may be helpful to ask questions which provide more context. Particularly if the patient is more auditory or kinesthetic than visual, these questions can survey different sensory experiences. “You might notice what you are wearing, if anything, on your feet.” “What time of day or night does it seem to be?” Other questions can address such things as whether the person is indoors or not, if others are present, if there is an awareness of any odors or smells, or if any sounds can be heard.

If emotionally intense content is encountered, it can be handled using a variety of standard trauma treatment strategies such as the screening room technique. Affect can be titrated by shifting to a third person perspective and moving to a safe distance to observe what is happening. Analogies to a VCR remote control device can be helpful in providing the patient with a way to fast forward over a traumatic scene, or to pause the action while utilizing relaxation techniques. Similarly, the person can mute the sound in the imagery, analogous to turning down the volume during the scary part of a movie so that the sound effects/music are not heard.

When the life of the person in the dream seems to be nearing its end, the therapist can suggest, “If it is okay, I’d like to ask you to move ahead in time to the end of [this person’s] life.” If needed, additional anchoring suggestions can be offered such as, “You might notice the circumstances, where you are, whether anyone else is present, or what is happening.” In practice, I seldom suggest an actual death of the person, and never suggest the specifics of how the person in the dream dies. When invited to explore the final part of the life of the person in the dream, most patients spontaneously include the death of the person. I rarely need to intervene as the person dies. Patients rarely report emotional distress of such intensity that they are reluctant to let the process continue<sup>4</sup>. Without any suggestion on my part, most spontaneously report moving out of the person’s body (OBE - ot of body experience) when he or she dies. The rare patient who seems to be in distress (acute anxiety symptoms) can be invited to view what is happening to the person “from a safe distance.” This is more likely to happen if the death was violent or the result of an accident such as a drowning. In such situations, the use of hypnotic treatment techniques for titrating affect is helpful. I typically remind the patient that he or she is physically safe in the office, and need not experience in the physical body any discomfort which is happening to the body of the person in the dream. Suggestions such as this serve to quickly abate acute anxiety symptoms.

#### NDE correlates

For the purposes of this article, I wish to focus on one particular aspect of the concept: what happens when patients experience the death of the person in the dream.

A review of the literature reveals a consistent cluster of experiences which people report having had during a true NDE. Not every person experiences every component during a near-death experience. Taken collectively, though, the interview data are strikingly consistent across researchers. Ring (1980) replicated the essential findings from Moody’s earlier research (1977). Ring delineated the core components as including the following:

- 1) a subjective sense of being dead
- 2) feelings of peace, painlessness, pleasantness, etc. (core affective cluster)
- 3) a sense of bodily separation
- 4) a sense of entering the dark region
- 5) encountering a presence/hearing a voice
- 6) taking stock of one's life
- 7) seeing, or being enveloped in, light
- 8) seeing beautiful colors
- 9) entering into the light
- 10) encountering visible "spirits"
- 11) a return to the physical body

Sabom (1982) summarized a similar set of core transcendental experiences :

- 1) a separation from the physical body
- 2) a dark region or void
- 3) a brilliant source of light
- 4) a transcendental environment
- 5) the nearness of some other personage
- 6) a life review
- 7) a return to the physical body

When my therapy patients experience the death of the person they were in a waking dream, they report very similar experiences. These occur independent of either the person's prior knowledge of NDE phenomena or religious background. Again, not all of the phenomena are experienced by each patient, but the pattern includes the following:

- 1) Patients report a sense of floating out of the body (OBE) at the moment of death. They typically report looking down at the body.
- 2) Patients report an intense calm, tranquility and/or peacefulness. While the intent of waking dreams is not to deal directly with the patient's belief system about death and dying, such experiences seem to have an implicit impact, independent of the person's religious background.
- 3) They are able to engage in a life review experience in which they survey their dream life much as described in the NDE literature. Unlike NDE's described in the literature, after retracing critical life events in trance the patient is able to substitute different choices of action based on the insight gained from the life review experience. Following the experience of living out the revised decisions, the patient dies a second time and conducts a second life review. This allows a more complete comparison of the consequences associated with each alternative, with full emotional involvement. As an analogy, consider the main concept of the 1993 movie Goundhog Day being done in a trance-induced virtual reality. In the movie, the main character finds himself trapped in a 24 hour

time loop. Every day when he wakes up it is the same calendar day. Each day he experiments with different ways of resolving his problems, drawing on his successes and failures from the previous attempts. When he finally works out a solution he truly likes, he gets out of the time loop.

- 4) For many, if not most, there is a sense of the presence of a guide or angel or significant other person who facilitates the life review and helps provide important insights or perspectives. This non-judgmental interpersonal hypnotic experience is quite a contrast for patients who have a long history of being criticized both by others and by their own superegos. The willingness to be introspective is enhanced by this complete absence of any judgmental tone to the experience. My experience is that patients who are normally defensive when not in trance show little evidence of being defensive during this part of the waking dream.
- 5) Some report profound experiences of insight, unconditional love or forgiveness by self and/or by these guides or angels or God. I would underscore that I am careful to let the patient define this experience, and avoid superimposing my own beliefs, labels or interpretations. Some describe this as experiencing a kind of total vulnerability matched with total safety and acceptance. Patients often have trouble putting the experience into words, but their facial expressions convey a lot. The patient's religious background appears to be largely unrelated to the form and content of these experiences.
- 6) The classic NDE experience ends with the person having the experience of returning to his or her physical body and subsequently regaining consciousness. By contrast, in waking dreams the person who has died does not return to the physical body of the dream character and resume living. Instead, patients often describe a sense of watching the person go off into the light.

#### Working with the death of the patient in waking dreams

At the moment in the dream when the OBE transition occurs at death, many patients report a significant shift in how they feel. This is particularly true if the death was secondary to some kind of accident or other trauma. Independent of the nature of the death, they report feeling very calm, tranquil, at peace, etc. Because this part of the experience is so consistently associated with the absence of any judgmental tone or attitude, it lends itself as an emotionally safe environment within which the patient may review and self-critique the dream content. As is the norm in the NDE literature, patients seem very open and non-defensive as they explore the content and implications of the dream content from this OBE perspective.

This may be done in a variety of ways:

- 1) The patient may review major decisions or conclusions, especially those made at the very end of the life.
- 2) The patient may notice pre-existing assumptions which were found to be invalid in the dream content.

- 3) Analogous to color anchoring<sup>5</sup>, the patient may establish an operant conditioning signal based on the dream to be used in the future to facilitate behavioral change.
- 4) Based on the life outcomes of the dream content, the patient may return to a critical decision point, enact a different choice, and live out the consequences of this new alternative as a way of experimenting with new solutions.
- 5) After the death of the person in the dream, the therapist can propose a dialogue between the person and the patient. The OBE person can be asked if he or she has any suggestions for the patient regarding the patient's own presenting symptoms based on the life experiences from the dream. The content of the suggestions which ensue are often predictable. However, the tone is usually quite different from that which typically characterizes internal self-talk. The tone of the person in the dream is described by patients in terms like "gentle, non-judgmental, supportive, encouraging, forgiving". Sometimes the suggestions are thematic. At other times the suggestions are very concrete and specific.
- 6) The therapist can use a split-screen image to suggest that the patient notice correlations between the dream life and the patient's own life. Even without suggesting specific possibilities, many patients will report personality parallels between other people in the dream life and current relationships in the patient's life. Just as Dorothy incorporated neighbors and family members in her dream experiences in The Wizard of Oz, patients often incorporate critical elements of their own relationships in waking dreams. These can be worked with in various ways to tease out faulty assumptions, to reframe aspects of the relationship, or to dialogue with the people involved in the dream about alternative solutions to the problem.
- 7) If the presence of guides or angels is experienced, the therapist can focus on the emotional healing potential of a relationship which has unconditional positive regard as its foundation.

#### Case examples of the clinical applications of waking dreams

The remainder of the article explores applications of these possibilities.

- 1) Patient review of major decisions or conclusions which are relevant to his or her presenting problems:

After the person in the dream has died, the therapist can suggest, "Notice any final thoughts or decisions you made just before you died." These very often have an obvious connection to one of the patient's presenting issues. As a part of this review, I suggest that the patient have a dialogue with the person (who just died). This dialogue can be understood in a variety of ways. It has parallels to Perls' technique of having the patient become different elements in the dream and giving voice to the dream content from that perspective<sup>6</sup>. Cognitive therapists can frame the dialogue as a vehicle for rationally evaluating the (dream) experiences and noting applications to the patient's presenting problems. Strategic therapists and those who work with NLP can define the dialogue as an effective tool for identifying faulty assumptions which have served to keep the person

stuck. Functionally, the review and dialogue seem to provide the patient with an internally generated way to reframe the presenting problem. In turn, this allows new solutions to emerge. Because the dialogue/critique is internally generated, I find that the patient rarely evidences resistance to the content, and is very unlikely to have a negative transference onto the therapist. Similarly, the patient rarely seems to have any negative transference towards the person in the dream. On the contrary, the emotional tone of this dialogue is almost always quite positive and supportive in nature.

One female patient, an only child, reported that she was able to be compassionate at work, but did not fare as well in her personal relationships. In one of her waking dreams she experienced herself as a young woman, Janie, who eventually murdered her younger sister out of jealousy over a man she loved and adored. Soon after she took her own life with an overdose of sleeping pills. The story had clear parallels for the patient regarding her own theme of still searching for someone whom she could similarly love and adore. For the next several therapy sessions, Janie and the patient continued to periodically dialogue about their respective experiences. In this symbolic way, the patient as Janie was able to work on several important personality traits including stubbornness, feeling “owed” by others, and problems with compassion for others. Janie agreed to serve as a behind-the-scenes coach for the patient. Whenever the patient was acting “bull-headed”, Janie would signal her with an agreed-upon visual cue. Immediately following those sessions, the patient reported experiencing the agreed-upon cue on a number of occasions. She concurred that her behavior at those moments was indeed stubborn or bull-headed. The cue gave her an opportunity to shift her emotional posture in those situations. She reported having received positive feedback from friends and coworkers regarding the changes they have observed since then.

From a clinical standpoint, the dream experiences in trance seem to have provided corrective emotional experiences that helped her be more open to looking at her interpersonal style. Functionally, she created an internally generated operant conditioning cue which now alerts her when she is acting stubborn. The post-death OBE discussions with Janie seem to have provided a vehicle for being more willing to being forgiven both by herself and others. (Psychological testing and clinical history both indicated the patient had no history of pathological dissociation, and she did not report anything subsequently to suggest she had transformed the woman in the dream into an iatrogenically created alter or ego state.)

2) Assumptions the patient finds are invalid as a result of the waking dream:

One male patient from a Jewish background had grown up with the belief that women possess magic and men do not. Therefore, he believed that in order to have access to it, a man has to be close to a woman. As a result, when the patient found himself between relationships, he experienced considerable anxiety. In his waking dream, the man experienced himself as a nun who lived her life in a convent. Even as a child, the woman

had understood that her father was afraid of power and of misusing it. He had brought her to the convent, in part, so that she might pray for family fortune, the success of people close to him, etc. As might be expected, her early memories of the convent were of feeling excluded from the world outside. Referring to other teenagers she said, “They are allowed out of the cell, this room, and I am not.”

As the dream continued, the patient reported a major shift: the young woman had experienced separation as a kind of exile, but suddenly had the experience “that God missed me.” The patient periodically interjected his own observations about correlations between physiological aspects of the hypnotic experience and memories of some of the Psalms from the Old Testament which had long held meaning for him. As he experienced being the nun, he described a kinesthetic sense of his throat area knowing what was true (“love”), as contrasted with his mouth area (“fear”) which he described as trying to dismiss what he was experiencing. He reported being quite moved by the parallels between his emotional reactions to the old Psalms, the young nun’s emotional experiences as she prayed, and his own physical reactions. In this context the woman commented at one point, “All songs are the same song.”

When I asked if the patient was willing “to explore the rest of [the nun’s] life,” he briefly reported about the tone of the nun’s adult life, and then had a spontaneous OBE experience following her death. The nun, who had since become the Mother Superior of the convent, found herself talking with Jesus and Mother Mary. In a dialogue involving the patient, the nun and the other two, the patient reported further insights. He had seen magic as something external to himself; something you go find and then get incorporated by it. As the nun, he had the experience of having created a space within himself into which the magic could enter. He also suddenly had the realization that power is just another form of magic. Taken together, these insights served to shatter his (faulty) assumption that only women could have magic (i.e., power). As he internalized these experiences and insights, he reported being “flooded with light.” Following the trance work he commented about the power of the contrasts of the two religious traditions, but even more so about the masculine-feminine contrast. He commented again about the “aha!” shift from perceiving power as something external to something internal.

- 3) Creation of an operant conditioning signal which the patient may use to change target behaviors:

One patient who was working on issues of jealousy had a waking dream in which she lived a royal life, but was married to a man who was blatantly unfaithful to her. For a number of years she was angry, jealous, and vengeful. Eventually, she turned her attention in mid-life to an enjoyment of nature. She spent time traveling and enjoying the out-of-doors. An unintended consequence was that her husband found her much more pleasant to be around and began joining her on her trips. Following her death, the woman began a dialogue with the patient at my suggestion, offering to help the patient as she

works on her own jealousy. The two of them agreed to use an image of “an October blue sky” as a signal to help her recognize when she was beginning to act in a jealous manner. This color anchor also would serve as a quick relaxation response, enabling her to re-focus on other aspects of her life and relationship with her boyfriend. (In her real life, there was no indication that her boyfriend was being unfaithful to her.)

Another patient established a similar signal at the end of a waking dream in which she experienced being a gypsy woman whose four year old son was killed when he was trampled by horses. For the rest of “her” life, she had walled herself off emotionally because of her grief, despite the numerous attempts of others to reach out to her. In the patient’s current life she has lost two long term life partners to fatal illnesses. She periodically struggles with the thought of giving in to the pain and erecting similar emotional walls. The gypsy woman in the dream offered to gently but firmly nudge the patient whenever necessary “to keep the door open” because of the after-death change of belief that remaining open to others is worth the pain. The patient reported a profound sense of comfort and validation from the experience.

- 4) Behavioral rehearsal of an alternative solution to the major problem in the dream which recreates a presenting problem or dynamic:

“With what you have learned, if you could live this life (in the dream) over again, is there anything you would change?” If the patient indicates something he or she would change, the therapist can suggest, “If you’d like, imagine what it would be like to go back to the moment when you would change what you did. Notice how things turn out doing it this different way.” I am careful to avoid any suggestion that the outcome will be interpreted as better or worse. Patients who have done this report experiences that are reminiscent of Jimmy Stewart’s role in It’s a Wonderful Life in which he gets to experience how his community would have been changed had he not been born. Again, this is not simply a cognitive “what if” exercise. The person seems to emotionally re-experience the life from that point forward, much like in the movie Groundhog Day. Taking the patient through the death experience a second time, the question can again be posed, “Having now dealt with that issue in two different ways, notice what you have learned and any decisions you have made.” The theme being addressed in this way consistently has parallels to the person’s presenting problems.

One female patient reported a history of holding back emotionally in relationships because of having been hurt in prior ones. As a young adult woman in one of her waking dreams, a man with whom she was very much in love left her to follow his career calling. A few years later she met a man whom she eventually married. Throughout the remainder of her life, however, she was aware of never fully opening up to his love for her. Following her death she reviewed this choice with considerable regret. I suggested the idea of returning to the point in her life when she decided not to risk being fully open with her husband. She did so, this time choosing to be fully open in the marriage. In the

dream she then re-experienced the life having made this choice. Following her death once again, she contrasted the two life experiences. As one might expect, she had a clear preference for the second alternative. I then suggested that the patient and the woman in the dream talk with each other. As they talked, the woman found that she could remember what she had learned from her previous relationships, and use it to help her make even better choices in the present tense, without having to rigidly hold on to the decision made years before that she would hold back in future relationships in order to never hurt that badly again. The dream content seemed to provide her an emotional, experiential affirmation that it would be worth the risk of being more fully open in her current relationship, beyond what any cognitive rationalization alone could provide.

- 5) Internally generated solutions while in trance that bypass the patient's normal ego defenses:

As an example of therapeutic dialogues between the patient and the dream figure, one patient reported the person in the dream playfully advised her to "lighten up!" and not take things so seriously. This was similar in function to the two patients described above who created internally generated operant conditioning cues to stem moments of stress.

Another patient met a spirit type figure in one dream who cautioned that her efforts to help her aging mother were well-intentioned but misdirected. She was given concrete suggestions about ways she might redirect those efforts that would not only be more helpful for her mother, but would help the patient get unstuck from some of the longstanding dynamics in their relationship. Because of the loving, nonjudgmental tone of the figure, she was able to internalize these much more easily than I believe would have been the case in traditional cognitive therapy. In the months which followed, she began implementing the suggestions with gradual improvement in their relationship.

- 6) Use of metaphor from the trance imagery to check for faulty assumptions or to reframe aspects of a problematic relationship:

Correlations between the patient's real life and the dream content emerge readily following the death of the dream character. In the example above of the dream about the nun, the beliefs of the nun's father echoed how the patient's own family of origin experienced the division of power. In the OBE experience, both the nun and Mary (two women) affirmed the patient's recognition (as a male) that faulty assumptions – not gender – led to his experience of being powerless. He chuckled out loud as the two religious figures gently teased him about how most people, including himself, make life much more difficult for themselves than they need to.

- 7) Emotional healing facilitated by the trance phenomenon of contact with an angelic being (unconditional positive regard):

One of the more profound aspects of the death experience which patients report during waking dreams is the NDE equivalent of the sense of being in the light or in the presence of some kind of guide or angel or spirit. In my experience, this occurs spontaneously the large majority of the time. If it does not happen after the person has died, the therapist can make a comment such as, "If you turn around, notice what you see. Let me know whether you become aware of something or someone you had not noticed before." At this point, most of the few who have not already begun to have this experience report seeing a light or someone coming towards them. Patients report that the emotional concomitants of this are almost always very positive. There is a complete absence of judgement combined with a wonderful sense of unconditional acceptance. To the extent that one of the goals of therapy is to create for patients this kind of corrective emotional experience, I have found this part of the waking dream experience to be particularly helpful. Especially for patients with overly critical superegos or years of unresolved guilt, a series of these experiences in trance can be part of a gradual transformation of self-perception and self-worth. At this point in the experience, it is common for patients to cry tears associated with such emotions as joy, relief, and feeling connected.

One patient who was wrestling with sexual identity issues had a waking dream in which the woman she was died while lying in a hospital bed. She reported, "I am lying in the bed. The walls look kind of tan, the light is low. It is peaceful, quiet, like the sound is shut off. I'm just looking at the ceiling, at those foam squares with the little holes in them. I'm not thinking much about my physical life. I'm just enjoying the room. It's so quiet. I'm not thinking about life being over because it's really not anyway. It's like you take a taxicab and you get out and you're somewhere else like at the museum so you're not really thinking about it.

[A moment later she added] "I'm trying to go back in [the body] and I can't. It's like I'm looking at the top of the head and I'm trying to go back in, sort of, but I can't. It's like a brick wall now. When the light comes I don't see the room anymore, I just see the light. That's kind of funny. I see a bunch of people floating around. This one is funny because she's wearing something like a sweat band. She has pretty long blond hair with curls. She looks like an angel but she's wearing a sweat band. I can't see the face very well. It is kind of distorted. It's a 'she' and she has very pretty hair, long and curly."

The angel then helped the patient review the life of the woman. The patient reported the following messages as she sought to understand the meaning of what was taking place: "To learn about loving unconditionally. (Pause.) To find strength, to endure, to be strong, to have faith. She (the angel) is just saying all these things. That was weird: For just a second I relaxed and it felt like I wasn't saying it... They are here anyway (the angels.) [She laughs.] It feels like there are more than I have met. Like there's a whole bunch of them, all warm and fuzzy. They said (laughing), 'Yea, they love me very much.'... They feel tingly. Mostly my arms from my elbow up to my shoulder as if I have a big warm tingly blanket around me. That way I can feel them as if they're standing all around me..."

This kind of unconditional love and support stood out in marked contrast from the patient's childhood experience of religion and religious schooling, which had been quite harsh and constricting. It provided a first, richly emotional experience that exploring the spiritual dimension of life might be worth a second chance, despite the negative history she had with organized religion as a child.

The following example demonstrates a variation on this phenomenon. During part of several waking dreams, a male patient in his 40's reported meeting an American Indian who seemed like a medicine man or healer. Meeting around a fire circle, the Indian offered non-judgmental emotional support and a place to "rest". On occasion the Indian facilitated experiences which helped the man challenge faulty assumptions. On one occasion, the patient reported an eagle flew up and landed on the Indian's arm. Holding out his arm to the man, the eagle stepped over onto the forearm of the man. As he looked into the eagle's eyes and felt the grip of the talons on his arm, he suddenly became aware of a faulty assumption he had long held about strength and power. He knew the eagle's talons had the strength to rip the flesh off his arms, though at that moment the eagle used only enough to stay safely balanced. The man understood that even when the eagle used its strength to kill for food, it never used its strength in anger. The man had a sudden realization that he had always equated strength with anger and the abuse of power in relationships. Looking again in the eagle's eyes, he emotionally understood in a way he never had before, that he could possess "strength" without it having to be experienced in negative ways. Strength (power, assertiveness, self-confidence, etc.) could also be used in constructive, beneficial ways in relationships. While this may be logically obvious, the patient cried deeply with a profound sense of release as he took in this truth.

For this patient, the medicine man and the fire circle symbolically functioned as a safe context in which, in a non-threatening, emotionally supportive manner, emotional conflicts could be brought into consciousness and resolved through the waking dreams. As a guide to the process, the Indian took on the core characteristics of the archetypal figure of the ideal father or wise grandfather.

#### Contra-indications for the use of waking dreams

The same general cautions that apply to the use of other fantasy or imagery tools are applicable here. The use of waking dreams may be ill-advised with patients who have difficulty distinguishing between fact and fantasy. Patients who already use escape into fantasy too often to cope with stress may be poor candidates. Patients with a dissociative history such as in Dissociative Identity Disorder (DID) may find the experiences too threatening or disorienting because of the tendency for altered states to weaken or lower the protective barriers of dissociative amnesia. Because of the common assumption by patients that hypnosis involves surrendering control to the therapist, patients who have experienced a significant abuse of trust (physical, sexual, emotional, etc.) may not be good candidates for this (or any) hypnotic work until their trust of both the therapist and hypnosis reaches a higher level. Some patients define the use of hypnosis as Satanic. In my experience, these patients will not remain in therapy with a

therapist who uses hypnosis with any patient.

#### Summary

The techniques involved in the therapeutic applications of waking dreams are straightforward extensions of standard hypnotic principles combined with dream interpretation, trauma treatment strategies, strategies used in cognitive therapy and family/systems therapy, and a basic understanding of OBE and NDE phenomena. A single such hypnotic experience does not produce the intensity of second order (personality) change which characteristically follows a true life-threatening NDE. Yet based on a decade of reports from my own patients and a growing body of research (e.g., Lucas & Blake, 1993; Stevenson, 1977; Almeder, 1987), I continue to find that a series of such experiences can have real therapeutic impact on a variety of presenting issues. Though not a focus of this article, waking dreams can also be applied to specific Axis I target symptoms such as fears, phobias and other symptoms of anxiety or depression. As discussed here, waking dreams can have important impact on the patient's understanding of personality, existential and spiritual issues. I recommend further investigation of the replicability and therapeutic potential of these hypnotic techniques.

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## Footnotes

1. “Virtual reality” is a term from computer simulation technology in which the person feels as if he or she is actually experiencing what is merely being simulated by computer software/hardware. In one version, the person wears a helmet which displays a 3-D image that changes as the person looks or turns in different directions.
2. As used here induction is meant to mean whichever permissive process the therapist employs to facilitate development of the kind of altered state associated with trance. Deep trance is not needed.
3. In the screening room technique, the patient is typically asked to imagine being seated in a small theater, sometimes with the therapist present. In front of the patient is a control panel similar to a VCR remote device. As the patient relives some memory, he or she can use the controls to do what a VCR remote can do: fast forward over a difficult scene, pause the action, advance it in slow motion, mute the sound, etc.
4. As a part of routine intake procedures it is advisable to discuss with patients the risks associated with any proposed treatment plan.
5. To help a patient deepen trance the therapist may have him or her notice a color in the internal imagery which symbolizes the tranquility or peacefulness he or she is experiencing. Then, while remaining in trance, the patient is asked to open his or her eyes and find something in the room which closely approximates that color. When it is found the suggestion is offered that, “you may let your eyes close and go twice as deep into trance.”
6. If a man had a dream about rowing a boat across a lake to an island, Perls might have the man speak as if he were the lake, the rowboat, the island, etc. His questions would be designed to draw out the symbolism or function of these aspects of the dream imagery.