gnostic when he departs from the consciousness of sensuous things" (*Creative Imagination*, p. 189). As a non-dreaming state which is focussed upon the non-sensuous, visionary imagining should not be confused with hallucinating. For hallucinating, whether it occurs in dreaming or in waking life, is always concerned with sensuous content, even if this content is only pseudo-perceptual. Therefore, it is questionable whether drug-induced experiences should be considered examples of the exercise of visionary imagination. Such experiences are, rather, hallucinatory in nature and are to be ranged under perception, not under imagination.

42 *The Myth of Analysis*, p. 180. It should be added that for Hillman access to the gods is also gained through psychopathology, as has been made clear in his 1972 Terry Lectures (forthcoming, Harper & Row).

43 Corbin, *Creative Imagination*, p. 195.

44 See Corbin, "*Mundus Imaginalis*", p. 4.

45 The statement of Lopez is in *Spring 1971*, p. 214.

46 Corbin, "*Mundus Imaginalis*", p. 12.

47 See Sartre, *L'Imaginaire*, pp. 81—2, 97, 118, 137—8.

48 Pascal, *Pensées*, ed. L. Lafuma (Paris: Seuil, 1962), p. 54.

49 Immanuel Kant, *Critique of Pure Reason*, trans. N. K. Smith (New York: Humanities Press, 1950), A 138 B 177, p. 181.

50 Letter to Paul Demeny, May 15, 1871.

THE WAKING DREAM IN EUROPEAN PSYCHOTHERAPY

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The experience of waking dreams, so well integrated into the daily life of other cultures, in our own has been most often acknowledged only by mystics and poets, madmen and geniuses. The history of psychology relates how waking dreams, the experiential phenomena and the attending attitudes, were slowly more popularly acknowledged and cultivated in the context of a "psychotherapeutic" worldview. By waking dream we mean not just an experience of dreamlike character received while awake, but an experience of the imagination undertaken with a certain quality or attitude of awareness. This conscious awareness differentiates the experience of imagination (whether conveyed through auditory and visual imagery, or activities such as automatic writing or dancing, or less translatable experiences of imagination) from daydreams and hallucinations.

The early psychologists[1] William James (1885) and F. Myers (1885, 1886-7) came to understand the automatic writing of psychic mediums as a means of access to the unconscious. Through studying this material, Myers and Flournoy postulated "functions" of the unconscious. The "mythopoetic function", as Myers named it, was the tendency of the "middle region" of the "subliminal self" perpetually to weave fantasies. Flournoy felt that these fantasies exhibited four further functions of the unconscious: the creative (enabling one to receive insights and wisdom unavailable to the conscious personality),

This article is a chapter from the author's book, *Waking Dreams*, to be published in 1974 by Gordon and Breach Science Publishers, 1 Park Ave., New York City, and appears with their kind permission.

the protective (offering warning and comfort), the compensatory or wish-fulfilling, and the ludic or play function (Ellenberger, 1970: 317). The association of the creative and mythopoetic functions was reminiscent of the Romantics' attempt to reinstate imagination among the inventory of man's positive faculties. Within the framework of psychology, though, attention was turned not only to eliciting fantasies through a combination of spiritist and hypnotist procedures (crystal ball gazing, automatic writing and talking under hypnotic trance) but of entering into them in the hope for some "change".

Janet believed the fantasies of his "hysterical" patients to express the other than "worldly" personalities, situations and ideas that lived in their unconscious. Once these were expressed, during an "abaissement du niveau mental", the doctor could in a variety of ingenious ways enter into the fantasies of the patient and slowly seek to alter the nature of the symbolic situation that contained so much of the patient's energy.

For example, one of Janet's patients (Justine) had a fear of cholera and would shout repeatedly "Cholera . . . it's taking me!" after which an hysterical crisis would ensue. Janet learned to enter the drama of her crisis in a dialogue fashion. "When the patient cried, 'Cholera! He will take me!' Janet answered, 'Yes, he holds you by the right leg!' and the patient withdrew that leg. Janet then asked, 'Where is he, your cholera?' to which she would reply, 'Here! See him, he's bluish and he stinks!'" (Ellenberger, 1970: 367).

By entering into the fantasy with his patient Janet could obtain a description of her experience, as well as assure himself of a position from which he could, as part of the drama, also influence it. This process is common (though more subtle) in other forms of psychotherapy, where the doctor enters the patient's drama and through his presence and "insight" helps to alter the patient's relation to the events, thoughts, and beliefs that inhibit their "preferred" development. Here Janet accomplished this on an imaginative level, where it could then be altered by the doctor through the media of fantasy, not interpretation. He tried to break down, to dissolve, the fantasy through substitution, "suggestions of a gradual transformation of the hallucinatory picture. The naked corpse [which Justine visualized next to her] was provided with clothes and identified with a Chinese general whom Justine had been greatly impressed to see at the Universal Exposition" (Ellenberger, 1970: 367–8). Janet was able, through suggestion, to make the general comical rather than frightening.

Jung came also to appreciate the mythmaker within and sought to experience the imagination in the waking state. He reserved this experience, however, usually for the latter half of analysis and as an activity to be primarily carried out by the analysand when alone. Contrary to Janet's approach, Jung put no emphasis on transforming, destroying, or substituting the arising imagery. It was rather the relation of the conscious to the unconscious, gained through the experience of active imagination, that was valued as a healing process.

Influences of the Romantics, Gaston Bachelard, Myers, Flournoy, Janet and Jung favorably prejudiced European psychotherapists toward recognizing the value of the imagination and of mental imagery as a means of its expression. In America, this acceptance was hindered by the growing self-consciousness of an increasingly behavioristic psychology that banished the subject matter of imagery when introspectionism had been disposed of as a suitable methodology.[2] In Europe, the imagination had been experienced, though not without considerable difficulty, as more than a metaphysical notion that could be easily abandoned by a science that could not account for it. The mythopoetic and creative functions of the unconscious became working assumptions, taken as fact, freeing the psychotherapist to ask *not if* these functions or qualities of the unconscious could be used in effecting a cure, but *how* they could be used.

Many arguments were advanced to express the advantages of using waking dreams as the central experience of the psychotherapeutic encounter. Most of these centered around four objections to traditional therapy: the limitations of verbal discourse, analytical interpretation and emphasis on the past, the high valuation of transference phenomena, and its consequent length of treatment. By dealing on a symbolic, non-verbal level the contents of the unconscious were believed to be more directly and adequately expressed. The image can reveal that which is being experienced but which often cannot yet be grasped or translated into words. The experience of waking dreams was considered useful both to patients who are not particularly analytical about their lives, who are not as amenable to orthodox analysis, and also to patients so analytically well-defended that a verbal rational method fails to be of aid. In both cases one does not have to depend

on the patient's understanding of and ability to relay the unconscious situation, but rather the unconscious situation can be allowed to emerge itself through the imagery. While relating to the therapist his waking dream as it occurs, the patient is most often not attempting to analyze or interpret his experience. Such attempts, one soon finds, usually hinder, distort or stop the flow of images. Freedom from interpretations allows the patient to be relieved of the embarrassment and anxiety that would often occur simultaneously on a verbal level, thereby making communication more threatening.

The emphasis is not on interpreting the material, but on the experience of the imagination itself. Interpretation is believed to be of use to those who wish to make a study of the interconnections between their daily lives and the images of the unconscious. It is not believed to be sufficient, nor usually necessary, for a "cure". The cure depends on getting in touch with the fantasies and myths occurring within and to learn how on that symbolic level to move more freely. Although one can see and analyze the similarities between daily life and the imaginal, the connection between the two is assumed from the beginning. Free movement on one level effects the way one moves on the other. Since both, supposedly, arise from the unconscious, dealing with one's movement on that level is felt to be a more direct way of influencing one's being-in-the-world. Resistance — those impediments to movement lying between the patient and his full participation in life (signified by his ability to participate fully in the waking dream) — takes a symbolic form which can be worked through on that level. There is an emphasis, foreshadowed by Janet's work, on learning new symbolic responses to the affect-producing situations and images in the waking dream so that the patient can gradually substitute what is considered to be "healthy response tendencies for the previously neurotic [movement impeding] responses of anxiety and avoidance" (Gerard, 1967b: 21).

Exactly how the myths that determine one's behavior evolved from the personal past is not considered as important as experiencing where one is in the present. Instead of immersion into the past, there is an active experience in the present — the past being dealt with by its influence in shaping the prevailing myths the individual is dealing with in the present. It is hoped that by training the patient to experience his fantasies from within, progress will not need to rest

on his projections (and their subsequent withdrawal) into the therapeutic situation. The transference is often seen as an unnecessary dependence on the therapist that prolongs therapy and promotes a more passive, irresponsible attitude to one's unconscious contents.

Before the experiencing of unconscious visual and auditory images could be used as an effective therapeutic technique, many things had to be discovered: how to train the patient to relax, to separate his consciousness from its usual contents, to turn his awareness towards the movements of the imaginal; how to help him learn to enter into his imaginary body, to insert himself in the imaginary scene, to move within it, to encounter threatening images and to allow affect to arise; how to recognize and work with resistances; how or whether to interpret and analyze the waking dream; how to see the patient's experience in the imaginal realm in relation to the other aspects of his existence. Many individuals contributed to the recognition and partial solving of the technical and theoretical problems arising in the psychotherapeutic use of fantasy. The ways in which they envisioned the problems to begin with as well as their contributions to the "solutions" convey their attitudes toward the imagination, toward the relation between the conscious and the unconscious, and the desired goals of psychotherapeutic practice and technique. It seems in retrospect that although imagination and two of her many children, the visual and auditory image, were invited into the consulting room, the invitation was not all in her favor. She was often put to work to serve the will and whim, belief and interest, of the doctor and his patient.

Early Contributors to the Psychotherapeutic Use of Fantasy: Binet, Happich, Kretschmer, Schultz and Luthe, Frank, Guillerey, Caslant, Clark

In Germany it was Alfred Binet's "method of *provoked introspection*" that stimulated the Würzburg group first to consider the subject of imagery. Binet had his patients, through a "*dialogue method*", talk to the visual images in their provoked introspection. He and Janet, both early proponents of dispsychism, believed that images arising from this introspection expressed the various unconscious sub-personalities of the patient. Carl Happich elaborated on Binet's early work by encouraging "*emergent images*" through the

use of muscular relaxation, passivity of respiration, and meditation. He postulated that between the conscious and unconscious lies a zone, the "*meditative zone*", in which "creations ripened in the unconscious appear to the mind's eye" *(geistiges Auge)*. Happich (1932), in contrast to Freud's change in emphasis from imagery to free association, argued that the experience of imagery from the "meditative zone", not verbal abstraction, was necessary for personality changes. Happich attempted to stimulate such imagery by suggesting various landscapes for the patient to visit in his imagination (prairie, mountain, chapel, sitting by a fountain listening to the water).[3]

These landscapes were much later explored by Ernst Kretschmer for their symbolic significance and integrated into his idea of "*meditative techniques for psychotherapy*". He would introduce an initial image to serve as a point of departure and crystallization for other symbols related to that particular psychic realm.[4] Unlike many religious meditations centered on images or concepts, the suggestion of surroundings was not as well-defined, and personal as well as more universal archetypal imagery was encouraged to arise, leading one away from the initial image. For Kretschmer the important necessity was to bring the symbols which "expose internal psychic problems" into a higher (conscious or supraconscious) level of awareness. He felt that the "art of psychotherapy" depends on the stimulation of the "deeper levels of the unconscious" and can really only be described by the "unscientific term 'exorcism'" (Kretschmer, 1969: 228). It is not clear what Kretschmer means by exorcism, but there is the indication that the contents of the imagination are brought up into the ego-world in an effort to separate them from their source.

Another group of researchers arrived at similar uses of waking dreams, not through the practice of introspection that was popular in psychology at that time, but through a bio-physical approach to consciousness. J. H. Schultz (Berlin), stimulated by Oskar Vogt's work on "autohypnotic" exercises, began in 1905 to study how hypnotherapy could be used without developing a passivity in the patient and a subsequent detrimental dependence on the therapist. Schultz noted in his hypnotic work that his patients experienced feelings of relaxation and heaviness in the extremities and then agreeable sensations of warmth. Instead of the therapist inducing a hypnotic state of consciousness that gave such physiological results, he had the

patients suggest to themselves, to imagine that they were having, the physiological feelings which he had found would in turn produce the desired state of consciousness and physiological condition. Schultz and Luthe (1969) developed "*meditative exercises*" to be done in this "*autogenic state*" of relaxation. These involved "*progressive visualizations*" from "static uniform colors, to dynamic polymorph colors, to polychromatic patterns and simple forms, to objects, to transformation of objects and progressive differentiation of images, to filmstrips, to multichromatic cinerama", or what might be similar to a waking dream. Through this training in relaxation and visualization the patient could gradually learn how to sustain complex imagery on his own and to use this for physical and psychological disturbances.

Ludwig Frank (1910) was, as Schultz and Luthe, discovering the importance of deep relaxation for the spontaneous occurrence of hypnagogic visions.[5] An outgrowth of Breuer's work with Anna O., Frank called his work the "*cathartic method*". The relation between relaxation and catharsis became important also to Schultz and Luthe. They believed that relaxation encouraged catharses and that these catharses, called "autogenic discharges" (the bodily components being emphasized), were results of the "self-normalizing activity of unknown brain mechanisms which select, co-ordinate, adapt, and terminate the release of a variety of neuronal impulses which are related to accumulated brain-disturbing material" (Schultz & Luthe, 1969: 6). The brain-disturbing material of the unconscious was related to the body through physiological reactions. Marc Guillerey (Swiss) in his experiments on "*directed revery*" also worked on the relation of psychological conflicts to "motor tendencies". He understood the conflicting images of the directed revery as proceeding from the neuromuscular tendencies, and that the solving of conflicts on an image level produces a "psycho-physiological harmonization" that promotes a cure (Fretigny & Virel, 1968). Guillerey believed that in "*lived dreams*", where awareness could be directed to imaginary kinaesthetic tactile sensations, many complexes dissolve without the necessity of stopping to analyze them.

These ideas connected the imagination to the body. On the one hand, the body's state of relaxation (attained through imagination) helps one to receive the emerging images. Through relaxation one approaches the physiological state of sleep, in which dreaming, of

course, occurs. On the other hand, the emotions belonging to the contents of the unconscious affect the physiological functioning and condition of the body (the basic premise of psychosomatic medicine). This realization has enabled the imagination to be selectively used for somatic control, especially of the autonomic responses (Chappell & Stevenson, 1936). The physiological state desired can be attained through different qualities of imaginative experience.

The psychoanalytic movement had several members in this early period who were interested in various forms of imaginal experience (Groddeck; Varendonck, 1921; Silberer, 1951). Pierce Clark (1926) attempted to integrate the viewpoints of psychoanalysis with the experience of induced revery. He had his patients use visual imagery, "*phantasms*", to return to their inner childhood. The reclining patient was asked to imagine with closed eyes the sensations, attitudes, and behaviour of his childhood (Virel & Fretigny, 1968). Clark sought to maintain the childlike state of defenselessness created by the technique until a catharsis had been achieved. He felt that this avoided the probability of the contents of the imagery simply returning to their former plane in the unconscious, and thereby re-creating the same situation for the patient (Virel & Fretigny, 1968). Kretschmer's notion of exorcism seems to be repeated. Subjects were reported to have often believed that the contents of their revery were only actual memories. As Freud had discovered, however, many of these "memories" were indeed really fantasies which revealed, as he saw it, the fixations and problems of the patient. Clark would try with the patient to discover the diversions from fact contained in the phantasms. He noted that progress depended not on intellectual understanding based on the terminology of psychoanalysis, but on gaining a closer relation to the imagery. This was encouraged through a process of "*secondary introspection*" in which the patient would complete a report on his imagery "seance". As in the reporting of dreams in analysis, omissions and refusals to do the reports were noted as resistances. Clark also used a method entailing the free association of imagery,[6] one of Freud's early methods (Singer, 1971a: 170). The patient would describe the flow of images occurring to him rather than associate from word to word.

Unlike Clark's work that combined memory and imagination imagery, Eugene Caslant (French) encouraged his subject to allow imaginary images to emerge, rather than reminiscences (1921). This allowed the emphasis to be on travel within imaginary space. Charles Henry, Caslant's teacher, had explored in *The Chromatic Circle* (1888) the associations created by directional movement in imaginary space. Henry found that movement was provoked in the imagination when one suggested to the subject that he move upwards from left to right, or downwards from right to left; whereas, up and down associated with the inverse left and right directions proved inhibitory.[7] Caslant used his teacher's observations to form a therapy based on ascensional and descensional movement in the imagination.

Caslant, in his darkened consulting room, taught his patients to ascend and descend from one imaginary level to another in order to obtain different affects and varying degrees of vividness of images. The therapist evoked the image of a ladder, a staircase, or a flying chariot and asked his subject to place himself on it and to begin venturing into interior imaginary space. Caslant noted that ascension not only brought about an inner feeling of elevation but also markedly affected the nature of the vision. The patient, by willfully being in control of what level he was on, could explore at his own discretion and return to a more pleasant level when he desired. Higher levels were *usually* associated with more pleasant affect than lower ones. Caslant claimed that the heights which a subject could explore were correlated with his stage of development. Through this type of self-controlled movement the patient could find his own speed of inner exploration (Caslant, 1939). Threatening affects and imagery too powerful for the present ego to withstand, in Caslant's judgment, could be balanced by returning to levels associated with pleasurable or supportively meaningful imagery and affect.

Le Rêve Eveillé Dirigé:[8] *Roberto Desoille*

Desoille, Caslant's student, continued work on the psychological effects of imaginary ascents and descents and eventually made them the principal technique of his "waking dreams". The waking dream for Desoille was primarily a means by which the patient could achieve a meeting with the "collective unconscious". This meeting enabled him to experience the collective background of his personal conflicts, to see his individual problems within the larger contexts of man's inherent problems (Kretschmer, 1969: 229). Desoille, however, was not con-

tent to rest with the symbols that arose spontaneously in his patients' reveries. He believed that psychological disturbances were the result of habitual vicious circles that make varied movement impossible. By introducing new symbols and symbolic modes of movement into the patient's waking dream the therapist could offer "new lines of force", alternatives to the patient's habitual modes. Desoille attempted to teach the patient not only how to participate with the various "archetypes" that arise but how "to control", "to be free from them and thereby to lose his fear of them" (Kretschmer, 1969: 229). Treatment thereby consisted of three phases: first, Desoille attempted to observe the patient's patterns of movement; secondly, he sought to decondition the "maladaptive" ones; thirdly, he tried to establish "new and appropriate dynamic patterns" of movement (Desoille, 1966: 30).

Desoille had the patient repeatedly insert himself into six archetypal imaginary situations (for example, descent into the ocean or a cave, meeting with a dragon) until the anxiety provoking images which appeared were drained of their painful affective charge. To Desoille the contents of the imaginary descent were symbolic answers to the question, "what is going on in the depths of your personality; what painful feelings are capable of upsetting you?" Moving downward patients experienced anxiety, fear, rapid breathing, coldness and shivering, darkness, faster pulse, and threatening images. Desoille associated this with the personal unconscious. In order to explore the psychodynamic level he would suggest to a relaxed patient (in a quiet, darkened room) that he begin to imagine himself falling and to report any sensation and imagery as they occurred. Ascension, often associated more with the spiritual levels of the psyche, produced warmth, slower respiration and heartbeat, sensations of light and euphoria, and more "positive" imagery.[9] Movement from left to right he believed was associated with the future, whereas movement from right to left led the patient to experience images from his past. Movement of the imaginary right arm (in right-handed people) was seen as indicating optimism, struggle, and altruism, whereas the bringing of the arm closer to the body was associated to feelings of fear, avoidance and the wish to retreat into oneself (Desoille, 1966: 18–19).[10] Desoille attempted to borrow from myth and fairytale not only the images he suggested but ways of moving among the images. For example, to help make the patient secure when faced with threaten-

ing imagery Desoille would sometimes suggest that he see a hanc reaching to help, that he have a magic wand that can produce desired metamorphoses of the images, that he could make an ascension to a level with more pleasant imagery.

Desoille's techniques arising from his theoretical notions can end, I think, by often imposing on patients' inner worlds a structure and set of values not necessarily their own. The possible beneficial results of having a person establish contact with his imagery and learn to move in that realm is compromised by a detailed schedule of places to get to and things to be accomplished that the therapist thought were important. For instance, in his sixth theme in which the male patient supposedly tries to come to terms with his Oedipal situation through the story of Sleeping Beauty, Desoille asks the patient to:

> evoke the memory of an experience he actually had with his mother, whether it was agreeable or unpleasant. I then have him ask his mother to lead him into a forest where they will look for the castle of Sleeping Beauty. When they find it, they enter and the man leaves his mother in one of the reception halls. He then goes upstairs by himself, finds Sleeping Beauty's bedroom, and awakens her. If all goes well, more often than not the subject will spontaneously feel that in emulating the prince of the fable, he is achieving adult maturity. I then ask him to offer his sword to Sleeping Beauty as a token of his esteem, to tour the castle with her, and to make an ascension in her company. I next have him imagine coming back down to the castle with Sleeping Beauty and introducing her to his mother; whereupon Sleeping Beauty welcomes her future mother-in-law to her home and leads her to a wing which has been reserved especially for her. In this symbolic way the mother permits her son to take a wife. Although completely imaginary, this theme can give rise to extremely dramatic scenes, even with men who have had many sexual affairs without being able to choose a wife. (Desoille, 1966: 7—8.)

Desoille emphasized that the use of suggested archetypal situations and ways of movement allowed for short-term treatment because time was not wasted waiting for the important scenes to arise from within the patient. Those familiar with waking dreams know, however, that by the end of a sequence like the above the individual will have had many incidents occur which did not fit into the scene. If the suggested scene becomes more important than what is actually emerging from the patient's unconscious the values behind the scene,

which are the doctor's, must be made explicit. Is it indeed sufficient to claim that the scenes are archetypal and are thereby the patient's as much as the therapist's? Desoille believed that his directiveness was justified because he understood the patient to be in need of alternatives for movement. However there is a harm, I believe, in not being willing to wait for the subject to generate his own symbolic situations and modes of being. The therapist assumes a set of ways of being and teaches them to his patients. This is done in good faith — it is sharing one's own way with the patient; but it is not helping the patient to find his particular way. These two kinds of "therapy" should be differentiated.

Those in favor of directivity and suggestion by the therapist argue that it is indispensable with "severely disturbed" individuals. Controlled situations are deemed desirable so that the patient does not feel overwhelmed or that he has too much material to deal with, so that he has enough "positive" experiences to offset the "negative" ones. It is also argued that directed visualizations encourage creativity. Friedrich Mauz (1948) in his work with "psychotic" patients used an extremely directed mode of visualization in which, as Kretschmer describes it (1969: 226), "the unconscious is most carefully tackled and channeled into productive performance". It is almost "a monologue in which the therapist depicts to the patient in plastic and sympathy-evoking representative pictures from childhood: the experience of a procession, Christmas celebration in the family, or children's song, etc." They are meant "to unlock and enliven the suppressed emotions of the psychotic so that later a real conversation can develop" between the therapist and the patient (Kretschmer, 1969: 226). Rather than letting the scene take its own shape Mauz impregnates it with symbols which he hopes will produce positive affect and meaning. He believes that through these feelings the patient becomes able to experience a connectedness with the world, and that through the energy behind these feelings and symbols the personality is helped to heal (Kretschmer, 1969: 226).

There exists the conviction that people in difficult periods of their lives often find it to their advantage not to encourage an open passivity to the forces they and the doctor are afraid of. The doctor then falls into the role of suggesting positive images — whether they be in the form of "hope", valued activities, or Christmas celebrations.

Does this attitude recognize any value in the "negative" imagery it hurries one away from? Such non-recognition may, in fact, constitute the primary dilemma. In imagination therapy, as in many other psychotherapeutic schools, fear and trembling first and avoidance and "caution" as fast seconds are too often experienced by both psychotherapist and patient when "negative" imagery arises. There is a rush to "securify" the patient, and thereby the doctor. Perhaps this is necessary. But it may also proceed from an assumption about how we would like the psyche to be. When it deviates more than a certain degree from this course, we feel fear, discomfort, and disagreement and begin to desert — fleeing back to the past, hopes, pastimes, and the ego. One loses the desire to stick by the psyche and her experience. One must ask "Why?" Does one distrust the patient's unconscious more than one's own? When one wishes to suggest where and how to move in the imagination, rather than allowing the other person to move as his or her imagination chooses, where is this helpfulness coming from and leading to? Does one not fall into the trap of peddling but one variety of soul, and with a feeling of self-righteousness? If the psychotherapist tries to "protect" the patient through an increased directivity (encouraging positive images, attitudes and meanings) he must ask himself if that directivity does not conceal a basic lack of trust in, a devaluation of, the unconscious processes in relation to the conscious.

Desoille felt that the introduction of new symbols to the person's unconscious liberated them from "vicious circles". These "vicious circles" may, however, be that person's means of getting in touch with his psyche. It seems that the value system of the therapist (and often of the patient's own conscious position) must be put aside in deference to the evolving myths and codes that are arising from the person who has come in search of assistance. One must question an attitude or action that accepts some parts of the unconscious and not others. There is always the possibility that what the unconscious presents in its imagery is truly its experience and that one is not aided in the long run by turning one's back. What are our fears and values? And what goals do they feed and protect?

Guided Affective Imagery: Hanscarl Leuner

Hanscarl Leuner's "guided affective imagery" (GAI) or "*symbol-drama*" provides a systematic synthesis of previous work with imagery (especially that of Schultz, Happich, Desoille). Through the use of "catathymic imagery" *(experimentelles Katathymes Bilderleben)*, "inner visions which occur in accordance with and are related to affect and emotion", Leuner is able to: 1) train patients who because of naivete or over-intellectualization cannot release their imaginations; 2) diagnose patients (GAI is called in this instance "*initiated symbol projection*" — ISP); 3) do free association through imagery; 4) check on progress of the therapy; 5) do "intensive" psychotherapy with patients suffering from "neuroses, psychosomatic disturbances, and borderline states" (not with "full-blown psychotics or with addicts"); 6) do short-term therapy (Leuner, 1969); 7) use when resistance occurs in the therapeutic dialogue (Horowitz, 1971: 303–4).

The first aim of training patients to recognize their faculty of imagination is accomplished by the introduction of three scenes which do not *usually* provoke negative emotions (meadow, mountain, brook). Through repetition of the scenes the patient becomes accustomed in an unthreatening way to the technique of travelling in imaginary space and relating what occurs to the therapist.

Virel and Fretigny (1968) have summarized Leuner's ten suggested themes which can be used for psychodiagnostic purposes as well as therapy and have suggested various meanings as follows: 1) a prairie (symbolic expresssion of present psychic harmony); 2) the ascent from a prairie to a mountain (excursion in one's field of existence); 3) the descent of a river's course (exploration of one's field of being); 4) a house visited from top to bottom (the house being one's personality); 5) a Christian name, then the personage of the same sex that it represents (the ideal personality); 6) a person in the subject's circle of acquaintances; 7) for a woman, a meeting with an automobilist on a lonely road (symbol of a heterosexual situation); 8) a walk in a swamp or cave (landscape propitious to the appearance of archetypal images); 9) images drawn from nocturnal dreams; 10) a succession of all these various images, a sort of summary. Each theme is left general so that the patient can project his own fantasies into it. When used for diagnostic methods, rather than for developing

intense feelings, the therapist "guides the patient quickly through a variety of imaginary situations" in order to get a "wealth of imaginative content". ISP (initiated symbol projection), usually taking from one to three sessions, proceeds by checking the following points:

> a) "The qualities of the different themes such as the meadow, the mountain, the rosebush, the house." [For instance, are there green grass and children in the meadow, or is it full of dead trees with little sign of regenerative potentiality? Is the mountain impossible to climb — perhaps indicating a feeling of hopelessness and impotence to reach desired goals?]
>
> b) "The factors that inhibit progress on the given tasks such as following the brook or climbing the mountain." [Is it always the mother, or a mile high wall, or fatigue, etc.]
>
> c) "Registering incompatible situations, for instance, in the landscape two seasons may occur at the same time, or the refrigerator in the house may contain no food."
>
> d) "The nature of the emerging symbolic figures and their behaviour. The latter can be tested by having the patient approach the figures and describe his feelings." [Is the patient's inner world essentially threatening at the present or is it supportive?] (Leuner, 1969.)

The therapist looks for hints of positive images that might later help the patient. A small patch of green grass in a barren meadow signifies an area of growth that can be encouraged. Perhaps amongst the threatening animals and people there is one that appears to be a friend. He might prove helpful in supporting the patient and leading him, for instance, into a cave or tunnel, where frightening psychodynamic material might appear. Leuner believes one can note the gradual progress in therapy by the frequency of positive images, the increased ability to face threatening ones, a decrease in resistances which curtail the flow of imagery. He checks on the development of transference periodically by leaving the room for a few minutes and noting the change in the patient's imagery. If transference or dependency is present the individual's imagery may suddenly become frightening or abruptly stop. As in the case of Desoille we must recognize that this view separates images into positive and negative ones according to certain values of the therapist and patient. Therapy then becomes a means to get from the negative to the positive. One attempts to get away from parts of the person and feels successful if this is possible.

Leuner believes the therapist should primarily remain passive. After the initial suggestion, he tries to leave the patient relatively free to follow what develops in his imagery. He does however use "six specific techniques for guiding and managing the course of the on-going symbol dramatic events":

> A) *Inner Psychic Pacemaker.* This pacemaker corresponds to the idea of a directive, purposive psyche. When given a chance, by the therapist's refraining from taking over the direction and velocity of the treatment, the psyche seems to help govern and protect the patient. Often a figure will arise from within the person (an animal, a mother-image, a good fairy, the wind, a god-image, a wise old man or beautiful maiden) and take on the responsibility of guiding him through those areas he needs to know about and confront in order to grow. The therapist helps the patient know how to recognize and talk with these figures.
> B) *Confrontation.* This is a strategy for situations in which images arise that threaten the person's safety (a snake, a bear, a frightening person, etc.). The patient is encouraged neither to escape nor to struggle. Instead he is instructed to stay put and watch, for example, the animal. He should notice and describe every detail. By staring at the animal the patient's feelings not only become neutralized but there is an opportunity created by which to "discover the message or meaning which the creature's existence conveys". "The frightening animal may become weaker and smaller, and it may sooner or later be transformed into another creature" — a less frightening and often even a benign one.
>
> "Psychoanalytically speaking, the end result of successful confrontation is a strengthening of the ego" (Leuner, 1969: 16—20). The ego confronts the imagination and in a variety of ways is taught to overcome it. The ego becomes stronger. One must sadly (or so it seems to me) assume that the imagination becomes weaker — less of "a threat", so they say. Learning to take a position toward the figures of the imagination so that they do not dominate us entirely does not mean necessarily that we must come to dominate them altogether either. It could as easily mean that we allow them a place . . . that we stand for them. Images tend to dominate us more completely when we try to lock them out, when we treat them as if they have no value. When the threatening image changes as we take time to be with it, we can realize the degree to which we infuse elements of ourselves with power (that then frightens us) by turning away altogether or by seeing them as things to be overcome.
> C) *Feeding.* Feeding is deemed appropriate when confrontation seems impossible because of the enormity and viciousness of the giant, fish, etc. The patient is urged to feed the image until it is overfed. This overfeeding makes, for instance, the giant drowsy and he usually lies down and goes to sleep. Often the giant will refuse the food, but patience and coaxing are reported usually to work. "In this symbolic fashion, the patient learns subconsciously that he can face frightening aspects of his own psyche, he can give them their due recognition and he can work out a *modus vivendi* with them. Subsequent confrontation may lead to transformations of the frightening giant into a milder, more benign symbol" (Leuner, 1969: 18).
> D) *Reconciliation.* Reconciliation can be combined with the latter two. Its purpose is to make friends with the threatening image — to show tenderness towards it. It seeks to use energy positively that might otherwise turn into more fear.
> E) *Exhaustion and Killing.* Leuner says this should be used only by experienced therapists who know the patient well enough to sense the wiseness of such an attempt. Since the image is an introject, the patient may himself experience the pain he inflicts on, for instance, the monster. Leuner warns to be cautious because the patient may not have the "ego-strength" to win. He does not take up the more difficult problem of how one tells if it is part of the person's myth to kill the image or not.
> F) *Magic Fluids.* Magic fluids (spring water, cow's milk, mother's milk, spittle and urine) are used for the "relief of bodily aches and pains".

In relation to the last technique Leuner warns that it "must always be done carefully because the reactions can be ambivalent. Much depends on whether a patient feels comfortable subjectively with what we are trying to accomplish in a given instance. In other words the patient must understand and accept the purpose and goal of treatment" (Leuner, 1969: 16—20). Here I believe Leuner states the case quite correctly. The therapist must himself understand the purpose and goal of treatment and what the assumptions and values beneath them are. Then the patient can see if his goals mesh with the therapist's. Leuner appears to ascribe to the hero's way of relating to the underworld. One goes down, experiences and observes, confronts and kills, and returns victorious, stronger than before. The treasures are stolen, i.e., brought up to the ego-world, separated triumphantly from their home. In this view of the conscious relation to the unconscious all that tends to keep the person in the unconscious, that refuses to be brought up, becomes threatening, "monstrous" indeed.[11]

Oneirodrama:[12] *André Virel and Roger Fretigny*

André Virel and Roger Fretigny (1968) have been the most successful in the attempt to consolidate and differentiate the European work done in the psychotherapeutic uses of imagery called, by them,

oneirotherapies. Their own resulting therapy — oneirodrama — they characterize as follows:

> 1) A thorough and scientifically conducted relaxation.
> 2) Some training so that the subject can translate his images into words.
> 3) The mental imagery, initially obtained by induction or suggestion, must become absolutely spontaneous. Only under this condition can it have a liberating function.
> 4) The use of precisely-determined standardized triggering-images is precluded because of its effects on the spontaneity of imagery.
> 5) The subject does not only conceive of a scene, but he participates in it.
> 6) The subject participates "bodily" — in what is called the Imaginary Corporal Ego.
> 7) The oneirodramas involve dramatization and are dynamic; they evolve constantly and build up to a breaking point.
> 8) All the categories of sensitivity, including the kinaesthetic ones are used. Cold and hot represent anxiety and securifying, respectively; on another level, light and dark represent revelation and uneasiness.
> 9) The operator should strive to bring the subject to attempt "second-degree imagination".
> 10) The oneirodrama may resolve itself in a abreaction, which should be the end result of a progressively structured imaginary dramatic situation (the immediate, or premature, abreaction, in fact, has traumatic rather than liberating consequences), necessitating a de-dramatization at the end of the seance of oneirodrama (Fretigny and Virel, 1968).

The treatment consists of three phases: 1) anamnesis, dialogue, analytical interpretation; 2) oneiric phase (engaging in the oneirodrama or waking dream); 3) maturational phase (between sessions the patient records his oneirodrama, tries to test and use his insights in his life, and works on any "homework" the therapist may give).

Virel (1968) believes the "fundamental imagery pattern of the individual" is "partially idiosyncratic in the sense of its relationship to family experience, partially shared with others of the same sex by virtue of constitution, and partially collective in the sense of commonality of culture and the emergent expression of man's primal development" (Singer, 1971a: 171). Exploring the particular pattern for each individual is the focus of the therapy. In general, the sessions are less directive than Desoille's, though initial images are provided. Virel recommends, especially for "non-visualizers" (people who have difficulty in seeing visual images), a ten to thirty microgram dosage of LSD to facilitate the oneirodrama.

In addition to their excellent summary work of the various existing "oneirotherapies", Virel and Fretigny have established a clearing-house for mental imagery techniques and a journal for the communication of findings in this field.[13] Virel, Fretigny and others in Europe[14] today are working to integrate the therapeutic insights already gained in oneirotherapy as well as to carry out organized research concerning the oneirodrama, its physiological parameters,[15] and the uses of imagery in psycholytic therapy.[16]

And Once We Know the Dragon's Hungry?

This history shows a gradual systematization of the use of mental imagery into a viable therapeutic process. The shared theoretical basis for the use of waking dreams in therapy is threefold: 1) visual images and inner drama express the situation of the patient, revealing his attitudes, strengths and conflicts; 2) the unconscious expresses itself in a creative way, often offering guidance, new needed attitudes, and support; 3) the conscious experiencing of and participating in the evolving myths of the unconscious as expressed in the images and actions of the waking dream is in and of itself liberating. The waking dream is now used for: 1) treating traditionally labelled neurotic and psychotic disorders; 2) group therapy (Rigo, 1970); 3) child and adolescent therapy (Rigo-Uberta, 1970); 4) aiding other forms of therapy; 5) psycholytic therapy; 6) therapy helping the individual to improve his contact and ways of working with and appreciating the unconscious for his general development.

Much conflict arose over the necessary degree of *directedness* needed for successful therapy. It was seen to vary according to the disturbance of the patient, his degree of security as regards his capacity for imagination, as well as the therapists' different views toward the value of spontaneous imagery, which appear to arise from more fundamental views concerning the desired relation of the ego to the unconscious. In general, it seems that a less directive mode than Desoille's has been adopted, though with some caution to provide a structure and a "meaningful" scene in which the patient initially projects himself.

"Fantasy-life symbolism really seems *there* for most of the European therapists; it is not merely a reflection of conflicts but a fundamental part of the personality that may require treatment and modi-

fication" (Singer, 1971a: 1974). The psychotherapists mentioned have a respect for it. They seem to have recognized it as more expressive and important than what the ego might say. And yet there is the notion of "treating" the unconscious or the imagination from the position of the ego, with some goal in mind. It leaves one with the feeling of trying to take the best from both worlds — which is usually accepted as an honorable and justifiable thing to do.

But I wonder. We know so little about the imagination that it seems presumptuous to doctor it. Might we not doctor out, or "exorcise", some things of value? Are we so sure that "negative" imagery is in fact negative and not the way we look at it? This brings to mind questions which should surround every psychotherapeutic technique or practice. What are we trying to nurture? What are we trying to destroy? Or what are we doing anyway and why? Which element of "we" is doing what to "whom", to which other elements of ourselves or the other?

First of all the European oneirotherapies sought to have individuals regain their ability to observe their imagination. Secondly, they encouraged the individual to enter into the fantasies. This allowed for dialogue between the ego and the arising images. Thirdly, the therapist sought to make suggestions as to how the patient could more effectively enter the scene and learn from the images.

Once the unconscious situation presents itself and the patient becomes aware of alternatives, his exercising any suggestion (either his or that made by the doctor) expresses a value, both as to *what* should be done — and *why* (though that is generally less apparent). The mythology of psychology sets up two lines of force — the unconscious and the conscious. The imagination is envisioned as lying in the unconscious, though the conscious experience of it requires the receptivity of the conscious ego. Through the waking dream one has an experience in which both the conscious and the unconscious are actively present. The attitude the conscious takes can vary though — that is the fact we have control of.

The imagination presents the perennial dragon and the dragon is hungry. Now what are you going to do? Watch it? (If it will let you...). Feed it? (If you can...). Tie it up? (If it only would succumb...). Try to kill it? (If you are a hero or aiming to become one). Protect yourself with magic potions? And when you put the

imagination back in its sack and decide that it is time to go home (which is a temptation when you understand the imagination as a place one can get away from rather than, for instance, a quality inherent in all experience), do you see the dragon as the dragon, or your mother, or your courage, your instinct or your archetype? Is the situation to be accepted? Meditated upon? Overcome? Is it to be appreciated? Assimilated? Transformed? Or destroyed? Each expresses an attitude of the conscious toward the unconscious and the relation between the two that is being sought by and reflected in the ego.

There is a strange admixture of these in the oneirotherapies. There is first of all the belief that participation in the fantasy is beneficial in and of itself and secondly that interpretation is not necessary, necessarily that is. These express a real valuing of the waking dream experience and an attempt to take it on its own terms. Not to kill it or convert it or assimilate it. One wonders though how the "anamnesis" is used, and the "homework"; what is meant by integrating the insights from the session into daily life; and how, in fact, by what means and methods of translation, were the insights derived. The person who travels in the oneirodrama is equated with the person whose oneirodrama it is, or who observes it — even though the imaginary body (or dream ego) and its reactions are often different from the habitual ego. There is an identification made which simplifies, or at least makes simple, translations from the waking dream to "real" life. It is possible that such translations are facile because the two worlds and the two travelers may not be the same at all. Is my imagination mine or is it itself? Or is it both me and myself?

What is the end point of therapy, the desired goal? Leuner looks for positive images, naturalistic congruent sequences, the ability to confront the frightening and not let it "get the better of us". Things in the imagination are returned to what the ego considers their rightful place. The food gets put in the icebox where it belongs; the tiger out of the living-room and into the jungle or cage. One seems to wait until the dragon is slain or turned into a helpful dwarf. In doing so it appears that we try to create the imagination in the image of the ego-world.

What makes it so difficult for us to leave the pie in the sky or the cannibals with their hunger? Do we really distrust the imagination?

If so, let us admit it. Is it because we know what we want (or think we do) and we realize that psyche has her own and different claims?

I mean only to have us become clear about the terms we have been setting as regards our relation to the imagination — just what we look for, what we turn away from, what we do and do not hear, what and at which points do we try to change things, at what junction do we pull out. And let us be certain that seldom have we asked the imagination when, where, and how she prefers to meet us. It is possible that her idea of a "therapy" (or even a more informal meeting between the two of us) based on the experience of imagination is quite different from the ego's or the therapist's.

I can suggest only that each of us who is so inclined, ask our imagination about this some day soon. And if you are a therapist and a theoretician (as most all I know are) ask her (or him if you insist) just how she prefers to come into the consulting room. Does her dragon want to be slain, or understood as your boss, or your mommy, or your ambition? I simply do not know but I do think that by all rules of etiquette (not to speak of those of science or understanding) we might at least ask. We have been assuming things a long time about that dragon and her Mother — without really knowing what they are. Good reason that they have to be breathing fire at us!

1 For the author's more detailed history of the contribution of Myers, Flournoy, du Potet, Janet, Freud and Jung to the study and use of waking dreams see "The mythopoetic function and early history of psychology", in *Waking Dreams.*

2 See "Imagery and imagination in American psychology", in the author's *Waking Dreams.*

3 Nachmansonn (1951) was doing similar work called "*experimental dreaming*".

4 Kretschmer (1922) called the process of inner visualization *Bilderstreifendenken,* "thinking in the form of a movie".

5 Frederking (1948) also had a system of therapy called "*deep relaxation and symbolism*" which attempted to combine these insights. For further work on relaxation see E. Jacobson (1938).

6 This method also proved useful to Kubie (1943) in the removal of amnesic blocks as well as to Reyher (1963) in his research on imagery (Singer, 1971a: 170).

7 The importance of directional movement to the imagination can be recognized in many rituals and myths. See: Eliade (1952); Jung (1961: 81); Gaston Bachelard's work on poetics and ascensional dynamics; Roheim's (1952) discussion of descension into and in the hypnagogic dream and sleep in terms of uterine regression; Durand; Godel.

8 Translated, "The Directed Daydream". "Le rêve eveillé", waking dream, was a term first used by L. Daudet.

9 For symbolism of ascension see the following: Egyptian funerary texts; literature on Orphic and Mithraic initiations; Tartar or Siberian shamanistic practices; Vedic sacrifices; Louis Beirnaert (1951); and the familiar tale of "Jack and the Beanstalk" (Eliade, 1952: 48—50).

10 It is important to understand that the associations with these directions are not always the same for each patient. There are theories about the significance of directions, but individual experiences (for instance, the association of movement upward with heaven and death) may reverse the meanings for some individuals (Fretigny and Virel, 1968).

11 Leuner (1970) uses symboldrama in short-term therapy of children and adolescents. He particularly recommends it for adolescents who, because of age, have outgrown play therapy and are not yet ready for adult methods of psychotherapy.

12 From *oneiros* (Greek) meaning dream; oneiric means dreamlike.

13 Société internationale des techniques d'Imagerie Mentale. The journal is *L'Arbre Vert,* 12 Rue St. Julien-Le-Pauvre, Paris V, France.

14 Mario Berta, Gabrielle Charbonnier, Gilbert Durand, Asvedo Fernandes, Jeem Granier, A. Jellinek, Emil Nobi, Leopoldo Rigo, Jacques de la Rocheterie.

15 To Desoille's observations of lowered rectal temperature and rate of respiration, Virel adds that the subject exhibits abundant alpha-rhythms, little reactivity, absence of reactivity to external sounds or all other stimuli *except* the oneirotherapist's voice, no forward diffusion of the alpha-rhythm, no slowing of the tracing to a sub-alpha rhythm. See also Costello and McGregor ("The relationship between some aspects of visual imagery and the alpha rhythm", 1957) and Antrobus, Antrobus and Singer (1964).

16 For other European work in the combined use of psychoactive drugs and waking dreams see Exher, Kraepelin, Daudet (1927), Munsterberg, Meyer-Gross, Delmus-Marsalet, Dupouy, Horsley, Rouhier, Jongh, Delay (1958). Gerhard Grünholz (1971), however, uses five sessions of guided imagery to help his patient replace the use of hallucinogenic drugs.

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