

# The Case of Superman

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The grass was cool and damp beneath his bare feet, but it was the sound of breaking glass that caught his attention. Or a sound *like* breaking glass—he wasn't sure. "They're after me!" he thought. Feeling more frightened than he'd ever been in his 24 years of life, feeling sure the police were chasing him, he began running across the lawn. As he scaled the 8' fence, he felt sure he would get a police bullet in his back. But he didn't. Jumping off the fence into the alley, he began running, running as if he were a college quarterback again. It was while John was running down the moonlit alley that he began to "wake up," to remember that he'd been sleeping at Ann's house, in her bed. And he suddenly realized that he was naked, running down an alley of an unfamiliar neighborhood in the early hours of the morning.

Gradually orienting himself, he found a plastic bag in a garbage can with which to clothe himself. Since he was unfamiliar with the neighborhood, he was unable to find his way back to Ann's house by way of the alley. Frightened and utterly bewildered, he walked 'round the block, and finally made his way to her front door. He rang the bell, repeatedly, with no response. And then as he knocked frantically, the police car arrived.

The police had been summoned by neighbors who had been awakened by a woman's screams. One officer seated John in the patrol car and provided first aid treatment for the severe laceration of his right arm and chest. The other officer went into the house with the EMT's to take care of Ann. He emerged a half hour later with the following story: Ann had been sleeping with John and was awakened with him astride her, beating her in the face with his fists. She had screamed, he had jumped off the bed, and then he had leaped through closed drapes and a closed window.

The police took John to the emergency room for treatment of his wounds; Ann did not press criminal charges. (John paid her substantial surgical bills.) John had no memory of the events related by Ann. He was as incredulous as you would be if you were accused of beating someone in your sleep last night. It was as if he were in a nightmare. Later that day, feeling that "something must be very wrong with me," John telephoned a psychology clinic. He was soon seen by a young clinical trainee. John presented his problem as concern and confusion over the events of the previous night. He wanted to know why it had happened and he wanted to prevent such a terrible thing from happening again. He reported being unaware of having any other problems in his life.

John was diagnosed as "hysterical dissociative" and psychodynamic therapy was initiated. Sixty-five therapy treatments later, John had little more understanding of his condition than at the outset of treatment and, most troubling, he had experienced increasingly frequent episodes of somnambulistic behavior—sleep-walking. He had frequently awakened in the night, out of bed, always utterly bewildered, disoriented, slowly coming out of a nightmare, sometimes having done some violence to his bed or his furniture. Once he awakened after shoving both his arms through a bedroom window (resulting in wounds that required extensive suturing). After nine months (sixty-five psy-

chotherapy appointments) the incidence of these somnambulistic episodes had increased to as many as four nights a week, never fewer than twice a week.

It was at this point that I was asked to take over the case.

At our first meeting, John presented as a well dressed, unusually handsome man, smilingly charming, somewhat apprehensive about seeing me. During the interview he was articulate, expressive, obviously very bright, enjoying a successful career, and remarkably unaware of his own psychology. His behavior during that night nine months previous remained totally outside his ability to grasp as having been *his* behavior. He was a gentleman, with no awareness of any violent thoughts or feelings. He was absolutely mortified and stunned that he had apparently hit a woman—that he had in fact beaten a woman. He was athletic, very physically active, muscular, and what might be described by his friends as a “gentle giant.” He was a model of the good-looking, friendly, all-American young man. He did not swear, he drank only at parties “to have a good time with the guys,” had many friends, was close to his parents and siblings, worked hard. There was absolutely nothing in his appearance or behavior to provide a clue to the understanding of the bizarre and terrible violence unleashed during his sleep.

There also seemed to be an underlying sadness about him and yet he was also apparently unaware of the sadness. In our initial conversation, I asked him what he was feeling (at a moment when I thought he looked momentarily sad). His reply, “Nothing.”

“Might you be feeling a little sad?”

“No.”

“What were you thinking about, just a moment ago?”

“I was remembering an old lady I saw on my way here. She was crossing the street, and was having a lot of trouble, a lot of trouble walking. I guess she has arthritis or something. I thought it was sad that she was having trouble walking.”

Thus it was that I began to be aware partially of the extent of John's lack of awareness of his affective experience. I also had the benefit of the results of his psychological testing. Psychological testing had revealed that John feared he was crazy, felt he had had strange experiences (appropriately enough, I thought, considering what had happened), and felt someone might have control over his mind (again, I thought, understandable, given the circumstances). His personality testing indicated the presence of a homosexual panic. The psychotherapist he had been seeing had written, “Specifically, the patient appears to be struggling with some sexual identity confusion, fearing possible homosexual impulses which have a paranoid flavor to them.” It was apparent, then, from the extreme nature of John's symptoms, that there was tremendous conflict at an unconscious level conflict that centered around control over impulses that were terrifying to him.

A striking feature of this man was his attitude toward women as expressed in his language. He consistently referred to women as “broads” and “chicks.” He had had one significant relationship with a woman while in high school. It had ended with a feeling of tremendous pain and loss for him. He felt he had never gotten over that loss. Subsequently, he had had no significant romantic relationships. On the contrary, he had had sexual experiences with many, many dozens of women, and almost never more than once with the same woman. Asked to describe the kind of woman he would like to have a relationship with, he could only reply, “a tall blonde.”

Another striking feature of this patient was his total disinterest in and understanding of the meaning of his dreams. Further, his dreams were not characteristic of adult dreams. John's nightmares were consistently the type that terrify small children. For instance, he might dream of being chased by "bad guys," or "Martians," or of being harassed by gigantic bumblebees. All his nightmares contained childhood creations of terror and helplessness: monsters or malicious men of one sort or another. John could not remember having nightmares about his present reality. He could not remember having nightmares that contained members of his family, his work colleagues, and the like.

John's only understanding of his problem was that the stress of his job must somehow contribute to it. What he didn't understand was why he couldn't handle the stress, since he always had in the past.

Careful review of his childhood history was made. Of significance is the fact that at age 2 John had had an episode of meningitis with associated high fever and subsequent history of night terrors. In college he'd had a few minor and inconsequential somnambulistic experiences. There was no evident precipitating variable that could predict or explain his earlier somnambulism or his current episodes.

To rule out the possibility of organic etiology (temporal lobe epilepsy, for example), neurologic workup was done, including routine EEG studies. All results were within normal limits. It was of concern to me, however, that the EEG studies were made without associated episodes of somnambulism (so the brain activity associated with that behavior had not been observed). What, I wondered, characterized John's EEG prior to and during such an episode? Preparations were made for hospital admission to accomplish sleep monitoring. Sleep monitoring of EEG revealed normal sleep patterns, with no evidence of epileptic activity. However, just prior to three somnambulistic episodes, the EEG showed a transitional period subsequent to slow-wave sleep (Stage 4) but prior to what could definitely be considered to be an REM period. It was as if the normal motor inhibition that characterizes REM (Rapid Eye Movement, the sleep stage during which we dream) onset did not occur at these times, and the REM period took place with active motor behavior.<sup>1</sup> (Lesioning of the locus ceruleus nucleus produces similar results. One could speculate that the childhood episode of meningitis with its high fever might have altered the functioning of part of the motor inhibitory system). So it appeared that there was no evidence of epileptic etiology of this syndrome. Further, there was no clearly indicated medical treatment for this syndrome. This is a rare entity (Pedley & Guilleminault, 1977), and the only reported treatment involves chronic use of tranquilizers before sleep to prevent the possibility of somnambulism.

Because hypnosis is effective in the modification of physiologic processes, including sleep, and because hypnosis can alter dreaming, in particular, hypnosis seemed to be the treatment of choice for John. Initially, hypnotic suggestion was used to modify the somnambulistic behavior, which by this time had become frequent and potentially very

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<sup>1</sup> Preparation for hospital admission (for EEG monitoring) took several weeks. During this time, hypnotic methods were successful in stopping the somnambulistic behavior entirely. In order to obtain somnambulistic behavior for purposes of the EEG monitoring, hypnotic suggestion was successfully used to initial temporary onset of the symptoms again.

dangerous. Subsequently, similar hypnotic methods were used in the context of psychotherapy to effect curative changes in the syndrome as a whole.

Therapy was initiated as an interpersonally-oriented, problem-solving process. Our stated and agreed goal was to end his somnambulistic episodes and to prevent their recurrence. I explained that, by way of reaching this goal, it was likely that John would also learn a good deal about himself. This was satisfactory to him.

The therapeutic agenda, then, was to work toward greater awareness of John's person and his conflicts and to help him to integrate a new understanding of himself. However, my initial and primary concern was for his physical safety (as well as that of others with whom he might come in contact during his somnambulistic activity). He had had at least two experiences of somnambulistically jumping out of windows. When I learned that he often traveled to other cities and often stayed in highrise hotels, I asked what precautions he took to prevent his jumping from those windows (with more potentially serious consequences than he'd previously experienced). With an amused smile he replied, "Nothing."

At the first appointment, as a consequence of my concern for his physical safety, two interventions were made:

- 1) John was instructed to make his bedroom relatively safe for his somnambulistic behavior (removal of dangerous objects, moving a bureau in front of the window, etc.).

- 2) He was hypnotized and told that, whatever the necessity of these "terrible and frightening occurrences," from now on "it is not necessary for you to get out of bed while you are sleeping, and you will not do so." Such suggestions were given repeatedly and quite emphatically. Suggestions were offered in an indirect manner (e.g., "You can really be proud when you awaken in the morning, and feel rested, and pleased that you spent the whole night in bed"), as well as in the clear and direct manner described above. My own attitude was absolutely clear and firm and confident with respect to these suggestions. There was no doubt in my mind that it was dangerous for John to get out of bed in his sleep, and I communicated that to him.

Further, as a result of concern for the safety of others, John's own precaution of not sleeping with someone else now was very strongly encouraged. There was no suggestion that he ought not have sexual experiences with others, only that he not actually go to sleep with someone.

At the second appointment, 2 days later, John reported that he had not found himself out of bed during the nights following our meeting, but that he had awakened from a nightmare the previous night, still in his bed, having thoroughly messed up the bedding (indicating that the hypnotic suggestions may have had a salutary effect).

Because of John's understanding that his problem was associated with his sleeping and dreaming and because the somnambulism apparently was associated with nightmares, dreams and their meaning became the focus of treatment at this second treatment session. Although I remained curious about the events that surrounded John's assault of Ann and believed they must be important to an understanding of John and his problems, I also felt that there was little likelihood of successfully investigating the events of that evening, at least for now. (I had the benefit of John's previous therapist's experience. That therapist's focus in therapy had often turned toward the assault itself and the events in

John's life at that time; this attempt had met with failure and, in the therapist's view, resistance and hostility from John). I would not learn what happened that evening until much later.

Since John's dreams were consistently a puzzlement to him and since he never had any conscious idea of their meaning, at the second session I hypnotized John and suggested, "Some night this week, and I don't know which night will really be best...but some night this week, you will have a dream. This dream will be interesting to you, and will tell you something you need to know about your life right now. As soon as the dream ends you will awaken, and you will remember the dream vividly as you write it down so you don't have to memorize it. And you can bring in your notes about the dream next time." I gave suggestions for amnesia about the dream instructions, John awakened, and without further discussion he left.

It was my judgment that John was not prepared for rapidly uncovering unconscious material. He needed to discover for himself that there was more to his mind than he was consciously aware of, and at least initially, the hypnotic experience would best be kept separate and out of his conscious awareness.

At the third appointment, 1 week later, John was hypnotized and asked if he had dreamed. He said he had had an interesting dream the night before and had written it down. I asked him if the dream meant anything to him.

"Well, is it possible to have, like, two parts of yourself? Like a private self and a public self? Could you have two parts of your self that were, like, in conflict?"

The astuteness of this question surprised me and was the first evidence of any awareness on John's part of an existence of his inner mental life. I responded by asking John to tell me more about what he might know, or even suppose, about those aspects of himself. The discussion that followed involved his newfound understanding about himself, based on his recall of a dream he'd had the previous night. He recounted the dream, in which he found himself standing, suddenly, and without explanation, atop a water tower in an unfamiliar town. He was frightened of being up there and wanted to get down and did not know how. He felt that one part of himself didn't want to admit how frightened he was, seeing himself, literally, as Superman (who could fly up to and down from the tower, effortlessly and fearlessly). The other part of himself, he was aware, was privately frightened and unwilling for anyone else to know that he was frightened. Discussion was focused, very gently, on things John was afraid of, and of the fact that he really could not admit this fear to anyone. This discussion took place entirely within the context of a hypnotic state. Toward the end of the session, suggestions were made again that John would have a dream in the next week, that the dream would be interesting and meaningful to him, that he would remember it when awakening and write it down. I also suggested that he would continue to remain in his bed at night (as he'd successfully done now for the past week), he wouldn't mind not remembering our session when he left the office, but he would probably leave with a sense of accomplishment and well being.

Each subsequent appointment, usually one per week, for 9 months, focused almost exclusively on the use of hypnosis to suggest a night dream during the week, and then working with that dream, using Gestalt techniques, to bring gradually to awareness unconscious material to be dealt with in therapy.

While the out-of-bed somnambulistic behavior essentially stopped subsequent to the 1st week's hypnotic suggestion that he not get out of bed, there was continuing,

though progressively less frequent, episodic messing up of the bed during nightmares. These episodes, too, diminished, and, within 2 months had ceased entirely. There was always the threat, though, of future episodes, since this was at least partly an organic problem, and his susceptibility to its exacerbation probably still existed. (It is likely, for instance, that emotional upset was, for John, a precipitant to the neural dysfunction underlying his somnambulistic episodes. So long as he had no better way of coping with fear and anger than through denial and repression, and so long as a significant amount of John's stress was caused by intrapsychic conflict, the possibility of future somnambulism was quite real. Given the potential for harm as demonstrated by his assault on Ann, this possibility was taken very seriously. I wanted to avoid future somnambulistic episodes.)

Subsequent to the third treatment appointment, we began an almost unvarying pattern of treatment. John would arrive in the office, seat himself in his chair, and, in response to posthypnotic suggestion, quickly and "spontaneously" develop a deep hypnotic state. While in this state, he would recount a recent dream that was of interest to him. I would then ask him to retell the dream, allowing its vivid recreation in his imagination, in the present tense, from his point of view. Many of the dreams were of nightmare or near nightmare quality and evoked significant anxiety, which was managed by supportive suggestions. Following the narration of the dream from his point of view, he would be asked to reexperience and narrate the dream again, this time from the point of view of a different character in the dream. When appropriate, he would be asked to have a conversation with one or more of these characters. This process would be repeated so long as there seemed fruitful material to be obtained by going through the experience of still other characters in the dream (Polster & Polster, 1973). I almost never made interpretations. Rather, I would encourage John to come to his own meaning, or would ask him what the dream (or part of a dream) meant to him. John was almost always able to come to significant meaningful awareness of some part of his character or life conflict through the dream.

The speed with which he developed new awareness about himself was quite remarkable. Within the first 4 months of psychotherapy, John became consciously aware of the following powerful conflicts: He had a peculiarly strong identification with the character of Superman. He felt inadequate as a man and feared that he was a homosexual. He felt enormously guilty about masturbating (which he did ritualistically and after much planning). He felt that he would be enormously successful in his career, yet paradoxically felt himself a total failure. He became consciously aware of the extent of his excessive alcohol intake and of his use of marijuana and became afraid of his dependence upon these substances. He became aware of a strong ambivalence toward his mother, now realizing that he hated her as well as loved her (though he did not yet know the reasons why he felt the hatred). All these conflicts are evident of deep seated confusion and conflict over his view of himself and, particularly, of his quest for and fear of personal power. Again and again in working with his dreams, he would refer to himself as Superman and comment that he both liked being Superman and loathed the artifice. This theme of ambivalence toward power was consistent throughout John's therapeutic experience.

A persistent nightmare developed, in which John found himself (in the dream) in his bedroom, on his bed, frightened that there were bombs "booby traps") hidden around his room, and unable to leave his bed without possibly exploding one. John interpreted these dreams to be his way of keeping himself in bed during his sleep.

Otherwise, the incidence of nightmares began to quickly diminish, and the character of the nightmares changed from the childish fears of monsters and giant insects to more adult themes (as illustrated, for instance, by a dream in which he confronted a man in the park who was intending to seduce him into sexual behavior). John quickly became fascinated with the process of psychotherapy, and his motivation to “be better” was now combined with the birth of an interest in discovering more about himself in the process of “getting better.” His characterization of “getting better” became more and more oriented toward becoming freer to express himself and toward being able to have more intimate contact with others.

John began the seventh treatment appointment with a wish to talk about what he was discovering. Up to this point, therapy had consisted almost entirely of work within the hypnotic state, nearly always focused on a recent dream. At this session, however, John discussed the fact that he realized his life was changing, he was sleeping better, he no longer got out of bed at night, he was having fewer and fewer nightmares, and he was feeling less afraid in his waking life. After this point, then, the dreamwork more often began after a discussion in the normal waking state of a new awareness that interested John, or sometimes of a discussion of a life problem that was troubling him. (At the 10th session, for instance, John talked for the first time about disappointments and difficulties in his professional career. Up to this time, John denied any but the most blissful characterizations of his career.)

It is unlikely that any of these issues were unknown to John's previous therapist. He had, in fact, made interpretations about many of them to John. Although John had “resisted” those interpretations then, he now was developing them himself.

An example of the dreams that John worked with in these early months is the following:

I'm asleep in my bed, then I dream that I wake up. I realize that my room has been booby trapped, and that I have to find and disarm the bomb before it goes off. I very carefully crawl around the room, scared that I'll set off the bomb, trying to find it. I wake up, thinking my bedside lamp is going to fall on the floor. But it doesn't.

My girlfriend lives in a bad part of town the gay part of town. I feel scared visiting her. I'm with her in the swimming pool of her apartment building, and the gay men share this same pool. I'm scared, but I don't know why. I go to her apartment to find her, and she isn't there. The place is dark except for gays. I'm scared.

I'm in an airplane a biplane my dad is the pilot. We're doing an air show down by the park for a huge crowd of people. I'm standing on the wing. I'm supposed to perform some kind of stunt, while my dad flies the plane. He doesn't seem to be watching where we're going. We're heading straight for the cliff. I'm out on the wing and can't control the plane from there. I shout to my dad to turn, but he doesn't seem to hear me. I see the faces of the crowd as we flash by. They're smiling, enjoying the show. But I know we're going to be killed.

In working with the dream of the air show, John retold the dream from the point of view of his father. In doing so, he became aware of his father's pride in him, his love for him, his confidence in his son's abilities. John retold the dream from the point of view

of an anonymous woman in the crowd, during which he became aware of the expectations others have for his abilities, and for his belief that women see him as incredibly sexy and have tremendous sexual needs for him. It was during the working through of this dream that John became aware of his ambivalence toward his father, of his wish to wrest control from his father (whom he sees as incompetent and weak), and of his terrible sadness at that impulse. He said he hated the idea of taking away control from his father. It made him feel embarrassed for his father, he said. (This issue of taking over from the father was a theme that became significant later in his therapy, as we will see.)

About 4 months into treatment, John became gradually interested in a woman to a far greater degree than he'd been familiar with previously. Up to this time, his experience with women (except for his high school sweetheart) had been to see them once or twice only, purely for the purpose of sex. This woman, Christine, had become a steady interest of his, and he began seeing her exclusively. He still maintained the prohibition of actually sleeping with someone else, however. (This was no difficulty for him, since he did not want emotional closeness with anyone, anyway.) His interest in Christine prompted conscious anxiety for him about being trapped by a woman. His dreams began to be more and more clearly dreams about sexuality and power. His homosexual fears seemed to diminish (particularly as he experienced Christine's absolute fondness and attraction to him). At about the 7th month of therapy, John had the following dream:

I'm Superman. I get my kicks by helping people, fighting bad guys, saving women and children, you know. And I'm in bed now with Christine, and we're making love, and she asks me to take off my Superman outfit. I tell her I can't, that it doesn't come off, that I've never taken it off. But she insists that it is only clothing, that it will come off, and she insists that I do take it off. We have a fight, and she won't make love with me if I'm wearing my suit. And I'm so horny that I agree, so I take it off. Only now I can't. I can't make love with her. I'm impotent. Christine is disgusted with me. I feel helpless now. It's like my genitals shrunk, got tiny, and I feel like a little boy, and I'm scared.

In working with this dream, John became aware consciously of his desperate need for power over women, fearing that they would otherwise have a fatal power over him. It was a frightening session for John, and a significant amount of time was taken with helping him to integrate this issue consciously. In the week following, John had the following dream:

I'm locked in a dark place. I can't see anything. It's hard to breathe. I'm being punished. My mother's mad at me. I don't know why. I did something bad. I don't know what. It's all dark, and I'm getting really scared. I bang on the door, but she won't let me out. No matter what I do or say, she won't let me out.

In working with this dream, I asked John to take the role of his mother and reexperience the dream. He felt totally incapable of even pretending to know what his mother felt or thought, or to even guess why she was punishing him (although he had not previously experienced difficulty in dreamwork).

After 9 months of psychotherapy, John rarely had nightmares, was seeing Christine on a steady and exclusive basis, was contemplating asking her to move in with him,

was succeeding very remarkably in his career, and had developed a very vivid interest in his inner life and in his personal growth. He became interested in philosophy and psychology, particularly the psychology of consciousness. He read books on the subject and more and more wanted to talk with me about these subjects. He was freer in his social behavior and was more readily willing to let others see his human, non-Superman self. He was developing a quite psychologically intimate relationship with Christine, and in fact told her about his experience with Ann. (He'd previously told no one but his therapists and his attorney.) In short, he was becoming a psychologically well-developed man.

Although the nature of his sleep disorder warranted continued monitoring, his need for therapy was rapidly becoming satisfied. At about this time, he asked me if I thought he was ready to find out what happened the night he assaulted Ann in his sleep. (He had previously mentioned his curiosity about this only in our initial interview. He almost never mentioned the event, and had not expressed curiosity about it.) I asked him to develop a hypnotic state, and after he had done so, I used ideomotor signaling<sup>2</sup> to inquire about his unconscious readiness to learn this information at a conscious level. He indicated that he was ready to let his conscious mind learn what had happened that night. I then suggested, as I had so often suggested before, that one night in the following week he would have a dream and the dream would be interesting and meaningful to him. This time, however, I suggested that the dream would reveal to him what actually happened the night he assaulted Ann. I suggested that this dream would reveal to him what had precipitated the event and what he was doing in his sleep as it occurred. I also suggested to him that he would be free to not consciously remember this dream until he worked with it in my office.

The next week he arrived feeling, he said, very excited. He said he'd had a dream the night before that he knew must be very important because he couldn't remember any of it. (By now he had a great appreciation of and interest in defense mechanisms such as repression.) I asked him if he was ready to work with the dream with me. He indicated that he was, and promptly developed a hypnotic state within which to work with the dream.

I'm in bed with Ann. We're making love. She teases me, and I get my feelings hurt. I don't know why, but I hate her for teasing me. So we stop making love, and we each turn away from the other and go to sleep. Now I'm sleeping. I begin to dream. In the dream I'm in bed with Ann, just like I really am, and we're making love, and she begins to laugh at me, to make fun of me. And suddenly I realize she isn't really Ann, she is my mother, in disguise somehow. And I'm in bed with my mother! And she's laughing, saying, "I finally got you. I finally got you!" And I'm so ashamed, so embarrassed, I just start hitting her to make her stop. Then she starts to scream, and I jump off the bed and jump out the window.

As John was describing the events of the dream, he was becoming progressively more agitated and upset, and, by the end of the account, was alternately panicky and cry-

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<sup>2</sup> Ideomotor signaling is a hypnotic technique that capitalizes on the patient's ability to "signal" (usually by lifting one of two fingers) in order to indicate "yes" or "no," which is often easier for the individual than the more complex behavior of talking while hypnotized.

ing. I offered the support of his knowing that I now knew what had happened and was not offended or horrified by what I knew; but rather, that I understood the terrible dilemma he had experienced as a child. I further offered an opportunity simply for time and quiet in which to absorb and integrate this experience. After a few minutes of more quiet sobbing, John began to arouse from the hypnotic experience. The remainder of the appointment was taken with consciously integrating this experience.

During the treatments that followed, John and I worked toward a conscious understanding of that dream, and of the childhood memories it had released. In the days following that dreamwork, John began to remember bizarre and painfully confusing incidences of sexual seduction by his mother. These incestuous incidences, it became evident, led him to his confusion over his feelings for his mother—his very deep love and affection, and his equally deep hatred and fear. His view of his own sexuality, and of his terrible need for both control over and distance from women, was also undoubtedly rooted in these early experiences. Finally, it became clear why the strength and unemotionality of Superman had seemed necessary to protect him from his sexual and emotional vulnerabilities. Memories of the actual torture of being locked in the dark closet (one of his punishments for not satisfying his mother), made clear how John had developed his dissociative capacities. Reviewing his early childhood fears of taking his father's place as his mother's sexual partner helped him to understand his contemporary view of his father as weak and incompetent (and of his current ambivalence about trying to take his father's place in the business world).

John experienced enormous relief from discussing these memories' meaning to him. He rapidly became more relaxed and at ease with himself and less fearful still about his own nature. After eight treatment treatments, John terminated therapy with the understanding that he could call and/or resume treatment again if he wished. From time to time since then, John has briefly reentered therapy for the purpose of sorting out current life problems.

It has now been over twenty years since the night John assaulted Ann. I remained in contact with John for seven years. Except for one minor episode within the year following treatment, he had no further somnambulistic episodes. Also during that time, John and Christine lived together for three years, and then were married. John's professional career has become very successful, and his life is that of a lively, increasingly self-aware man struggling with the same dilemmas life presents us all.

The successful resolution of John's problem might have been achieved through therapeutic means other than hypnosis. Hypnosis was used as the major therapeutic technique for two primary reasons:

1. The primary syndrome involved behavior during sleep. Hypnosis has a rich history of use for treatment of sleep disorders and offers the potential for rapidly altering their symptoms. In this case the symptom necessitated rapid alteration, since there was the potential for serious harm to the patient and others.
2. The patient's symptom involved troubling dreams, so dreams offered the obvious focus for working through issues that were outside the patient's conscious awareness. Since Gestalt therapy includes techniques for dreamwork that are easily combined with

hypnotic techniques, it was natural to combine these therapeutic techniques (Barber, 1983).

It is likely that hypnotic suggestion to alter the symptom of somnambulism would not have been sufficient for treating the problem. John's deeply felt confusion over power conflict, combined with the extremely ambivalent, incestuous relationship with his unusually seductive mother, required a working through of these themes to relieve the conflict and, thus, the nightmares. The goal in therapy (once the immediate danger of the out-of-bed experiences was past) was to enable John to become aware of himself (particularly his confusion over issues of power) and to integrate this awareness with a growing sense of his own inner wholeness and strength.

John is now able to use his lessened need for power and control within the healthy context of his work and no longer needs to hide what he regarded as his base and evil self. Superman had been needed to save a little boy from pain and terror from which he could not save himself. Superman is no longer called upon to make to polarize John's impulses in order to make him feel safe from them. John is now a man and is learning to master the power and strength he now knows is his own.

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