
CORRESPONDENCE

On listening to the dreams of children affected by serious physical illness

TO THE EDITOR: Recently, *Minerva Pediatrica* published an interesting review on “Sleep problems in children”¹ in which the most common sleep problems affecting children and adolescents were discussed in relation to their prevalence, manifestation, symptoms, assessment and management. One aspect of sleep and sleep disorders that was not addressed in the review however, and that we believe worthy of further study, regards the related ability or inability to dream (“related” as opposed to “consequent”, as the direction of the causality is not always obvious).

More specifically, we would like to draw attention to the dreaming of children affected by serious physical illness, and the consequences that the listening skills of the caregivers (parents, nurses, doctors, teachers etc.) may have.

During sleep our mental activity does not cease. What changes is the relationship that the dreamer has with reality: “*Perceptive reality is replaced with hallucinatory reality [present also in waking state] with self-representations and strong emotional participation in the dream events*”.²

The dream, as with creativity, is a kind of territory in which to work through personal experiences; it follows that if we are in the presence of insomnia, sleep-disordered breathing, parasomnias etc. the work of dreaming of our waking state³ will require more space; sleep disorders thus become dreaming disorders as well, and dreaming is a process that is anything but secondary in importance for the psychophysical health of children.

How will an adult, too intensely distressed over the death of a child, be able to approach a child who has a fear of death and be able to offer a space in which to listen and share? Adults can connect with children, their dreams, as well as their drawings and plays, only if they have been able to perceive, tolerate and contain their own emotions, including their personal sufferings, but they must also be able to reconcile the realm of reality with that of their own creativity. This is because the identity of one (the suffering child) can only exist in a more integrated way if in the presence of another person: *if I cannot speak to you of my pains and of my fears of dying, I will not exist for you as a living and suffering child.*

When the adult is not capable of reaching out, it is possible that the child’s dreams, play and fantasies are perceived and treated as futile, meaningless, and devoid of any connection with the experience of illness, rather than being the outcome of creative psychic work in the child’s own world. The child’s creative attempts through dreaming, playing, and fantasizing are emptied of their substance and depth because an avoidance mechanism of defence against depression is taking place within the adult responsible for the child.

Something similar occurs also with dreams: if parents are caught off guard, and if they consider their child’s dream irrelevant or bizarre, the child will not befriend his/her own unconscious, and give credence to his/her dreams⁴; the child will only uncanny elements (Giannakoulas, 2010, unpublished material).

As a matter of fact, in such a scenario, all that dreams, drawings and creative activities can communicate is lost. And, as a result, the process of sharing and working through, with the accompanying effect of giving meaning to experience, is blocked.

Because of the caregiver’s failure to accept the child’s feelings and give them meaning, the child has no way of dreaming about his own emotional experience. And if, like Shakespeare, we believe that “We are such stuff as dreams are made on”, then the stressful and dramatic effect on the child will be undeniable.

This implies that this child “*is unable to change, or to grow, or to become anything other than who he has been*”,⁴ namely a sick child even when he/she has clinically recovered. It represents a blindness to the connection between events and experiences, and, more importantly it is a missed opportunity for adults and children to become re-attuned and when these children have no other recourse, they end up colluding in the adult’s attempt to avoid anguish. Such an outcome leads to the danger that “*Everyone stands alone at the heart of the world pierced by a ray of sunlight; and suddenly it is evening*” (Salvatore Quasimodo).

Sometimes moments of truly intense and painful clinging may be witnessed between child and adult, denoting a defensive need to be reassured

and, through a sort of blending, to deny separateness and ultimately the possible death of one of them. To be fully and completely attuned to the child at the reporting of a dream, to view a drawing with delicacy and sensitivity, or to attentively listen to a suffering child means establishing, at the heart of the relationship, a mechanism of exchange and communication with which to connect the healthy and unhealthy, the present, past, and future, the possible and impossible, the fears and hopes, the presence and absence, the inner and outer worlds.

A dream is also a means of expression, a phenomenon which can be made to take the shape of one's own fantasy, allowing the adult to relate to the child — and also allowing the child to develop a sense of trust in a relationship, a crucial foundation for experiencing a psychological and physical containment, in which to freely explore all the possibilities of communication. If this connection does not occur, all personal relationships are emptied of meaning. They become artificial. Time stops and the condition of illness is placed in a state of “suspended animation”, representing a potentially protracted blocked process, a black hole of time tending towards stagnation and implosion, until the evolution of the illness, removing the child's body from this subjective world, will force everyone to face disillusion and breakdown.

Attempting to pinpoint the meaning of dreams, child-play, and drawings is, in a way, equivalent to asking how the sadness, pain, happiness, and laughter of ill children are being handled, and if children are, in fact, talking about themselves and their lives through their dreams, drawings and playing. It also implies imagining an environment in which emotions and thoughts can be shared. These are questions that cannot be considered trivial or an impediment a propos therapeutic emergencies. In-

stead they are a meaningful benchmark of the quality of the cure.

A different yet logical perspective on how suffering and anxiety generate modes of expression and various approaches to care management, leads one necessarily to observe how the medical team functions in terms of treatment. There can be no outlet for expressing the suffering of these children and parents if there is no inviting and secure space, created by an individual caregiver or the team as a whole, in which these experiences can be shared. Would it not be useful to include among the standards of excellence for health facilities, the ability, upon the part of the medical staff, to cope with these intense emotions and the capacity to work through these feelings of anxiety and sorrow?

A. STEFANA

Private Practitioner, Brescia, Italy
alberto.stefana@email.it

A. GAMBÀ

Private Practitioner, Monza, Italy
alessiogamba@tiscali.it

MINERVA PEDIATR 2015;67:1-2

References

1. Baweja R, Calhoun S, Baweja R, Singareddy R. Sleep problems in children. *Min Pediatr* 2013;65:457-72.
2. Mancia M. The dream between neuroscience and psychoanalysis. In: *Psychoanalysis and Neuroscience*. Milan: Springer; 2006.
3. Bion W.R. *Learning from Experience*. London: William Heinemann, 1962.
4. Ogden TH. *This art of psychoanalysis: dreaming undreamt dreams and interrupted cries*. London: Routledge; 2005.