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Oneiric Manifestations and Psychophysiological Dynamics: When the Dream Facilitates the Installation of Psychosomatic Disorders

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Abstract

Since the advent of scientific theories about dreams, people in sub-Saharan Africa do not seem to have integrated them. For them, the dream is perceived almost exclusively as a divine means of communication or the evil act of witches and evil spirits. These interpretations are not without impact on the variations of the level of anxiety of the subjects in these populations and raises the problem of the failure of the dream functions. This study explores the future of dreams for these dreamers. It aims to understand and describe the psychophysiological mechanisms or processes that can provoke somatization in the dreamer of African culture during and / or after the dream. It is based on the hypothesis that the dream experience contributes to the genesis of psychosomatic disorders in the African black dreamer. The formulation of this hypothesis was guided by the theory of integrative psychosomatic, important in this work by its multiaxial approach. Participants, Black African patients whose reasons for consultation were closely related to their dreams, were selected by reasoned choice. The data were collected by semi-directive interview technique, psychometric and biometric tests. These data were the subject of a functional analysis. Three of the four participants, who mystified their dreams and had a high stress vulnerability score, regularly had neurovegetative disorders leading to clinically significant changes in homeostasis parameters. The participant who rationalized his dreams did not show clinically significant physiological variations, despite the fact that he suffered from renal failure and paradoxical sleep behavior disorder. These results show that the dream experience can contribute to the genesis of psychosomatic disorders in the African dreamer. These variations of homeostasis are, on the one hand, the consequence of intense cerebral stresses during certain dreams and, on the other hand, the consequence of the anxiety induced by emotions, cognitions and behaviors related to dreamlike manifestations developed by the subjects after waking up.

Keywords: *Dream; Emotion; Cognition; Behavior; Psychosomatic Disorder*

Introduction

Today, the dream problematic concerns almost all human sciences, such as philosophy, psychology, psychoanalysis, anthropology, sociology, natural sciences such as neuroscience, and metaphysical sciences such as astrology and theology. In psychology, the dream is considered as a mental process allowing memory consolidation and the expression of affects [1] or simply as a mental activity that takes place during sleep (Braconnier, 2007). When we look at cognitive-behavioral psychology, which attributes the causes of psychological problems to defects in mental constructs, it is necessary to pay attention to dream phenomena. This need can be justified by the particular interest that our Black African cultures give to dreams [2].

The dream function in particular and the function of sleep in general is the least studied in psychology and biology [1,3]. The dream is certainly an objective reality, perceived and experienced by all humans since the dawn of humanity, however, the impossibility of accessing the dream of the other without the use of introspection remains the first obstacle to study of this great psychophysiological function. Since Jouvet (1959), we know the dream period, which has been called "paradoxical sleep", and is characterized by Rapids Eyes Movements Sleep and fast waves [4], but several questions remain unanswered about his function: Pichot and Delay (1971: 310) affirm "... we agree to recognize a role to dream, although the nature of this role is discussed"; For Gay (1999: 115) [5], "the dream escapes all restrictive theorization"; For Schalchli (2004, quoted by Crabbé, 2010 [6]), "Force is to recognize that dreams are still far from having delivered all their secrets"; When-in Tavris and Wade (2007: 95) [7] "there is, in fact, much to learn about the role of the dream, and sleep itself"; as for Sherwood (2008: 135) [8], "the role of sleep is unclear"; "Godefroid (2011: 524) [2] wonders: "what is the meaning of the dream? ... How to understand the presence of other characters acting" in the mind "of the dreamer?". All these questions show to what extent the dream problematic concerns researchers from the 1950s to the present day.

Motivated by the fact that many inpatient internal medicine patients seem to attach great importance to their dreams by linking them to their suffering, we are interested in the impact of these concerns on their physical health. This theme is part of the vast field of psychosomatic, particularly in neurobiological or cognitive-behavioral psychopathology. The problem raised here is that of the role of the dream experience in the genesis of psychosomatic disorders and is formulated as follows: by what processes can the dreamer's body suffer from the quality of his dreams? In other words, what are the psychophysiological mechanisms or mental processes related to dreams, which can account for the transition from an elaborate mental state in relation to the dream to somatic suffering? We want to explore the relationships that the cognitions, emotions, and behaviors that the dreamer develops in relation to his dreams, maintain with his somatic functioning. Thus, we ask ourselves the following general research question: Does dream experience contribute to the genesis of psychosomatic disorders in the dreamer? In other words, do the cognitions, emotions, and behaviors that the dreamer develops in relation to his dreams contribute to the genesis of physiological disorders in him? The general objective of the research is to understand the mechanisms or processes that may lead the subject to somatize during and after the dream. The working hypothesis is formulated as follows: The dream experience contributes to the genesis of psychosomatic disorders in the dreamer. If this hypothesis proves to be relevant, it would make it possible to review or restructure the therapeutic attitude of sleep and dream management specialists, namely psychiatrists, neurologists, psychologists and psychotherapists on the one hand. And will also raise awareness among our populations about the risks that their subjective conceptions of dreams may have for their health on the other hand. In this work, the observation and the interview allowed to collect the data of which a functional analysis made it possible to give them meaning, by referring to the cognitive-behavioral approach of the integrative psychosomatics. The complexity of this theoretical approach that as, by its eclectic or mixed method, put us before many data which did not facilitate the task of analysis.

Dream and socio-cultural context

The earliest writings dating back to over 2000 BC reveal that since the dawn of time, human beings have always been interested in their dreams [5,9]. These dreams are probably the first psychic phenomena having intrigued the first men. Starting from a metaphysical conception since the dawn of humanity, it was not until the 1900s that Freud conceived the first so-called scientific theory of dreams, attributing to them a psychological, intrapsychic value, which was stripped of any social value [10]. This Freudian theory has gained European cultures in such a way that in these societies "dream ethnography" has been almost absent until the last decades, because dream phenomena are not studied in these cultures, or so that the knowledge popularized in these cultures are those stemming from the psychoanalytic approach.

In Africa, on the other hand, or better in traditional societies, there is a diversity of dreamlike conceptions, having in common the existence of a detachable soul of the body, which can leave the body during sleep to visit the spirit world, visit the dead, or visit other sleepers [10]. This metaphysical conception, almost absent in Western societies, is present and dominant in African societies or cultures in general, and Cameroonian in particular. Similarly, based on the idea that religion is defined as belief in spirits, Burnett [10] places the

dream at the center of a theoretical foundation of religion, a foundation fueled by the notion of 'soul'. This idea seems to have its full value when we observe the behavior of individuals in our societies: those whom dreamers consult on awakening are almost all men of God, marabouts, healers, in short spiritualists [11-14]. Thus, the dream here seems to be the only way to visit the water-de-là, to communicate with the dead, to predict the future, all this advocating a conception and a social use of the dream, this opposing the individual and intrapsychic conception that Freud has constructed.

The traumatic situations that Africans are experiencing in this environment of cultural mixing, political crisis, lack of employment, precarious health, are not without implications for the formation and the nature or the manifest content of the dreams of the African on the one hand, and on the interpretation, beliefs, feelings, and behaviors related to these dreams. We know today that the amount of agonizing dreams is proportional to the difficulties the subject has met during the waking period [2] and that the subjects remember more of their dreams after a period of tension or depression only when the day went off without problem [2]. In the field of psychophysiology and neuroscience, the impact of repeated or intense emotions on the nervous system in particular and the organism in general is no longer to be demonstrated, and even more so when they are negative [15,16], because they can lead to very serious psychophysiological or psychosomatic disorders [6].

From all the above, we think that proposing a descriptive model at the end of this study would allow future research to have some basic elements and some benchmarks to be able to set up an explanatory model. In addition, we believe that a globalist approach to dreams can help to better understand this phenomenon, which is considered complex and controversial in terms of its understanding and results [2,5,15].

Generalities about dreamlike approaches and their limits

The writings on the dream phenomenon are found today in the literature of almost all the human, social, and biological sciences. It is found particularly in the works of philosophers, theologians, traditional healers, psychoanalysts, neurobiologists, anthropologists, sociologists, and psychologists. It will be a question here of briefly presenting the main conceptions of the dream in these different domains, to highlight their different limits or problems that they pose.

Religious such as Christians and Muslims view the dream as a means of divinatory communication that can be used by God or the demons to come into contact with man [17].

The problem with this approach is that it is essentially dogmatic and subjective, and, in addition, opposes the administration of evidence.

Cultural and shamanic conceptions provided by anthropology reveal that dreams are conceived as a means of communication with ancestors, of prediction and bewitchment [18,19]. This is also the case in Cameroonian crops in general, and in the Bamileke cultures of West-Cameroon in particular [20]. For the Grassfields of West-Cameroon, the dream is a way to understand the illness and suffering of the patient and is "determined by the concept of personality, mental disorder and social order" (Nuekeme 2001 [1]: 64-65). In the Ambuun of the Democratic Republic of the Congo, the dream is the means by which invisible entities communicate with men in order to orient them in daily and spiritual life, and is based on five functions, namely the premonition, the expression of Bewitching, means of treatment of diseases, marker of identity, and finally, as a form of reminiscence [9]. After a study among the Yaka, Brodeur [21] concludes that the dream has a social meaning in this community, that is to say that it is only a reflection of the real life of the community.

In Africa, the dream is a reflection of cultural life and is interpreted as such, and not as the West has developed it [14,22]. For Poirier (1994: 105) [19], "In the Aboriginal societies of the Western Australian Desert, the dream is a true experience, an integral part of the real and the event flow." Thus, traditional and shamanic conceptions attribute to the dream a divinatory, premonitory, mystical, and social function. For the followers of this approach, the dream is the consequence of something supernatural. However, the interest of these studies is that they make it possible to understand the place and influence of dreams in the sociocultural functioning of humans.

The problem posed by these conceptions is that they approach the dream according to common meanings and stereotypes, which are transmitted from generation to generation and without concern for verification. This knowledge is based on the theories of common sense, on the generalization of individual perceptions.

For psychoanalysis, the dream is the "royal road" leading to the unconscious. In 1900, Freud will lean towards the hallucinatory expression of unconscious desires, Adler in 1910 [23], will advocate for the expression of the will of power turned to the future, Jung in 1912, envisioning it as a premonitory and reminder from the past (Archetypes), Bion (cited by Meltzer, 1984) apprehends it as a means of mentalization allowing the maintenance of the sleep-wake relationship. The interest of psychoanalytic approaches is that they make it possible to understand the place of the dream in the psychic and fantasmatic life of the subject and allow, during consultations and care, to access the intrapsychic conflicts of the subject and to identify situations who trained them.

For psychoanalytic psychosomaticists like Sami [24], the dream is not only the nocturnal dream, the imaginary is nothing but the dream in the waking state, and on this, must be treated as such. For the author, the presence of the dream is an indicator of poor repression and its absence indicates that the subject has repressed the representation well.

The common point between these psychoanalytic approaches is that they view dreams as an indicator of psychic health. However, this poses a problem at the level of the dream function, which remains purely psychic, whereas science has now proved that a neurobiological system, namely the Ponto-geniculo-occipital system (PGO) and the nucleus accumbens are at the origin of dream production [3,15].

For physiologists, this is the expression of the cerebellar stimulations interpreted by the cortex during sleep [3,15]. These dreams can be accompanied by very intense emotions, resulting from the quirks of its content [25]. The Association of American Psychiatrists [26], insists that the discontinuity of sleep resulting from awakenings caused by nightmares is at the origin of the marked suffering of the subject and the alteration of its social and professional functioning. Crabbé [6] states that "anything that impresses a patient, consciously or not, has objective physiological consequences". He insists that paradoxical sleep disrupts the homeostatic principle, seems dangerous, consumes inexplicably enough energy, and above all, can cause in holy subjects heart pauses of several seconds, which can lead to the failure of a vital function and lead to death. These studies highlight the relationships between dreams and physiological processes on the one hand and between mental life and somatic life on the other. However, they also come up against the level of the dream function and the explanation of certain dream processes such as its cyclic appearance [27].

In psychology, cognitivists see it as a "repair workshop" Godefroid (2011: 526) [2], as a means of solving daily difficulties [2], as processes of "active unlearning" (Crick & Mitchison, 1983, quoted by Purves*., et al.* 1999 [28]) to break unnecessary and parasitic connections in the brain, as a hippocampal consolidation procedure [2]. In neuropsychology, Jouvet [29] sees it as a means of expression of genetic background and psychological individuation. In psychophysics, dreams are considered as the expression of brain processing of sensory information received by the body during sleep (Bergson, cited by Lefranc, 1996) and as the expression of organic disorders [30,31]. These psychological studies come to show the indispensable place that the dream occupies in the mental life of the subject, that is to say in his adaptation to his environment, in the fixing of memories and the emotional discharges without which the subject would be permanently prey to anxieties and frustrations. However, these psychological approaches are monistic, that is to say, consider the dream as a phenomenon or a purely psychological process, whereas psychic-somatic duality is not to be demonstrated today [26,32].

Despite major advances since the 1950s, research on sleep functions and dreams remains deficient and contradictory in terms of their functions. Several authors support this idea. With regard to the thought of dreams, Delay and Pichot (1971: 310) ask themselves these questions: "Does it nevertheless have a psychological function? ... At present, there is agreement to recognize a role in the dream even though the nature of this role is discussed. For Gay (1999: 115) [5], "the dream escapes any restrictive theorization". For Purves., *et al.* (1999: 501) [28], "despite the wealth of descriptions available about the phases of sleep, the functional role of the various states of sleep are not known". Schalchli (2004, quoted by Crabbé, 2010 [6]), says about the dream function that "Force is to recognize that dreams are still far from having delivered all their secrets". When-in Tavris and Wade (2007: 95) [7], "there remains, in fact, much to learn about the

role of the dream, and sleep itself". Sherwood (2008: 135) [8] states that "the role of sleep is unclear". Godefroid (2011: 524) [2], pushes further his questions: "what is the meaning of the dream? How to explain, that in the absence of any movement, that we feel sensations of spinning or sudden fall? How to understand the presence of other characters acting "in the head" of the dreamer? ... ". All this highlights the problematic of the presumed functions of dream or paradoxical sleep in particular, and those of sleep in general.

Contrary to all these conceptions which envisage and question the dream on the conditions of its appearance and its possible natural functions, we are interested in the dream during and after its production.

Nightmares and sleep paralysis are usually accompanied by intense emotions, regularly arousing the dreamer [5,6,26] and may accentuate the onset of seizures in the epileptic (Feré, Janz, cited by Ossemann, 2011 [33]), of which 45% during sleep versus 34% during waking, the rest being associated with specific situations [33]. According to APA [26], child nightmares disrupt 10-15% of parents of 3 - 5 year olds, 50% of adults have occasional nightmares, and 3% of adults frequently have nightmares that hinder their well-being to be daily. Nocturnal terrors frequently affect children aged 3 to 4 [5], causing the subject to cries of terror, sudden awakenings, frights, delirium, tachycardia, rapid heartbeat [2]. Sleepwalking affects nearly one in six children [2], 5% of the general population, 15% of children aged 5 to 12 years, 70% of children so at least one of the parents was a victim of sleepwalking [5]. Foulkes (1979, cited by Godefroid, 2011 [2]) considers these night terrors as a panic reflex in reaction against the decline of vital neurovegetative functions. Some studies [34] have shown that dream disorders such as paradoxical sleep behavior disorders (TCSP) are precursory signs of neurovegetative pathologies such as Parkinson's disease and Alzheimer's disease. Other studies have shown self and hetero-aggressiveness in some sleepwalkers with no history of psychiatric illness [2].

Regarding the relationships between dreams and certain pathologies, nightmares are the expression of anxieties and anxiety or neuroses according to the psychoanalytic nosography [6,25]. Boss [35], observes nightmares and premonitory dreams in subjects in the prodromal phase, well before the active phase of schizophrenia, but does not discuss the causal link between these two entities. Vaschide and Pieron [30,31] conducted an experimental observation on volunteers and suspected a direct relationship between the manifest content of the dream, the period of appearance, and the location of certain organic pathologies. However, for Sami [24], it seems impossible to establish a direct relationship between these two phenomena which we are at least sure they are associated.

More generally, the above information raises some questions, for example, whether there is really a linear relationship or not, whether there is an interaction between dream and illness and, if so, what is the nature of this relationship, what are the processes involved? This is because each theory or author makes arguments that are quite different or opposed to those of others.

In the daily life of the people of western Cameroon, the search for the meaning of the dream is a reality: the children tell the parents when they wake up; young people refer to it to predict or visualize their future; parents use it to appreciate their social, family and spiritual relationships. The dream world seems as real as the physical world in this society. People spontaneously tell their dreams when they wake up trying to find meaning for them. In this society, as in many others in Africa, the situations encountered in the dream are as worrying as those encountered in daytime life. On this subject, a healer met in the city of Makénéné says: When a person goes to see an insider of the traditions, who can be a "Kamsi", or a "Gakaar" to tell him his dream, he is as excited and attentive as when one goes to see a doctor for a pain of head or chest and we expect the results of the exams that give the devices... (Batchaga, personal communication, February 6, 2014).

The dream is perceived in these societies as a means of communication with the afterlife, and with other members of society and the family. After a night full of scenarios and charged with emotion, the dreamer worried and anxious, first tries to find for himself a meaning to his dream. When he cannot come to a satisfactory conclusion, he will ask for help. From then on, his behavior or his reaction will depend on the meaning that one would have given to his dream. For example, as in traditional societies, wizards are said to use the meal to reach the victims, especially at night [11,13,14,22] after a "night meal" that is to say, a dream in which the sleeper has eaten a meal, he will pick a grass in the morning and consume it on an empty stomach. If this type of dream persists, the dreamer will interpret his dream

to know who is behind this persecution, then how to counter it. If it happens that the interpreter identifies an individual who is at the origin of these attacks, the dreamer will be able to face him physically or spiritually too, or reinforce his protection by armor ceremonies during which certain potions of protection are introduced into the body of the concerned after scarifications, and other rituals, which constitute the dimensions of the traditional therapeutic treatment (E. Batchaga, personal communication, February 6, 2014). In any case, the relationship between the dreamer and the alleged persecutor will deteriorate or become more complicated, maintaining the anguish of the persecuted person, sometimes also of the alleged persecutor, especially when the latter claims to be innocent. If these dreams stained with intense emotions persist or seem to exceed the skills of the traditional therapist, anxiety and anguish seem to grow, and gradually alter the relationship of the subject with his sleep, perhaps even drag the subject into a Nyctophobia or fear of the night or a litiophobia or fear of going to bed, as one patient under consultation that we interviewed in our research structure: [...] I often prefer to waste time on the computer, wait around 11 pm to 12 pm before going to bed because I'm afraid of going to bed and having too many nightmares [...] I go to bed only when I cannot do otherwise. It's as if people there are only on the bed waiting for me. When I close my eyes, it's hell that starts after [...] sleep, we should feel bin in the morning right? But at home, it's not that! I feel pretty bad. It's like my heart is going to come off. I do not know what to do [...] (patient, personal communication, July 18, 2014).

This could then lead to another form of request, namely medical demand. On this medical field, the problem seems even more complex. The patient will usually go for sleep disorders such as insomnia, or other physical symptoms. During our internship, these types of patients represented 38% of cases of insomnia complaints encountered in the neurology department. In about 12% of cases, nightmares are freely discussed by the patient in consultation. The attitude common to general practitioners and even specialists such as neurologists, psychiatrists, and psychologists is that they all seek to find the cause of symptoms only in the somatic, in rare cases they can search for the cause of nightmares also in the life events of the subject, without however taking into account the relation that these dreams can maintain instantly and after the awakening with the body of the subject. In other words, consultants envision dreams only as the expression of a latent dysfunction. With some patients in hospital, when nightmares occur for example, they are not taken into account in the treatment scheme by health care staff who minimize their effects, despite the frequency of complaints made by the patient on this subject. In some cases, the situation is classified psychiatric and psychotropic drugs are prescribed. As soon as the treatment stops, the same problems start again and the prescription is updated. Therefore, the prolonged use of psychotropic drugs in the management of these insomnia and other psychophysiological disorders could lead to other complications such as addictions and addictions, which thus become new objects of concern for patients. This situation would facilitate the use of traditional therapies and religious therapies, thus contributing to the proliferation of revivalist churches that we observe in our present societies.

Of all the above, we can summarize the empirical problem in that the perceptions and representations that the subjects in our African cultures make of the night and their sleep in general, and of their dreams in particular, seem to disturb their psychic and somatic well-being. The dream itself seems to generate anxiety. The search for meaning seems to amplify it when the meaning retained is that of a threat or persecution. The physiological variations caused by some nightmare and painful dreams seem to disturb the functioning of the organism. Yet religious and traditional conceptions view the dream as a means of communication and especially as a means of persecution [14,22], of violation of the commandments of God [17]. For these conceptions, the problem is to know if the one who makes repetitive nightmares is a persecuted person or a persecutor, in other words, is it rancor, guilt or persecution manifested in him? Does he come to see the priest, the pastor or the shaman because he suffers from these dreams and wants protection or guilt? And if it is by what he suffers from these dreams, will the caregiver take charge of his subjective or organic symptoms that he presents? With regard to the psychoanalytic approach, we find that all his dream theories perceive the dream as a dependent variable, resulting from the expression of desires [25], orientation and problem solving [23], premonitions and individual history (Jung, 1912, cited by Trigano and Vincent [36]). However, this psychoanalytic conception did not question the future of the dream. Moreover, Freudian theory clashes with neuroscience research that has proven that dreaming occurs even before birth [3]. Biology, in turn, focuses on the mechanisms of production, inhibition dreams and their functions. It has not been sufficiently interested in the relation between the intensity and the expressive modalities of

the dreamlike manifestations on the one hand and the functioning and the organic balance on the other hand, in spite of the proposal of Hobson (1988, quoted by Purves., *et al.* [28]), suggesting to examine the dream from its surface and not below as Freud did. It will come back, in a neuropsychological perspective, to examine the impact of the dream on the psychic and the somatic and would have a considerable merit of the fact that neuroscience has shown that dream and schizophrenia have the same biological support namely the cortex brain, and the nucleus accumbens supports hallucinations and delusions in this schizophrenia [37]. Biology tries to explain the dream through neurophysiological processes but neglects the feedback it can have on the body. For example, the theory of genetic reprogramming [29], even if it is confirmed, does not take into account the experience of the novelties brought by these genes in the life of the sleeper on the one hand and, in its diurnal organic functioning of 'somewhere else. The multidisciplinary approach reported by Crabbé [6] is very interesting because it takes into account both the psychodiagnostic power of dreams and the effects of dreams on somatic disorders, but he did not dwell on the mechanisms at the origin of these disorders, and especially on the direct interaction between the expressive modalities such as cognitions and behaviors, of these dreams and the psychosomatic disorders expressed by the subject. Psychological theories are centered on integrative and cathartic functions [2] of the dream. However, the cognitive and socio-cognitive approaches of psychopathology have shown the pathogenic effect that recall, remembrance or a simple stage view can have, more or less close to a traumatic situation previously experienced by an individual [2]. The integrative psychosomatic approach is the one that comes closest to our work. Moreover, it is this approach that serves us as a reference theory in this work. She proposes to approach psychosomatic disorders according to three perspectives namely psychoanalytical, medical, and neuroscientific. This approach has been built since 1993 [32]. The approach of Sami [38] seems interesting to us in the sense that, contrary to the traditional psychoanalysts who conceive the dream as semiological expression of psychic disorders [25,35], he studies it in his antagonistic relations. With the process of somatization: the presence of dreams equal poor repression and its absence translates a good repression. For Sami, the subject's relationship with his dreams would explain the presence or absence of somatic disorders: poor repression is at the origin of dreams and prevents somatization; the good repression, which is observed in psychosomatic patients, is at the origin of the somatic troubles in the sense that it is the dream which supplies the resources to the imagination. Therefore, the subject who does not dream will regularly end up in situations of impasse that will induce him psychosomatic disorders.

However, this approach also presents some difficulties that we can report. First, it seems too theoretical and speculative. Like the Freudian approach, it does not seem to lend itself to verification. Secondly, it is reductionist because it is limited to the analysis of the process of mentalization, and also in the sense that the dream becomes a purely psychological process, devoid of the biological dimensions, since it asserts that an individual can live without dream. Finally, this conception remains symptomatic in the sense that the dream is presented as an indicator of poor repression. In other words, the greatest fault that we face here is the fact that he associates the dream with the disease: his presence is a sign of bad repression and expresses a psychic pathology, his absence is a sign of good repression and justifies the presence of organic disorders. This would mean that the dream would have a negative influence on the health of the individual, and the fact that neuroscience has shown that the dream precedes consciousness or waking state does not argue for this reasoning. This modern conception of psychosomatic acknowledges the possibility that the dream may be added to the symptoms after the event [24,38], but does not envisage the opposite possibility, that is, the fact that Idiopathic, isolated dream may be the main cause of a proven pathology. This can be explained by a simple cultural view that the knowledge that their societies have dreams are conventional knowledge or more or less scientifically proven as psychoanalytic conceptions, while in Africa, the knowledge that people have of these dreams are highly spiritual knowledge, very close to death, suffering and persecution [14,22].

In sum, we can say that current dream theories are limited to the attempt to explain the essence, the origin of the dream, or better, "dig under the dream" [7] but are not interested in its surface, that is to say, in the dream itself, in its future, in the link that the dreamer can build with his dream, in the interaction between the dreams that the subject makes and the physical health of the latter, the relationship between the experience of these dreams and the somatic state that is to say its impact on the functioning of the body of the subject. Contrary to the psychoanalytic approach which considers the dream as the expression of neurotic symptoms [25], as object of prediction of the future and of problem solving [23], as object of communication and the expression of a collective unconscious [36]; contrary to

the psychosomatic approach [24] which is opposed to the Freudian conception and which considers the presence of the dream as the indicator of a "bad repression" and, its absence as the indicator of a "good" repression ", in contrast to the neurobiological approach that envisages the dream as the consequence of erroneous interpretations by the cerebral cortex of nerve impulses randomly coming from the brainstem [2,28]. In this work, we are interested in the processes by which these dreams, whatever their origins, can lead a subject to somatize. We note that all the dream theories that we have been able to identify during the exploration work envision the dream as the consequence of another process or phenomenon. From these observations, we wonder if beyond all these conceptions, the dream itself cannot contribute to the genesis of a suffering in the dreamer, and, in the case of this study, a physical suffering in particular.

In other words, the problem is whether the dream itself cannot be one of the sources of the dreamer's suffering. We thus wonder about the question of dream experience in general, and particularly about the mechanisms or processes by which dream experience can contribute to the somatization of affects in a subject. Thus, we ask ourselves the following initial question: By what processes can the dreamer's body suffer from the quality of his dreams, that is, what are the psychophysiological mechanisms or mental processes related to the dreams, which can account for the transmission of an elaborate mental state in relation to the dream, to a somatic suffering? We want to know by what pathways can certain mental processes triggered by dreams lead to somatization. As we are only at the beginning of the exploration of the situation, it is not a question of questioning a linear causal link between the dreamlike manifestations and the occurrence of certain somatic disorders, but of questioning ourselves about this relation. By keeping it in the overall situation the subject is going through, namely his personal and cultural beliefs, his cognitions, his personality, his history, and all other components present in his situation.

In this study, we question the processes by which these dreams can contribute to somatization. We want to know if an individual's dreams can trigger psychophysiological processes that can impact somatic well-being. On this, we ask ourselves the general question of research which is the following: Does dream experience contribute to the genesis of psychosomatic disorders in the dreamer? In other words, do dreamlike manifestations contribute to the development of physiological disturbances in the dreamer? By dream experience we mean the subjectivities (representations, interpretations) that accompany the post-dreaming awakening on the one hand, such as the beliefs, the representations, the stereotypes that immerse their thoughts upon awakening and, the variations Objectives such as the parameters of homeostasis and behavioral that accompany the dream during its production or its elaboration on the other hand. The general research goal is to understand and describe the psychophysiological mechanisms and processes developed by subjects with dreamlike manifestations, which may lead them to somatize during and after the dream. In other words, we want to understand and describe the relationship that dream experience can have with psychosomatic disorders (such as disorders of cortical activity, cardiac and respiratory frequencies, blood pressure, blood sugar, etc.).

This involves understanding their emotions during and after the dream, the meaning that the subject gives to his dreams and the behaviors he adopts during and after these dreams. The interests of this study can be grouped into three added values, namely socio-cultural added value, professional added value, and scientific added value. Socio-cultural added value: This work could enable the people of Black Africa to understand the link between their attitudes in relation to their dreams and certain sufferings associated with them. The study could also allow some people to rationalize their dreams. This understanding may enable them, not to change their usual ways of life, but to readjust them in order to protect themselves from the malaise, suffering, or intrapsychic and interindividual conflicts that may ensue. Socio-professional added value: The conclusions of this research will enable mental health and neurological practitioners to introduce the representations that the subject has of their dreams, or to take into account the dream experience of the subject. The understanding of suffering and in the process of taking care of it. This consideration may provide relevant information on the therapeutic observance, on certain semiological variations that occur during treatment such as psychic complaints and somatic complications unexplained by the physiopathological, and on the attitudes and behaviors of some patients when taking in charge. Scientific added value: The theoretical interest of this research is to propose a dream model capable of facilitating the description and understanding of report dream-somatic diseases. For, she will be able to inform us about certain other factors and mental processes involved in the

occurrence of certain pathophysiologies which are at the origin, at least in part, of the suffering of certain persons preoccupied with the meaning and expression of their dreams, such as this is the case of our participants. Also, it will allow to include in the clinical situation, another dimension or modality able to account for or explain the errors of prognosis. Finally, this research can complete the psychosomatic paradigm in general, in particular their dream-like approach to psychoanalytic psychosomatics, which focuses on the therapist's interpretation of the dream. Psychosomatician practitioners, psychologists, psychiatrists and psychotherapists will have at their disposal a model that will allow them to better understand the sufferings of the patient, especially when they are nourished by the imagination.

Methodology

The technique we used is the judgmental sampling technique. It is a technique in which the researcher chooses the cases or participants of his study by judging the relevance of each case he encounters. With this method, the searcher retains those he considers most relevant to his study, those who can make it more easily achieve its objectives. In the wide variety of patients in the neurology and internal medicine department that we cited earlier, we were interested only in those who not only freely evoked a difficulty or suffering related to their dreams, but also that this one the main reason for consultation. Thus, we started from those who freely evoked a suffering related to their dreams to target those who presented physical or somatic disorders without an organic etiology being identified. Among those who were accessible, we selected 4 cases that we consider more relevant because of the high intensity of somatic expression in the situation. However, the choice of cases was made over a period of about 6 months, as the cases fulfilling our criteria did not occur every day. As a criterion of inclusion, the participant must be an adult, since adults are more prone to psychosomatic disorders [25,39] and are generally more attached to cultural beliefs [9,19]. In consultation, he must introduce himself complaints related to his dreams. That is, in the patient's reasons for consultation, complaints about dreams must come out freely. For example, a patient who complains of having nightmares regularly, a patient who thinks it is after a dream that his troubles have started, and a patient who says he is afraid to sleep alone. We believe that this is the most important criterion in the sense that it is this criterion in itself that constitutes our general clinical situation. -it must have somatic symptoms whose medical causes are little or not identified. For example, a patient who complains of heart palpitations or other discomfort when medical examinations do not objectify a biological cause that may explain these disorders. This criterion focuses on the presence of symptoms with a psychosomatic tendency. -the patient must be concerned himself about his dreams. He must be looking for a solution to his situation and in relation to these dreams - finally, the patient must accept and be willing to our interviews.

Four cases were selected. It is:

1. Joseph (Mr. J), 58, public servant, whose diagnosis was that of the TCSP or paradoxical sleep behavior disorders, (DSM-V criteria);
2. Georgeline (Ms. G), 22, student gendarme, diagnosis of nightmares (DSM-V criteria);
3. Mireille (Me Me), 31, nurse, diagnosis of social anxiety (DSM-V criteria);
4. Michel (Mr. M), 30, soldier, diagnosis of PTSD.

As data collection techniques, we used the semi-directive clinical interview and the armed clinical observation (HAD, EPI, glucometer, blood pressure monitor, and electroencephalogram). The interviews were conducted in two phases, namely, the pre-interview and the actual interview. The pre-interview phase concerns the contact, the confidentiality clause, the presentation of the objective of the study, and the agreement on the spaces and principles of the actual interview and evaluations.

The observation of psychological parameters was made by passing HAD (Hospital Depression and Anxiety Scale) to assess anxio-depressive manifestations, and EPI (Eysenck Personality Inventory) to assess personality traits. That of the physiological parameters was made by the glucometer to measure blood glucose, the blood pressure monitor to measure the blood pressure, and the electroencephalogram for the evaluation of the cortical electrical production. The successive use of these 5 tools may seem abusive. But when it comes to deciding

on the variations of homeostasis, or better to describe the psychosomatic disorders, the measurement of a maximum of data is necessary to better apprehend the psychological and physiological variations which are disturbed.

As a data analysis technique, we used the functional analysis by referring to the SORC model (stimulus-organism-response-behavior) and its SECCA grid (stimulus-emotions-cognitions-behavior-anticipation) of the approach cognitive behavior. This analysis responds to three analytic processes namely clinical behavioral analysis, synchronic data analysis, and diachronic analysis of data. The choice of this model was motivated by his overall and profound apprehension of the subject and the problem situation. Its diachronic dimension traces the subject's overall life history while its synchronic dimension presents the situation that the subject is currently experiencing. For Cottraux [40], this method can be used by a clinician alone during treatment, but in the context of research, teamwork is necessary to collect reliable data. Quantitative data have not been subjected to a true statistical analysis, since the study is not intended to generalize the results, but to describe a complex process of global functioning of the human organism, which does not can be explained by controlling or neutralizing certain variables.

Results

Results interviews

SORC model	Ms. me (social anxiety)	M. M (ESPT)	Miss G (nightmares)	M. J (TCSP) m.
Situation	Humiliated publicly and regularly by her husband and by her mistress who intends to settle soon in her conjugal home Crying and moaning during his sleep (+ +)	Repetitive nightmares to the type of persecution (see the head burst or be cut by the enemy).	Almost total insomnia (+ + +) with intrusive nightmares (+ +) nightmares to type of persecution. A persecution attributed to a boy who was conned by his aunt, promising him to give her Miss G in marriage	Intriguing behaviors and language productions during sleep NB: Mr. J suffers from high blood pressure and kidney failure for several years
Body	During sleep: -tachycardia (+), ↑respiratory frequency, sweating, regular alarm clock (+ +) Waking up: asthenia (+), psychasthenia (+), headache (++), irritability (+ +)	During sleep: -tachycardia (+ +), ↑ respiratory rate, ↑, sweating, over jumps, Waking up: -dizziness and Vertigo, ↓ vigilance (+ +), -asthenia (+ +), psychasthenia (+), headache (+ + +), irritability (+), -loss of knowledge (+ +), anesthesia (+), dyskinesia (+), Visual blur (+ +)	Sleep: no peculiarity apart from nightmares to type of persecution Alarm clock: -sensation of ball in the throat (+), tachycardia (+ +), ↑ respiratory frequency, ↑, -awakening quasi-permanent (+ +), -asthenia (+ +), psychasthenia (+), headache (+ + +),	Production of hit points (+ +) Production of verbal expressions (+ +) Believes in premonitory dreams, but not in a mystical cause No anxiety, no depression Slight mnemic deficit

Answers	Daytime anxiety (+ + +) Sadness and depressive mood Seeks to understand what is happening Hypochondriac concerns (+ +) Believes that there is a mystical component of the situation	Aggressiveness (+ +) Wants to take care of traditional therapy. Security search (affective) Behaviors with a sociophobic tendency Believes in a mystical component in the complication of the situation Anxious mood	Questions about the cause of the situation (+ + +) Anxiety (+ + +) and depression (+), anger (+), irritability (+ + +), mood-Roach (+ +) Non-compliance (+) Anhedonia and Avolemia (+ +) Anguish at nightfall (+ +) Believes that there is a mystical component of the situation Does not believe in the efficacy of conventional medicine	His entourage forced him to consult (+ + +) Prefers medical consultation to traditional or religious consultation
Consequences	Insomnia (+ +) Is awakened regularly by nears Avoid sleeping outside the House (+ + +) lower productivity Feeling of shame (+ +), fear (+ +), helplessness and persecution (+), guilt and regret (+), anger (+)	Sleep avoidance (+) Inability to fulfill professional duties (+ + +) Affective dependency (+) persecution (+), guilt and regret (+), anger (+)	Conflicts with the Entourage (+ +) Suspects his aunt to want him mystifying (+ +) Inability to assume professional tasks (+ + +)	Anger (+) Conflicts with the Entourage (+ +) It is suspected of mystical practices

Result of biometric and psychometric observations

Me. me	Mr. M	Ms. G	MR J
Biometric observations (parameters taken before and after interviews, every morning and evening)			
For three days **Ta average** (mm Hg): front = 122/80 mm Hg; after = 164/90 Morning = 144/88, evening =126/81 Mean **blood glucose** (g/l): before = 0.96; after = 1.00 **Electroencephalogram** Result: traced characterized by the presence of an abundant Alpha base rhythm, regular, frequency 8 to 12 cycles/second, maximum in occipital, bilateral, symmetrical, normovolté which does not disappear completely at the opening of the eyes and stimulation Light. It is associated with regular, frequent, diffuse, normovolted beta waves with a frequency of 12 to 14 cycles/second. Conclusion: cortical hyperactivity, probably emotional	During 6 days of hospitalization -**Ta average** (mm Hg): front = 124/85; After = 139/84 morning 143/86 evening = 129/88 -**Average blood glucose** (g/l): Front=0.71, after = 0, 78 **electroencephalogram** Result: electric activity Theta at 5 cycles/second, hypovolted, symmetrical and synchronous, reactive at the opening of the eyes, X. HPN does not change the background rhythm. Conclusion: TRACED EEG in favor of diffuse cortical suffering	For 8 days **Ta average** (mm Hg): front = 129/83; After = 148/87 morning 151/91 evening =131/84 **Average blood glucose** (g/l): Front= 0.86, after = 0.89 **Electroencephalogram** A route characterized by the presence of the abundant, normovolted, bilateral and symmetrical Alpha base rhythm, with a frequency of 8 to 12 cycles per second, which does not disappear completely at the opening of the eyes and is associated with a frequency beta 12-18 cycles per second, diffuse normovolté. Conclusion: cortical hyperactivity characterizing anxiety	Blood pressure: before and -**your average** (mm Hg): front = 118/76; After = 126/81 morning 123/82 evening =117/80 **Average blood glucose** (g/l): Front= 1.02, after = 1.02 **electroencephalogram** Route characterized by the presence of the alpha base rhythm of 8 to 12 cycles per second, normovolté, bilateral, symmetrical, which does not disappear completely at the opening of the eyes. Conclusion: EEG without particularity: normal path
Observations psychométriques (EPI et HAD)			
EPI E-score (introversion-extraversion): 13/24 → moderate extraversion Score N (stress vulnerability): 13/24 → moderate stress vulnerability Score L (social desirability or falsehood): 6/9 → moderate social desirability **HAD** Anxious pole: 12/21 (certain anxiety) Depressive pole: 7/21 (depression absent)	**EPI** E-score (introversion-extraversion): 11/24 → moderate extraversion Score N (stress vulnerability): 17/24 → vulnerability to high stress Score L (social desirability or falsehood): 5/9 → average social desirability **HAD** Anxious pole: 14/21 (certain anxiety) Depressive pole: 8/21 (doubtful depression)	**EPI** E-score (introversion-extraversion): 10/24 → rather introvert Score N (stress vulnerability): 16/24 → vulnerability to high stress Score L (social desirability or lie): 4/9 → desirability to moderate stress **HAD** Anxious pole: 15/21 (certain anxiety) Depressive pole: 11/21 in (certain depression) Conclusion: certain anxio-depressive syndrome, implying some anxiety and depression.	**EPI** E-score (introversion-extraversion): 14/24 → moderate extraversion Score N (stress vulnerability): 8/24 → slight vulnerability to stress Score L (social desirability or falsehood): 6/9 → moderate social desirability **HAD** Anxious pole: 6/21 (no detectable anxiety) Depressive pole: 4/21 (no detectable depression) Conclusion: no detectable anxio-depressive syndrome.

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Discussion

In all 4 clinical cases that we have just interpreted, we find two groupings of characteristics, common to 3 of them (G, Me, and M). This is, on the one hand, physical suffering namely neurovegetative disorders (such as increased blood pressure, blood glucose, heart rate), and secondly, psychological suffering (such as the search for the meaning or meaning of dreams, the anxiety whose permanence will generate anxiety, followed by an endogenous depression in the case of Miss G). The main symptom of this anxiety in Miss G is sleepless sleep insomnia and marked irritability that alters the relationship between the participant and the caregiver. This is also the case of Mr. M and Me Me. This corroborates with one of the hypotheses of the APA (2005: 730) [26] according to which "the frightening dreams or discontinuity of sleep resulting from the awakenings are at the origin marked suffering or impairment of social or professional functioning". The problems of short-term memory and working memory that are objectified in our three anxious participants can be justified by the fact that their attention is constantly focused on what concerns them, that is, the search for meaning. Of their dreams, their ability to focus on another situation would be reduced, in terms of time or intensity. This is consistent with the anxiety function described by Douiller and Philippot (2008) according to which it has a function of detecting danger or threat in a potentially dangerous environment and that of Shackman., *et al.* (2006, cited by Van Der Liden, 2007), that anxiety has two facets "anxious anxiety or apprehension that is mental and ruminal-based and cognitive assessment and anxious awakening that involves a attention to the physiological symptoms of anxiety. The three participants who thought about imminent danger developed anxiety.

In terms of personality trait outcomes, it would appear that the level of vulnerability to stress increases with the intensity of somatic symptoms. The most profound or severe symptomatology is the coma of Mr. M, who had the highest vulnerability score (17/24), followed by the almost total insomnia of Miss G who has a score of 15 / 24, then weeping during Ms. Me's sleep, which was 14/24. However, Mr. J, who has a rather low vulnerability score (8/24), showed no physical symptoms related to anxiety and anxiety. These results do not allow us to decide whether this absence of symptoms is the effect of the degree of vulnerability to stress or that of knowledge acquired by Mr. J. However, we believe that these factors are all involved in this process of coping.

From the interviews with our participants, it emerges that the most dominant emotion in the dream is fear, and that it is more expressive during the dream than during the waking period. Likewise, it is more associated with nightmares than with painful dreams and stigmatized dreams, which are more associated with worry. Given the fact that the vast majority of mental illnesses are caused by fear (Organization of Mental Health [WHO], quoted by Encyclo, 2014), we can imagine, the number of disturbances that the fear developed by these participants may generate on their state of health.

It emerges from these speeches that at awakening, it would take a certain amount of time estimated in a few minutes after waking up so that the dreamer does not realize that he is coming out of a dream. This would be justified by the fact that once awake, the cortex needs a minimum amount of time to gather the information, then compare it with the emotions from the dream period.

The three patients with anxiety complained of predominantly frontal headache, which would be a consequence of cortical hyperactivity, particularly that of the prefrontal cortex. This frontal hyperactivity was objectified by the EEG in these three participants, which goes in the direction of the anatomo-functional correlation established by Van Der Linden (2007), according to which the hyperactivity of the right prefrontal cortex would be at the origin anxiety. In the speeches of the participants, we note a predominance of the predictive and communicational functions of the dream. This is in line with the conclusion of Nuekeme [1] who asserts that in the Grassfields of Cameroon, the conception of the dream is closer to that of Jung than to that of Freud and, "is understood as a possibility of the understanding of the situation of the patient" [1].

With regard to the somatic changes in the participants, particularly in Miss G, Me Me and Mr. M who present both very emotional dreams and very expressive organic disorders, we perceive a discrepancy between these observations and Sami's hypothesis [24] according to which the so-called psychosomatic patients do not dream, because they are under the influence of a successful repression. He asserts that a successful repression would censure the dreams of the sleeper and, deprived of the solutions proposed by the dream, the subject would

end up in a situation of impasse that would generate organic disorders. However, in light of these results, we have 3 participants who remember perfectly their dreams and who present concomitant physiological modifications marked by a neurovegetative hyperactivity, particularly the orthosympathetic one, and of the psychological sufferings which are more or less associated there.

With regard to the psychogenic pain presented by these three participants, namely the feeling or the feeling of going crazy, this can be justified by the fact that the two main brain structures most important in the elaboration of the dream are, as points out Gottesmann [37], the same who are responsible for hallucinations and delusions in schizophrenia. This would explain the presence of hallucinations in severe forms of anxiety and depression. Regarding the neurophysiology of this relationship, the author states that, "Despite the necessarily multi-factorial nature of brain function, monoamines and glutamate currently appear to be the keystone of mental activity and the troubling commonality of dream and schizophrenia" [37]. If we start from the idea that "to think is to dream" (Meltzer, 1984: 57; Bion, quoted by Meltzer, 1984), this will justify the intense psychasthenia, that is to say the great fatigue observed in Mr. M and Miss G whose nightmares are more frequent and more expressive. Mr. M's coma, for his part, could be justified by a reduction in the epileptic seizure threshold because of the reduction in the duration of his paradoxical sleep period, as the experiments of Basil., *et al.* (2000) on animals, have shown, "the decrease in the duration of paradoxical sleep causes a decrease in the epileptic seizure threshold and therefore, would facilitate neuronal excitability." The persistence of the situation of Miss G (more than three weeks) and Mr. M (several months) is explained by a process of negative conditioning, which we have described in the interpretation. This would justify the hypothesis of Ohayon and Synthelabo [41] that "Recurring nightmares can perfectly cause a negative conditioning towards sleep and lead to the perpetuation of sleep disorders".

It emerges from this discussion that emotions, cognitions and behaviors that an individual produces in relation to his dreams can contribute to the genesis of somatic disorders in him. The results of this study are in line with most research on dreams. However, a contrast that we consider quite important is to mention, it is the fact that these results seem to oppose the psychosomatic hypothesis of Sami [24,38], according to which it is the absence of dreams that is the cause of psychosomatic disorders while their presence spares the sleeper of these disorders, by proposing solutions to his problems.

Conclusion

Faced with erroneous interpretations and anxieties experienced by dreamers, their physical and psychological health can be disrupted. This led us to raise the problem of knowing whether, beyond the various functions attributed to dreams, it could contribute to the genesis of physical suffering in the dreamer. In other words, the problem is, what are the psychophysiological mechanisms or mental processes related to the body, which can account for the transfer of a mental state in relation to the dream to a somatic suffering? The general question of research is: does dream experience contribute to the genesis of psychosomatic disorders in the dreamer? That is to say, behaviors, cognitions, and emotions elaborated in relation to one's dreams, do they contribute to the genesis of physiological disorders in the dreamer? The general objective of the research is to understand the mechanisms involved in the process of somatization in relation to the dream. The working hypothesis formulated on this subject is: Dream experience contributes to the genesis of psychosomatic disorders in the dreamer.

The study has 4 participants. It is about two men so one, 58 years old, suffers from TCSP and the other 30ans, suffers from PTSD; and two women, one 31 years old and suffering from reaction anxiety and the other 22, suffering from chronic nightmares, all of whom had consulted at the neurology and internal medicine department of the Yaoundé Military Hospital, for a main reason for consultation in relation to their dreams.

The participants were selected by reasoned choice. In terms of data collection, we used focused interviewing and observation. The observation focused on participants' physiological parameters and psychometric tests of personality and disability. The combined use of all these techniques is a requirement imposed by the theoretical approach that guided this research, namely the integrative psychosomatic approach. This approach proposes to combine the knowledge of medicine, that of cognitive and behavioral neuroscience, and that of psychoanalysis to perform an intervention on the human being, whether for therapeutic or research purposes.

Three of the four participants had psychosomatic disorders that were more or less directly related to their dreams. This is Mr. M who after complaining of nightmares for several months, dives several times in a coma after awakening a nightmare; of Mrs. Me who cannot sleep in the presence of another person or in her service because she is almost always awake when she begins to cry in her sleep; Miss G who cannot fall asleep because she thinks the witches come to persecute her when she is asleep; Mr. J who is almost in conflict with his family members by what he refuses to consult for aggressive behavior that he presents during his sleep. With the exception of Mr. J, all three others presented somatic disorders such as increased heart and respiratory rate, cortical hyperactivity, increased blood pressure and blood sugar during the period lasted the concerns related to the dream. These variations were more or less directly attributed to three main variables namely the emotions, cognitions, and behaviors that the sleeper produces in relation to his dreams. This is in line with our general hypothesis which predicted a relationship between dream experience and psychosomatic disorders. These results also show that the damage that can be caused by dreams, such as agonizing dreams, painful dreams and nightmares as they unfold, seems to be identical in the participants and feeds on the intensity of the instinctive emotions, while The damage that these dreams can cause during the waking period varies from one person to another, depending on one's personal and cultural beliefs, cognitions, and behavioral responses. However, the analysis of the data also shows that this relationship is not linear, and that these three main variables (emotion, cognition, behavior) interact with each other, by soliciting both the socio-academic level and the level of stress vulnerability of the subject.

For Cottraux., *et al.* [42] cognitive-behavioral therapies use the dream according to two conceptions: it is the objectivist approach elaborated by Beck, Freeman and White (quoted by Cottraux & al., 2007) according to which the Dream is the expression of the schemas and distortions experienced by the subject during the awakening and, of the constructivist approach, considering the dream as the expression of the creative capacity of the man. Our study complements this constructivist approach, showing that these creative constructions, when they are poorly developed, can generate suffering for the dreamer, just like traumatic situations actually experienced by the dreamer. In view of these results, we can also propose in the same way the development of cognitive-behavioral therapies, a pragmatic approach of the dream, centered on the maintenance of explicitation. It is a type of interview used in the field of education. We propose to use this interview in CBT, to break the constructs and the erroneous schemas, elaborated by the subject and nourished by his personal and cultural beliefs, related to the dream and many other situations and phenomena still mystified in the African context [43,44].

At the end of this work, we believe that an experimental study using fewer instruments, perhaps only functional magnetic resonance imaging (fMRI) would have confirmed with a degree of reliable significance, the assumptions of this study. Another study could focus on understanding the endocrine variations of these patients or, better, on the effect of different physiological variations on the manifest content of the dream. However, we wonder if dreams can be useful for semiological and etiological diagnosis in the pathophysiology? If yes, how?

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