Stopping the Nightmare: An Analysis of Focusing Oriented Dream Imagery Therapy For Trauma Survivors with Repetitive Nightmares

Leslie Anne Ellis

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Philosophy in Clinical Psychology

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Dedication

This dissertation is dedicated to the survivors of trauma at VAST who bravely and generously agreed to take part in this study, and to refugees everywhere seeking a safe place to call home.

Abstract

This study has two parts: first, the development and execution of an abbreviated focusing-oriented dreamwork (FOD) treatment protocol for those with replicative PTSD nightmares, and second, and interpretative phenomenological analysis (IPA) of the experience of refugees who participated in the treatment. Participants included five clients from the Vancouver Association for the Survivors of Torture (VAST) who experienced clinically significant PTSD symptoms, including repetitive trauma-related nightmares. As a result of their participation in the FOD treatment, most experienced clinically significant reductions in PTSD symptoms, and their dreams began to change in specific ways, including a shift in the nature of the aggressor, dream ego actions, temporal and setting changes, and reduced fear responses within and after their nightmares. The fear responses in the dream content appear to relate directly to the physiological fight, flight or freeze responses the body initiates in response to threat. For those who are good candidates for the intervention, the FOD protocol appears to break the cycle of fear response and move the dreamer toward more empowered responses within dreaming and upon waking, and positively affect daytime functioning.

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Chapter 1: The Nature of the Study

This dissertation is a two-part project that includes the development and use of an abbreviated focusing-oriented dreamwork (FOD) treatment protocol for trauma survivors with repetitive PTSD nightmares, and an interpretative phenomenological analysis of the use of this treatment for five participants. This introduction provides the background and justification for the development of the protocol, and ends with a brief description of the methods of analysis of the data and the rationale for choosing interpretative phenomenological analysis (IPA).

Focusing-Oriented Nightmare Treatment

Repetitive nightmares are cardinal features of posttraumatic stress disorder (PTSD; Mellman, David, Bustamante, Torres, & Fins, 2001; Spoormaker & Montgomery, 2008; van der Kolk, Blitz, Burr, Sherry, & Hartmann, 1984) and they cause significant distress in at least two ways: They bring the trauma memories back to mind in an intrusive way, and they also disrupt sleep (Spoormaker & Montgomery, 2008). Among those with PTSD, 50-70% experience chronic, distressing nightmares, and often the nightmares continue after other symptoms of PTSD have been alleviated (Spoormaker & Montgomery, 2008). Treating nightmares directly is an approach that appears to have some success in not only reducing nightmares and their related distress, but also in reducing PTSD symptoms (David & Wright, 2007; Krakow, Hollifield, et al., 2001; Krakow et al., 2000; Moore & Krakow, 2010). The common feature of these empirically supported nightmare treatments is imagery rescripting, a protocol which asks nightmare sufferers to imagine a new ending to a nightmare and rehearse this in their minds.

Why might therapists need another imagery-based approach when the existing ones, imagery rehearsal therapy (IRT) in particular, appear to work well? One reason another therapy

is needed because IRT does not work for everyone; drop-out rates can be high and compliance low (Lu, Van Male, Whithead, & Boehnlein, 2009). In addition, IRT is a two-part protocol that begins with psycho-education about nightmares as a sleep disorder, and its focus is on treating nightmares as a sleep disorder (Spoormaker & Montgomery, 2008). The evidence cited to support nightmares as sleep disorder is that when treating PTSD, all other symptoms except for the nightmares are alleviated (Spoormaker & Montgomery, 2008). However, this could mean that nightmares are simply the most intractable symptom of PTSD, and not that they are a separate disorder. In particular, it is difficult to argue that those whose nightmares started post trauma and who dream repetitively about the trauma have a sleep disorder separate from their trauma. Yet Krakow (2006, 2014) stated that for IRT to be effective, it is crucial that nightmare sufferers view their nightmares as a sleep disorder, a learned behavior that has become something separate from their trauma. He stated that those who felt that their nightmares were part of their PTSD symptomatology were less likely to believe their condition could change, and were therefore unlikely to benefit from IRT. Krakow (2014) also suggested that those whose dreams are only replicative of trauma would not be good candidates for IRT but would require exposure therapy for PTSD. Krakow stressed that the focus of his work is on treating sleep disorders rather than PTSD; however his research has shown treating sleep disturbance also improves PTSD symptoms.

Like IRT, the protocol developed for this study, an abbreviated version of focusing-oriented dreamwork (FOD), has an imagery rescripting component as a core element. However, the FOD intervention is carried out quite differently; it is an embodied experiential rather than a cognitive behavioral intervention. This reflects the fact that the purpose of the focusing-oriented intervention was not the restoration of restful sleep alone, but rather was designed to help restore

the dreaming process itself. It is hypothesized that the dreaming process is linked to the ability to think metaphorically. Without this ability, which is not purely cognitive but also includes sensing into the body, thoughts and dreams may become rigid and repetitive, potentially preventing the process of recovery from trauma. The FOD intervention is based on *focusing* (Gendlin, 1996*)*, an approach to therapy that encourages symbolic and expressive movement in a direction Gendlin called "life-forward" (p. 293).

Focusing is the process of bringing attention to one's inner experience in a particular way. Gendlin (1978/1981) discovered this natural process in the 1960s while exploring questions about what makes psychotherapy effective. In his research, based upon listening to hundreds of psychotherapy sessions, he discovered that the key difference was a client variable: those clients who naturally paid attention to their emerging bodily felt sense of the whole of a situation in an open, curious way were more likely to benefit from therapy (1978/1981). He developed the method of focusing as a systematic way to teach this process. The *felt sense*, a cornerstone of the focusing process, is a physically tangible sense that cannot yet be articulated, but when patiently attended to, can be found to carry multiple and complex meanings.

Gendlin (1986) also developed a method of working with dreams, and the FOD intervention is based on central aspects of this method. Gendlin (1996) argued that dreams represent one's problems in "images that implicitly contain an energy that moves toward a solution" (p. 199). He believed this was true for all dreams, even nightmares. However, I would suggest that finding forward-moving energy in repetitive trauma dreams poses challenges not found in ordinary dreamwork. When these recurrent dreams contain only exact replays of trauma, they have none of the novelty or imaginative variation that can be said to carry the dreamer forward. In spite of this, the potential benefit that can come from working with PTSD

dreams is considerable for those whose dreams themselves have become distressing symptoms. The FOD protocol developed for this study is a further development of Gendlin's dreamwork method because it addresses the unique features of PTSD nightmares, providing a way to work with dreams in which no 'help' can be found.

There is evidence that those with PTSD dream differently from those without it. Most dreams are imaginative and rich in associations to the dreamers' life (Antunes-Alves & De Konink, 2012; Domhoff, 1999; King & DeCicco, 2007; Pesant & Zadra, 2006; Valli et al., 2005). Idiopathic nightmares often contain bizarre elements (Robert & Zadra, 2013) while PTSD nightmares replicate actual trauma events, and tend not have bizarre or unusual elements. Although there is considerable debate about dream function, evidence has shown that dreams perform emotional regulation (Hartmann, 1998; Kramer, 1991; Kuiken, Lee, Eng, & Singh, 2006; Nielsen & Carrasco, 2007) and memory consolidation functions (Neilsen & Stenstrom, 2005), both of which are compromised in those who suffer from PTSD (Lanius, Bluhm, & Frewen, 2011). Hartmann (1996a) suggested that PTSD nightmares are not really dreams but flashbacks that occur during sleep. Wilmer (1996) identified PTSD nightmares as a distinct category of dreams marked by their repetitive and concrete qualities. Wilmer also found a correlation between improvement in PTSD symptoms and a shift in the quality of dreaming from concrete to increasingly dreamlike or metaphorical. It is as though PTSD sufferers have been deprived of the imaginative and symbolic qualities of dreaming (Agarkov, 2011; Boulanger, 2005). In waking life, those with PTSD also exhibit a loss of imaginal flexibility suggested in their sense of foreshortened future, a symptom formerly used to diagnose PTSD (DSM-IV, 2000). The ability to think metaphorically appears to correspond with the ability to have symbolic dreams and to imagine into the future. In this study, FOD was tested on a group of

highly traumatized refugees who experience repetitive nightmares. The intervention was developed based on 15 years of clinical experience, during which I have found that a focusing approach can help those with PTSD nightmares rekindle the creative and metaphorical qualities of their dream life.

A number of studies have demonstrated that a progression of the dreaming process corresponds with clinical progress. However, there is limited research on the specifics of how recurrent trauma dreams begin to change toward normal dreaming, and this study in part addresses this gap in the research. Zadra (1996) found that most recurrent dreams have negative content and are more prevalent during times of stress. Domhoff (1993, 2000) suggested that there is a continuum within repetitive dreaming aimed at the resolution of emotional issues and that once the issues are resolved, the repetitions stop. The continuum begins with trauma dreams and moves to repetitive dreams, then repetitive themes, and lastly, frequently-repeating dream elements only. Therefore, Zadra suggested that the cessation of repetition in dreams can indicate clinical progress. However current evidence does not show the direction of causality between dream content and waking emotional states. Zadra suggested that a study in which dream content is manipulated using lucid dream or waking imagery exercises could help to determine the direction of causality. FOD works directly with dream imagery in a waking state (which is more reliably accessible than lucid dream states). Changing the dream content does appear to have an effect on waking emotional states for participants in this study, and suggests the direction of causality could be from dream to waking state in this particular situation (although further study would be required to state this with confidence.) This is likely not an either/or situation, as both may be true: dreams affect waking life and vice versa. There is considerable evidence to support

the continuity hypothesis that dreams reflect waking-life concerns (e.g., Domhoff, 1996; Schredl, 2003, 2006).

Another important element of FOD as a treatment for nightmares is its attention to the embodied nature of trauma, and this is another factor that differentiates FOD from IRT. FOD is compatible with approaches suggested by current research into the neurobiology of PTSD. Those with PTSD store memory differently than those without it, and the retrieval of PTSD trauma memory activates parts of the brain responsible for implicit, non-verbal memory rather than explicit memory (Lanius et al., 2004; van der Kolk, 1996a, 1996b). FOD, based on focusing-oriented therapy (Gendlin, 1978/1981; 1996), encourages a particular way of sensing inside that combines imagery with interoception, emotion and cognition. The process may contribute to neural integration and is potentially an active ingredient in restoring metaphorical dreaming and thinking functions. Focusing encourages the creation of an inner space that allows novel responses to emerge, a process that can be linked to metaphor in the cognitive-scientific sense (Lakoff & Johnson, 1980) as an embodied, preverbal and foundational way of thinking and perceiving. As such, researchers have suggested that metaphor plays a major role in the organization of emotional memory (Modell, 2000), and "is an essential element in the transformation of traumatic memories" (Modell, 2005, p. 137).

A third important element of the FOD protocol is that it is designed as a one-on-one intervention rather than as a group process. In a study that compared group and individual lucid dream intervention, researchers found individual therapy to be a more effective way to treat nightmares than group therapy (Spoormaker & van den Bout, 2006). A meta-analysis of dropout in treatments for PTSD found that group versus individual treatment predicted increased dropout (Imel, Laska, Jakupcak, & Simpson, 2013). Also, there is considerable evidence that the

empathic attunement of the therapist is one of the main factors in the effectiveness of psychotherapy, irrespective of modality (Horvath & Greenberg, 1994). PTSD is not generic. People with the diagnosis can experience hyperarousal or dissociation in response to their trauma memories (Frewen & Lanius, 2006; Lanius et al., 2001, 2002), and would require a different approach in therapy based on these very different responses. The FOD protocol is standardized and abbreviated for the purposes of this study, yet it is also designed with some inherent flexibility as the nature of focusing involves encouraging the client to follow their internal, moment-to-moment responses as they attend inwardly. This approach works best and most safely in a one-on-one format that can effectively account for individual differences in response and pacing requirements.

Imagery Rescripting: Background

Cognitive behaviorists have conducted considerable research in the past decade into imagery rescripting (IR) as a method to treat nightmares (Long & Quevillon, 2009). IR is a major component of imagery rehearsal therapy (IRT), now the most widely supported modality for PTSD-related nightmare treatment (Davis & Wright, 2005; Escamilla, LaVoy, Moore, & Krakow, 2012). IRT researchers have shown that teaching those with repetitive nightmares to work with their innate imagery system to invent a new ending to their distressing dreams, and then to rehearse that new dream, can not only change the nature of their dreams, but also improve sleep quality and PTSD symptoms (e.g., Krakow, Hollifield, et al., 2001; Krakow et al., 2000). IRT researchers have demonstrated that dream therapy, which engenders increased use of imagination, can be a safe and effective treatment for PTSD nightmares.

There is considerable empirical evidence to suggest that exposure helps to reduce PTSD and anxiety symptoms (Foa, Keane, Friedman, & Cohen, 2009. This evidence informed how

Davis and Wright (2005) developed exposure, relaxation and rescripting therapy. ERRT incorporates the nightmare imagery rescripting process, but adds both exposure and relaxation elements to the IRT protocol, and changes the psycho-education component from information about nightmares-as-sleep-disorder, to education about the nature of PTSD. Another less-studied variant using IR is imagery rescripting and reprocessing therapy (IRRT), originally developed for treating survivors of sexual abuse (Smucker & Dancu, 1999), but there are limited empirical data on IRRT.

Imagery rescripting has become the treatment of choice for trauma-related nightmares due to the growing base of empirical support the developers of IRT and ERRT have amassed over the past 15 years. This phenomenon has recently drawn considerable attention to the use of imagery in clinical practice, as though imagery techniques were something newly discovered. In fact the use of imagery has a long history in psychology (Horowitz, 1986; Long & Quevillon, 2009). The use of imagery has not been separated out in the recent cognitive methods for treating nightmares, so the active ingredient(s) in the success of the intervention have yet to be identified. However, Moore and Krakow suggest it is the revival of the imagery system that may be the critical therapeutic element in their approach: "IRT appears to jump-start a natural human healing system that was previously dormant" (2001, p. 62).

The Importance of Somatic Approaches in Trauma Therapy

Cognitive-behavioral imagery rescripting (IR) protocols could be expanded upon to address different areas of concern for those with PTSD. A major omission, from the point of view of those who support somatically-informed approaches, is the role of the body in the etiology of, and recovery from, trauma. A large body of evidence has accumulated over the past two decades about the importance of somatic approaches to trauma treatment (e.g., Levine, 2010;

Ogden, Minton, & Pain, 2006; Rothschild, 2000; van der Kolk, 1996a, 1996b, 2002a, 2002b). There is evidence that for those with PTSD, trauma memory and responses activate areas of the brain associated with nonverbal memory retrieval (Lanius et al., 2004), and these memories are often not accessible by the hippocampally-mediated explicit memory system (van der Kolk, 1996b). Therefore, psychotherapy for PTSD must include ways to work with implicit, sensory-based and emotional response systems that are not accessible through purely cognitive approaches. Although IR methods currently being used and further validated are promising and effective, it is possible to build upon this approach by adding a somatic component that is more directly informed by current neurobiological research into the effects and healing of trauma.

Theories that inform cognitive approaches to working with trauma suggest that for the trauma to be healed, the fear memory must first be activated (Foa et al., 2009; Long & Quevillon, 2009). This is the basic idea behind exposure therapy: one must be exposed to the fear to be progressively desensitized to it. In somatic approaches, there is also a need for the client to access the feelings associated with the trauma, but in a measured way: there is the added notion of the therapeutic window of tolerance (Briere, 2002; Siegel, 1999). In accessing trauma memories, it is important to ensure the activation level of the client falls between the extremes of hypo- and hyper-arousal because trauma memories become integrated and time-situated in this more relaxed physical state which makes trauma healing possible. Hyper-arousal can re-traumatize the client, while hypo-arousal renders the trauma memory and associated thoughts and feelings unavailable for processing. If clients stay within the therapeutic window (Briere, 2002), they can revisit the experience of the memory and begin to process the associated affect. This may be what repetitive trauma dreams are attempting to do.

Effective trauma therapists monitor and assist in modulation of affect and physiological

arousal so that the level of activation does not drop below or exceed the client's ability to integrate the process. Acquired emotional regulation skills can expand the client's window of tolerance enabling trauma processing across a greater range of intensity. Somatic approaches privilege the body, working with the often-wordless felt sense of a trauma and encouraging relaxed attention, and articulation of experiences that may have timeless, wordless qualities. Somatic approaches to trauma, and specifically focusing-oriented methods, enable those with PTSD to begin to articulate trauma experiences that appear as flashbacks because they have been stored in a way that allows for non-verbal memory retrieval only. The act of translating the felt sense of a trauma into words sets it in a time and place, allowing for integration and storage of the trauma as a painful, but normal (rather than intrusive, fragmented, implicit) memory.

Those who work with trauma in the body have suggested that after establishing safety, it is often therapeutic for the body to complete actions or impulses that were thwarted at the time of the trauma (Levine, 2010; Ogden, Minton, & Pain, 2006). Horowitz (1986) also articulated the notion of a completion tendency, although he conceived of the drive to complete interrupted process as cognitive rather than somatic. He accounted for the repetitive nature of intrusions of memory in those with PTSD as the result of a compulsive need to integrate the trauma experience into their existing inner set of beliefs about the self and the world. More recently, Levine (2010) and Ogden (2006) have suggested that a sensorimotor process of completion which encourages the client to allow their body to move through and experience urges to flee or fight that were thwarted or truncated during the actual trauma experience can be the key to a shift in autonomic responses to reminders of trauma. They base their method and theory on accumulated clinical experience; however, empirical study into the efficacy of this somatic completion process is needed. Focusing theory would suggest a slightly different emphasis.

Rather than viewing trauma therapy as the completion of an action that was blocked in the past, Gendlin (2011) suggested that the whole of the past is implicit in the present and therapy could provide something new in the interaction that now enables carrying forward to occur.

Similar to the way sensorimotor trauma enactment may allow the completion of a truncated bodily action, FOD encourages dreamers to allow their trauma dreams to be completed based on somatic cues. The protocol encourages participants to allow their bodily felt sense of what could happen next in their dream to play out in their imagination. Gendlin (2012a) called dreams pieces of unfinished business that people remember because the body wants to complete the business of the dream. The focusing process is not only somatic. Accessing the felt sense begins with the body, but also includes emotional, cognitive and symbolic elements, a complex mix that is difficult to articulate. Most importantly, the felt sense contains within it the implying of a next step of further living that moves beyond the repeated pattern. Repetitive dreams may keep occurring because they represent an insistent impulse towards the forward movement and completion of the process of trauma work depicted in the dream. Gendlin (2012) called this "reiterative implying" (p. 19) and suggested this would continue until something occurred to carry the situation forward. In my clinical experience, and supported by the results of numerous IRT studies, just one session spent revisioning a new ending for a repetitive dream can change the dream and its impact in a positive way for the dreamer. Sometimes the nightmare simply does not recur. Shapiro (2013) has found the same result using EMDR, another experiential protocol for working with trauma.

In IRT, the instructions for imagining a new ending to the dream are open-ended and brief: participants are invited to change the dream in any way that feels right to them. The participants are then instructed to keep reimagining this new ending on their own. For those who

find this method works, the protocol appears to incorporate enough support. However, the initial IRT study, and some subsequent studies had a high percentage of drop-outs (Krakow, 2000; Lu, Van Male, Whitelhead, & Boehnlein, 2009), and in one study, only 47% of participants actually did the imagery rehearsal homework required of the protocol (Lu et al., 2009). For a certain percentage of people, IRT does not work, possibly because they need more direct support with re-building their imagery capabilities, and/or they have trouble or feel unsafe continuing to do the imagery work on their own. This may be due to the variability in trauma responses recently documented, and the need for individually-tailored approaches. It could also be that some people naturally sense what might carry the dream situation forward when asked in an open-ended way to invent a changed dream, in the same way that some people can naturally do focusing. However, others may benefit from specific guidance to attend to the felt sense of the dream and to sense into what it may be implying is the next step forward for the dreamer. What the felt sense implies may be quite different from what the conscious goal-directed mind invents as a dream ending. To access and listen to the felt sense requires a special kind of attention, an open, curious reverie that is closer to day-dreaming than directed problem-solving and allows novel ideas and next steps to emerge that were previously not in awareness.

The FOD protocol is designed to provide a safe and supportive environment for those with PTSD to work with their nightmares. Part of the goal of this study was to develop, test and refine the FOD technique so that a general protocol could be developed for trauma therapists who may not otherwise know how to proceed in working with PTSD nightmares directly. Based on the study design presented in this dissertation, VAST therapists served as the professionals administering the research protocol. They used a standardized, abbreviated FOD sequence on a small number of moderate to severe PTSD sufferers with repetitive nightmares to determine if

FOD is worthy of further research and development. Participants attended two intervention sessions, and both qualitatitive and quantitative data were gathered before and after the intervention to assess changes in their PTSD symptoms and changes in the nature of the dreams. In the qualitative part of the analysis, particular attention was paid to the dreams themselves and to the specific ways in which dream elements changed from the initial recurrent nightmare after the FOD intervention. Quantitative data were included in the case studies where appropriate. However, due to the small sample size and exploratory nature of this study, the emphasis in the data analysis portion was on the qualitative analysis.

The focusing process was the basis for the nightmare intervention in this study. It is both a client-centered and body-oriented approach that encourages clients to attend inwardly to a bodily sense of the dream (even when no words or further images are yet present) with curiosity and equanimity. Focusing techniques allow clients to find the right distance from a felt sense and to develop a friendly attitude toward the complex combination of sensations, images, emotions and memories that arise from an internal felt sense (Gendlin, 1978/1981). Focusing is a middle way (Elliott, 1998) between methods that employ high levels of exposure and none.

Focusing-Oriented Therapy and Possible Mechanisms of Action

Gendlin (1996) not only developed a focusing-oriented therapy manual based upon the felt sense, but also outlined specific methods for using focusing to work with dreams. Many of the steps outlined in his dream book (1986) and more recent articles (1992, 2012b) are incorporated into the intervention developed for the purpose of this dissertation. I have emphasized or adapted particular aspects of focusing-oriented dream techniques for work with PTSD nightmares, and incorporated both imagery-based and current somatically-informed approaches to trauma work. The FOD protocol uses Gendlin's dreamwork method as a base, but also incorporates elements

of Jungian active imagination and current somatically-oriented approaches to working with trauma. It was designed to enable participants to safely begin transformation of the frightening, intrusive images of PTSD nightmares into meaningful, experiential events via active collaboration with their innate somatic, metaphoric ability to re-imagine their dreams. A possible key to this forward movement is the development, or re-ignition of the capacity for imagination and metaphor that are often lost with exposure to severe trauma (Agarkov, 2011; Boulanger, 2005). For this reason there is an emphasis re-entering the dream state in the FOD protocol so that the new dream ending is not merely invented but is rather an actual continuation of the dream. New endings that are not tidy or simplistic solutions to the problems presented in trauma dreams, but rather are surprising or creative continuations, are indicative of the type of experiencing the FOD process is meant to engender.

A focusing approach also places high value on in-session experiencing. The FOD protocol, like all of methods which employ imagery rescripting, encourages the use of imagination to call up the dream images in the mind's eye, and then to allow the dream to continue. This is designed to provide a novel experience of the dream that might bring some kind of forward movement and positive change for the dreamer. The FOD approach offers individual support for the process of trauma dream recall and the imagination of a new ending. The intervention can be paced according to client needs in a one-on-one format, and therapists can encourage calming techniques (such as a return to the cleared space) as needed so that traumatized clients do not become too activated or dissociative when working with their nightmares. The process encourages the dreamer to look for forward movement by first asking them to attend to a bodily felt sense of what could happen if the dream were allowed to continue. It is generally better if the newly-imagined ending is more positive than the dream itself. Studies have shown that rescripted

dream endings yield better results when they have less violence (Harb, Thompson, Ross, & Cook, 2012) and when the dreamer feels an increased sense of mastery over the trauma material (Germain et al., 2004). However, the process may not be as effective if one forces an easy solution. The further imagining of the dream must feel authentic. The new ending must feel right to the dreamer, as the IRT protocol suggests, but not in a contrived or simplistic way. The direction provided by attention to the felt sense may assist the dreamer in finding an authentic way forward.

The experiencing element may be a critical difference in the focusing versus cognitive dream rescripting approach. In a study on the effects of expressive writing on those who have suffered trauma and loss, Kuiken, Dunn, and LoVerso (2008) tested three writing conditions: factual, emotional and experiential. In the emotional condition, participants were asked to recapture feelings about their trauma or loss, while in the experiential condition they were asked to attend to a bodily felt sense that arose in response to the feelings and then write about their present experience with that felt sense. Given exposure theory, one might expect that the emotional writing condition, which brought up the strongest emotions and greatest exposure to distressing content, to have the most effect for the trauma group. In fact it was the experiential condition, derived from Gendlin's focusing theory, which showed the most beneficial outcomes. Accounting for this, the authors paid particular attention to the experiential instructions, which suggested that participants pay quiet attention to the felt sense of the whole of the events they were writing about. "Participants were encouraged to create a 'space'… within which to wait for freshly descriptive expressions to emerge from their felt sense of the situation as a whole" (p. 89). They speculated that this space allowed for the creation or rehearsal of a constructive alternative to their entrenched ways of seeing their role in the trauma they experienced.

This speculation generally echoed the support for rescripting or reimagining and experiencing novel ways of thinking about the trauma for those who suffer from PTSD. The research into imagery rescripting for nightmares appears to suggest that the process of revising dreams begins to change the nature of the dreams themselves, although this has not been the focus of study. However, the shift in the dream content of PTSD sufferers is an important step worthy of more attention as it appears to coincide with the beginning of recovery from the trauma. In formulating a theory of the mechanism of action for the focusing intervention, the imagery component, also used in IRT, could be the active ingredient (Moore & Krakow, 2001). However, the use of imagery alone may not be sufficient without a particular experiential way of attending to the body in relation to imagery (Gendlin, 1980). Current trauma theory and neuroscience support this, and both point to the inclusion of the somatic as an important area of focus for intervention in PTSD treatment. However, this understanding of the role of the body in trauma work has not been integrated into a model for work with nightmares per se. The unifying mechanism of action in the FOD intervention may come from the innate human capacity for metaphorical understanding and experiencing. Metaphor, according to Lakoff's (1980) theory, is a way of understanding the world that precedes language and includes the body. Metaphor categorizes and connects emotional memory at both conscious and unconscious levels (Modell, 2005). According to Gendlin's theory (1997), this symbolic function interacts directly with the felt sense by carrying forward the new understanding through a bodily living of this new possibility or meaning.

Modell (2005) observed that when more perceptual channels operate at once, it is more likely that new neural pathways will develop. The focusing-oriented approach is one that invites the client to keep their attention in several places, beginning with the body, and allowing

memory, emotion and image to arise from there. Focusing invites attention to internal sensation, and responses to these, as well as awareness of the person guiding the session, and the gentle support they provide. Accompaniment to internal processing can feel safer and allow for deeper material to emerge. For those with PTSD, this process has the potential to open up a new channel that is between the conscious and unconscious (Gendlin, 1978), a mediating function that allows new perspectives to emerge that help move the client forward in some way. (This may be what Jung (1948) was referring to when he spoke of the transcendent function.) The development of generative metaphorical thinking leads to creative and novel ideas and solutions. Like dreaming, this mode lifts out patterns and combines them in novel ways. This capacity for the generation of fluid, novel metaphor is one of the functions that is compromised in the thoughts and dreams of those with PTSD. Attention to the body and the resulting direct experiencing of an inner felt sense of a situation appears to open a doorway to metaphorical and creative thinking (Gendlin, 1978). Conceptual metaphor theory (Lakoff and Johnson, 1980; Gibbs, Lima and Francozo, 2004) might begin to explain this as it links the body and pre-verbal cognition with verbal expression of abstract ideas. An advancement of this that may be even more relevant is the concept of *emergent properties* of metaphor, which refers to the novelty that emerges from combining two elements in a way that goes beyond mere similarity to create something new (Torangeau and Rips, 1991). Working with PTSD clients using an experiential, body-oriented approach to create new endings to their most intractable nightmares can be seen as re-kindling the natural process of metaphorical perception and thinking that had become rigid and frozen (Modell, 2005) in the aftermath of unmanageable trauma.

Research Questions

This study was comprised of two parts. It was originally conceived of as a quantitative study based on the following premises: The main hypothesis was that focusing-oriented dreamwork (FOD) facilitates the forward movement of the dreaming process from repetitive, concrete and trauma-related towards a dreaming process that is more varied and symbolic. A major goal of this study was to determine if it is possible to engender significant change in the dreaming process along a continuum that is less replicative and repetitive and instead more metaphorical as a result of the FOD intervention. A related question was whether by changing the dreaming process, FOD would alleviate PTSD symptoms.

However, the original data collection process had to be shortened due to funding cuts at the study site, and with a sample size of just 5, the research design was changed to a qualitative approach. The main research question for the qualitative study could be summarized as: an inquiry into the process of change within the dreams of the refugees receiving FOD treatment for their PTSD nightmares. Although it was quite a setback to abandon the initial study, the alternative IPA approach allowed for a much more detailed analysis of dream material and participant experience. The results that came from this analysis were quite different from that which might have been discovered in the original quantitative analysis, providing greater insight into the nature of dream changes and possible mechanisms of action.

Qualitative information was gathered by recording the intervention sessions themselves, and by asking the participants to speak directly and freely about their experience of the treatment. Given the nature of the recorded data, the qualitative analysis focused on the dream material itself and was guided by the following questions: How does FOD effect change in the dreaming and waking lives of those who experience recurrent trauma nightmares? Specifically,

how does the dream content begin to change, and is there a relationship between these changes and the nature or depth of experiencing as participants imagine new dream endings? What are the convergences and divergences across participants? Inquiry was also directed toward delivery of the FOD protocol and how to improve upon it and future research design.

Summary of Remaining Chapters

The review of the literature begins with a definition of nightmares and briefly outlines the debate about nightmare definition in the dream research community. It covers clinical approaches to working with nightmares, and then briefly discusses past and current theories about PTSD with a focus on somatic approaches to treatment. The background of focusing and a précis of relevant research are included as well as literature on working with torture and other extreme forms of trauma. The concept of metaphor and its potential role as facilitator and indicator of trauma recovery, as well as a discussion of imagery, a common element to the modalities reviewed above, completes the review of the literature.

The methods section begins with an explanation of how the study was designed and the rationale for use of data from an initial study that had to be cut short. This is followed by an overview of the IPA analysis and reasons for choosing this method. A reflexivity section outlines the particular stance I took during the process of analysis, and notes my biases, previous knowledge and relevant experience. A section on the process of analysis outlines the nature of the data that were captured in more detail. I describe the specific areas of focus within the large amount of interview discourse that was transcribed, recorded and condensed into major themes.

The data collection method from the initial study is described in detail, including how participants were chosen and screened, justification of sample size, measures, detailed

descriptions of the session protocols and ethical assurances that included confidentiality and consent procedures as well as a risk/benefit analysis.

The results chapter moves from the specific experiences of individual participants toward general statements that can be gleaned from an ever-broadening analysis of dream changes and resulting experiences for participants. The chapter begins with summaries of the interviews from each of the participants, and then examines the changes in the dream content and experience pre- and post-intervention. Comparisons are then made across participants, with a focus on changes in their dreams, specifically with respect to the main themes that emerged from an initial thematic analysis. Tables are used to facilitate efficient presentation of the data and ease of comprehension. What emerges is a clearer picture of how a focusing-oriented dreamwork intervention effects change in the dream lives of trauma survivors.

The final chapter, the summary, conclusions and recommendations, begins with a summary of the study, including its objectives, rationale, data collection and analysis process. The conclusions offered here move beyond the results and analysis in Chapter 4 to present a theoretical overview of my understanding of what was working for the participants who appeared to benefit most from the intervention. I discuss possible mechanisms of action, delineate the study's limitations and provide detailed recommendations to improve the protocol and study design. Recommendations for further research complete the report.

Chapter 2: Review of the Literature

Chapter Overview

This literature review will begin with a brief review of relevant research and theory about nightmares and outline the various therapeutic methods that have been developed to treat nightmares that occur as a result of trauma. One of the reasons for choosing to study trauma dreams is that they offer clarity about the possible sources of dream material (Hartmann, 1999). Trauma-related dreams are striking and memorable, and therefore often easier to document and study than ordinary dreams. They can also be diagnostic: Nightmares have been shown to move through a progression from realistic to more dream-like as recovery from trauma progresses (Eudell-Simmons, 2005; Wilmer, 1996; van der Kolk et al., 1984, Zadra, 1996). As a result of this, trauma dreams can inform the general process of dreaming and reflect responses to interventions. In surveying dream therapy methods, this review provides detailed overviews of focusing-oriented dream work (FOD) and methods using imagery rescripting (IR). Both of these methods involve imaginally revising trauma dreams. An overview of the empirical evidence that supports their use is provided.

The components of the FOD intervention used in this study are supported by current trauma and brain research that provides evidence for the importance of a somatic orientation in working with trauma. Current somatic approaches to trauma work are surveyed, and a brief section on the neurobiology of PTSD and trauma-related nightmares is included. As well, special considerations for the survivors of torture are surveyed because survivors comprised the population studied here. The link between metaphor, trauma, and the body is explored as a possible mechanism of therapeutic action. The review of the literature concludes with a section

on imagery, a common thread at the intersection of dreaming and waking. The capacity to imagine and to deliberately project and interact with images in the mind's eye is a human capability and a therapy method that has been documented for more than a century. Imagery has received renewed interest and attention with the advent of imagery rescripting techniques for the treatment of trauma-related nightmares.

Defining Nightmares: A Moving Target

Despite the fact that Domhoff's (2001) neurocognitive theory ascribes no purpose to dreaming, many scholars who immerse themselves in the study of dreams believe that dreams are purposive and promote mental health, wholeness and/or integration (e.g. Jung, 1934/1974; Gendlin, 1986; Hartmann, 1998; Lifton, R. J., 1996). If this is so, how does one explain the nightmare, a dream that disrupts sleep and engenders fear and anxiety? Freud considered trauma dreams to be a different category of dreaming. Freud could hardly say that nightmares constitute wish fulfillment and preservation of sleep, so he suggested the theory, still alive today (Kramer, 1991), that nightmares are failed dreams that were not able to contain fully the negative emotions experienced during sleep.

For the purposes of this study, a definition of nightmares was sought because this was one of the main inclusion criteria for participants. This subject is a matter of debate in the literature. Levin and Nielsen (2007) found there is no consensus on a standard definition of nightmares despite many attempts by various researchers to arrive at one. This makes it difficult to correlate literature on nightmares because researchers are not using a standardized operational definition. Both the Diagnostic and Statistical Manual of Mental Disorders, 5th edition, (DSM-V; APA, 2013), and the International Classification of Sleep Disorders, version 2 (ICSD-II; American Academy of Sleep Medicine, 2005) are consistent in defining nightmares as highly

disturbing dreams that tend to happen in the latter half of sleep. Both previously used awakening as a major diagnostic criterion but this recently changed. In the revision from DSM-IV to V, the awakening criterion was dropped from the diagnosis for nightmare disorder. Another change is that the DSM-V states that emotions associated with nightmare disorder are fear and anxiety, plus "other dysphoric emotions" (p. 404), a qualifier that was added for the current edition. The ICSD-II also includes other distressing emotions, such as grief and rage, in its diagnostic criteria.

The awakening criteria were considered problematic because they are not a reliable measure of intensity and do not provide a clear distinction between nightmares and bad dreams; both can be intense and distressing (Zadra & Donderi, 2000). Levin and Nielsen (2007) resolved this problem by grouping nightmares and bad dreams into a single category: disturbed dreaming. Zadra, Pilon, & Donderi (2006) suggested that the two should be differentiated because their research indicated that nightmares are in fact more emotionally intense than bad dreams. Fireman, Levin, and Pope (2014) examined content differences between nightmares and bad dreams using daily dream logs from 312 undergraduate students over a period of 21 days. Using the Hall and Van De Castle content analysis system, the researchers found significantly greater fear, aggression and death references, and fewer articulated expressions of both negative and positive emotion in nightmares. Overall, the authors found that the main differentiating content between nightmares and bad dreams could be summarized as level of aggression, and they speculated that the greater aggression in nightmares indicates hyperarousal and the fight response. They concluded their findings support the use of the awakening criteria to differentiate nightmares from bad dreams. They also suggested that nightmares are indicative of greater deficits in emotional regulation than bad dreams.

Kuiken (2006) suggested that standard definitions of nightmares have some "troubling inconsistencies" (p. 260). One problem he highlighted is that nightmares were defined by the awakening of the dreamer, however this awakening can happen in other impactful dreams as well. Even adding the requirement of emotional disturbance does not distinguish nightmares from a category of dreams Kuiken has called existential dreams. He stated that definitions of types of dreams should rely on general resemblances rather than a small number of discrete attributes.

Zadra and Donderi (2000) conducted what they believed was the first study to distinguish between nightmares and bad dreams. Their findings suggested both that nightmares are more prevalent than commonly believed, and that "nightmares are a more severe expression of the same basic phenomenon" (p. 273) of dreaming. The researchers studied the dream logs and recorded seven measures of well-being for 89 participants and found that "nightmare frequency had more significant correlations than bad-dream frequency with well-being" (p. 273). The researchers used the awakening criterion to distinguish nightmares from bad dreams. The measures of well-being included neuroticism, trait anxiety, depression, general psychopathology symptoms, life-stress events and personal adjustment.

Robert and Zadra (2014) conducted a comprehensive study to further distinguish nightmares from bad dreams by examining the content of 9,796 dream reports from 331 participants. They found nightmares contained more physical aggression, substantially greater emotional intensity, and content that included more bizarre elements, failures and bad endings. Nightmare emotions were predominantly fear-related, but 35 percent contained other emotions (while 55 percent of bad dreams contained emotions other than fear). The researchers concluded

that compared with bad dreams, nightmares represent a more severe, and less prevalent expression of the same phenomenon.

Kuiken (in press) suggested that using a profile of attributes might be a better way to define nightmares. He advocated a polythetic approach to classification in which no single attribute is strictly necessary for a dream to be classified as a nightmare; however the dream must have a significant or minimum number of specified attributes to qualify for inclusion in the classification. (This is similar to the way DSM diagnoses are made.) Yet another set of distinctions must be made to separate traumatic and idiopathic nightmares, but this is simpler. Trauma nightmares appear to have the main attributes of nightmares but, as the DSM-V suggests in its diagnostic criteria for PTSD, traumatic nightmares are distinctive because they are recurrent and related in affect and/or content to the traumatic event.

For the purposes of this study, the awakening criterion was used as inclusion criteria for participants because at the time of writing, it was the most commonly-accepted way to distinguish nightmares from bad dreams. The other attributes required for participation were that the dreams be recurrent and related to the trauma.

Differentiating idiopathic and trauma nightmares

Although it is generally agreed upon that both idiopathic and trauma-related nightmares contain intense emotion that often causes the dreamer to wake up, there is at least one noteworthy distinction between the two. Most trauma dreams do not contain bizarre elements, but are unimaginative and purely replicative of real-life trauma events. By contrast, the idiopathic nightmares surveyed by Robert and Zadra (2014) contained substantially more bizarre material than bad dreams. This distinction matters in this study because it tracks the progression from trauma-related, replicative nightmares toward more normal dreaming.

This change toward healthier dreaming can be seen as one of the goals of the FOD intervention, so it is important to have a clear distinction between healthy and pathological dreams. Inherent in this statement is the assumption that healthy dreams are desirable and serve a useful purpose, whereas trauma-related nightmares do not. This, as with most topics associated with dreams and nightmares, is a subject of debate. Some cognitive neuroscientists (Domhoff, 1999) have suggested that dreams are not purposeful, but rather a by-product of the mind while in REM asleep. Dream researchers who have conducted empirical studies to discover a purpose for dreaming most often suggest a role in memory consolidation, emotional regulation or a combination of the two. Among the most popular theories are those that suggest dreams attenuate emotional distress (e.g. Hartmann, 1998; Kramer, 1991; Kuiken, Lee, Eng, & Singh, 2006; Nielsen & Carrasco, 2007).

Emotional and Mood Regulation Function of Dreaming

In their overview of studies of nightmares and emotional regulation, Nielsen and Carrasco (2007) found both theoretical and empirical support for the idea that dreaming serves an emotional regulation function. Specifically, they suggested that "dream characters and their emotion-laden interactions with the dream self may mediate this regulatory effect" (p. 274). Kramer (1991) spent decades researching dream function and his studies support the notion that dreaming serves to regulate mood. He was able to show that dreams, and not simply sleep, are responsible for the consistent improvement in mood from evening to morning, except in the case of nightmares or bad dreams, which he describes as a failure in dream function.

Kramer (1991) proposed a mood regulatory function of dreaming that is similar to Freud's theory of dreams as protectors of sleep (1900). Kramer suggested "the 'emotional surge' that accompanies REM sleep is contained by the psychological experience of dreaming. The

nightmare occurs when the integrative capacity of the dreamer is exceeded, not because of the content of the dream, but because of the altered emotional state of the dreamer" (p. 277). Kramer gathered evidence to show that in PTSD dreaming, not only do dreams exceed the emotional tolerance of the dreamer, but the dreams overflow into non-REM sleep, and the dreamer's arousal threshold is elevated (Kinney & Kramer, 1985; Kramer, Schoen, & Kinney, 1984; Schoen, Kramer & Kinney, 1984). Kramer (1991) suggested that one might think of a dream as an "emotional thermostat" (p. 279) that corrects the level and range of the changing mood of the dreamer.

Kramer, Whitman, Baldridge, & Lansky (1964) found two main patterns of dream development that progress through the night. The first type, which they called *progressive-sequential*, involves the dream stating, working on and resolving the problem the dream presents. In the second type, *repetitive-traumatic*, the problem is simply stated and re-stated with no progress towards a solution. The second type of dream would be one way to characterize the typical nightmares of participants in this study. It describes the vicious cycle those who suffer from PTSD dreams must endure: they experience emotional distress as part of their symptom picture as well as consistently experiencing the types of dreams that specifically do not alleviate this distress. A solution is suggested in Kramer's notion that PTSD nightmares exceed the dreamer's emotional tolerance. If this tolerance can be increased through a therapeutic intervention like FOD, this might be one way out of the recurring cycle.

Another feature that distinguishes nightmares is level of distress upon waking. Belicki (1992) was able to strongly support her hypothesis that psychopathology is related to the level of nightmare distress experienced by the dreamer, but not to nightmare frequency. "Such findings underscore the need to differentiate nightmare frequency from suffering (waking distress

associated with nightmares) and suggest that although frequency may be related to an intensification of dreaming process, suffering is related to waking emotional adjustment" (p. 592). This is relevant to the proposed study because it demonstrates that nightmare frequency, often used as an outcome measure in studies of nightmare treatment, may not be as important to the dreamer as the intensity of feelings that nightmares engender. Therefore, an appropriate treatment goal may include help for nightmare sufferers to develop a better relationship with their dream material, rather than to focus only on reduction of the frequency of their nightmares.

Nightmares as Sleep Disorder

There is debate in the literature about the role of nightmares in PTSD and some evidence that they may be part of the symptomatology of a separate diagnosis of sleep disorder, which develops separately from PTSD and requires its own treatment. This is the basis for a significant portion of the IRT intervention, which focuses about half of its treatment protocol on education about nightmares as sleep disorder. This part of the protocol is a major differentiating factor between FOD and IRT, currently the treatment of choice for PTSD-related nightmares.

One argument for nightmares as sleep disorder is that treatments that target PTSD do not generally relieve nightmare-related problems, and that having nightmares predates the trauma (Forbes, Creamer, & Biddle, 2001; Rhudy et al., 2010). Further support for this theory is the evidence that treatments such as IRT and ERRT that directly target nightmares not only improve sleep quality and reduce nightmare frequency and/or distress, but they also appear to improve symptoms of PTSD and depression, although these are not specifically targeted in treatment (Davis & Wright, 2007; Krakow et al., 2001). The idea put forth by those advocating a separate diagnosis of nightmares as sleep disorder is that if PTSD were the central issue, then PTSD treatment would help with nightmares, rather than the reverse.

However, Pruiksma, Rhudy, and Byrd (2011) have more recently found contradictory evidence to the nightmare-as-sleep-disorder theory. In their study of whether nightmares contribute to the development of PTSD, they investigated the differences in nightmare characteristics, symptoms, treatment outcome and history of trauma between trauma-exposed civilian groups who had lifelong versus only post-traumatic nightmares. They reported that those with post-traumatic versus lifelong nightmares experienced more depression and PTSD symptoms and were more likely to report nightmares that were similar to, or replicative of the trauma. They also found that, contrary to their hypothesis, both groups responded equally well to treatment (imagery rehearsal therapy). Rather than predisposing one to psychopathology, the authors tentatively concluded that nightmares prior to trauma exposure may actually provide some protection against the development of PTSD.

Krakow and colleagues conducted several studies with various samples of trauma survivors and amassed considerable evidence linking PTSD, nightmares and sleep disturbance. In a study of 187 sexual assault survivors with PTSD symptoms (Krakow et al., 2002), 168 of the women with sleep-disordered breathing (SDB) reported significantly worse nightmares and PTSD symptoms than the 19 without SDB. Krakow concluded that SDB is highly prevalent in sexual assault survivors seeking treatment for nightmares. In a study of 44 crime victims with PTSD and nightmares, Krakow and colleagues (2000) found that 40 had SDB, 22 with obstructive sleep apnea and 18 with upper airway resistance syndrome.

However a recent study (Pagel & Kwiatkowski, 2010) challenged previous studies linking nightmare frequency with obstructive sleep apnea (OSA) and in fact found that those with severe OSA reported significantly fewer nightmares than those with less severe symptoms. The study questioned 393 participants undergoing clinical polysomnography about their dream

and nightmare frequency and recall. The researchers found that nightmare frequency has an inverse relationship with apnea-hypopnea index (AHI) scores. As the AHI score increased, frequency of nightmare recall decreased in a linear fashion. The authors concluded that OSA suppresses nightmare recall for most patients.

The conflicting evidence about the relationship between PTSD nightmares and sleep disorders call into question the suggestion that nightmares, the most common symptom of PTSD (Pagel & Kwiatkowski, 2010), are a separate sleep disorder warranting sleep treatment. Although it is true that some patients with PTSD could also benefit from treatment for sleep problems, the above evidence suggests this is not a general rule. The above analysis supports the rationale in the FOD treatment protocol to treat nightmares as part of the PTSD symptom picture that focuses on aspects of trauma treatment rather than sleep disorder treatment.

Evidence of Progression from Disturbed to Normal Dreaming

One useful result of the recent spate of research into disturbed dreaming is a greater understanding of the different types of nightmares and the resulting benefits for both diagnosis and treatment. There are a number of ways that nightmares have been shown to progress toward healthier dreaming, and these are useful to compare with the results of this study, which offer further evidence of such a progression, as well as possible ways to encourage such changes.

Wilmer (1996) divided trauma dreams into three categories. In his formulation, a category I dream is the repetitive nightmare of the actual trauma event, a classic symptom for sufferers of PTSD. Category II dreams contain plausible trauma events, but also may contain images from the dreamer's current life. Category III dreams are like ordinary nightmares in that they include some symbolic or bizarre elements, and also include references to the dreamer's current life. According to Wilmer:

> It is hypothesized that in psychotherapy, or in spontaneous healing, Category I dreams are transformed into Category II dreams and then into Category III dreams, although in clinical practice one might encounter the change from I to III and not any intermediary stage. If this theory is correct, the emergence of an ordinary nightmare after prolonged recurrent reliving of the exact trauma in dreams is a healing process.... It is the psyche's attempt at healing. (p. 89)

In an attempt to clarify dream types and related distress, Davis, Byrd, Rhudy, and Wright (2007) collected dream data from 94 people, including 20 women, who had been exposed to trauma. While most participants reported that their nightmares were not exact replications of their trauma, there was a positive correlation between the degree of similarity of the dreams to the actual trauma and degree of related distress. Replicative nightmares caused the highest degree of distress. The authors recommended future study to assess the relationship of nightmare content to treatment outcome. Their results suggested that chronic nightmares are a major component of response to trauma extending beyond areas of functioning affected by PTSD.

Domhoff (2000) also identified a progression in dreaming process, specifically with respect to recurrent dreams. He believed the repetition was aimed at resolving emotional concerns. Zadra (1996) reviewed this and other dream research and found the collective results do support the notion that advancement along Domhoff's repetition continuum from traumatic, to recurrent, to repetitive themes to repetitive elements correlate with increased measures of well-being. In one of the studies supporting this conclusion, Brown and Donderi (1986) compared measures of psychological well-being among 67 recurrent, past-recurrent and non-recurrent dreamers and found that recurrent dreamers scored the lowest, and past-recurrent

dreamers scored the highest on measures of well-being. These results were replicated with a younger sample a decade later (Zadra, O'Brien & Donderi, 1987).

Kuiken (1993) studied dream types after significant loss and found a progression in types of dreaming from nightmares to what he calls *existential*, and then to *transcendent* dreams, in that order. He later suggested (2006) that each dream type might have its own "psychological priority" (p. 277), and that these might best be considered integratively when one looks for theories of dream function.

Van der Kolk and colleagues (1984) identified a progression of dream content from the concrete to the symbolic in a study comparing the nightmares of veterans who had been in combat to those who had not. They found that those with combat experience had nightmares that were more realistic and could occur in or out of REM sleep, yet this was not the case with the nightmares of veterans who had not been in combat. In his study of 25 veterans, van der Kolk found that all 15 participants who had PTSD said they experienced repetitive nightmares versus three of the 10 without a PTSD diagnosis. He found that those with lifelong nightmares but no PTSD have the replicative or repetitive nightmares characteristic of PTSD sufferers.

Evidence to the contrary was presented by Phelps, Forbes, Hopwood, and Creamer (2011), who conducted a study to determine the phenomenology of recurrent PTSD dreams. They wanted to determine if a replay of the trauma was required to fit the DSM diagnostic criterion for PTSD dreams. The authors studied 40 veterans with chronic PTSD using self-report measures and structured interviews to determine if there were differences in their symptoms based on types of dreams. Dream types were identified as either a replay of the actual event, a symbolic representation of the event or a mixture of the two. In all cases, the dreams caused distress and their emotional impact was similar to that of the original trauma. The authors found

little evidence that dreams that replayed the actual trauma were associated with more severe PTSD symptoms than those whose dreams were more symbolic of the trauma. They also found no evidence that symbolic dreams were associated with increased emotional processing. What was common across dream types was their repetitive nature and the similarity of dream affect to the emotions experienced during the traumatic event. From this study, it is possible to speculate that it is not the symbolic nature of dreams per se that could indicate trauma healing, but the progression from one type of dream to another, or simply any change in the nature of the dream content and its emotional impact.

The above formulations are indications of various ways dreaming can be said to progress from trauma-related to normal or healthy dreaming. This is relevant to the current study because one of the main areas of analysis is on how the content of PTSD dreams changes post-intervention. The studies above indicate there is evidence progression from trauma-related nightmares to more normal dreaming that correlates with trauma recovery, although the exact nature of the dream changes that indicate progression is not clear. The current study could shed some light in the specifics of dream content changes post-treatment that are related to trauma recovery that might help to guide further content analysis studies.

PTSD Dreams as Flashbacks: When is it Best to Forget?

Nightmares related to trauma are considered a core feature of PTSD (Brewin, Lanius, Novac, Schnyder, & Galea, 2009). In fact, in their argument for a reformulation of the DSM diagnostic criteria for PTSD, Brewen and colleagues presented evidence that the two re-experiencing symptoms, nightmares and flashbacks, may be the key distinguishing symptoms that differentiate PTSD from other anxiety disorders.

Hartmann (1996a) suggested that "the post-traumatic nightmares of PTSD are not truly nightmares, but a memory intrusion into dreams as well as into waking life" (p. 100). He also noted that although war veterans often describe their PTSD dreams as exactly the way things were, there is often alteration of at least one significant detail. Hartmann (1998, 1996a) stated that a function of dreaming is to make connections from recent, challenging material to older memories, thus dispersing the negative charge. He studied trauma dreams because this process of connecting and absorbing trauma shows itself most clearly. "The PTSD nightmare appears to involve an absence or failure of this 'connecting' or 'absorbing' process... It is branded or etched into memory. It is 'encapsulated' somewhat like an abscess, separated from the body by a wall and yet tender to the touch" (1996a, p. 109). Hartmann (1996a) found that those who develop PTSD are more likely to be young, and to have lost a close friend. However, surprisingly, those likely to develop PTSD tend not to have what he calls "thin boundaries", which he defines as people who "are open, sensitive in many senses, easily hurt, self-disclosing, vulnerable" (p. 111). This is a surprising result because people with thin boundaries tend to suffer from lifelong nightmares. Hartmann offered this possible explanation:

> Perhaps those who tend to form thick boundaries -- character armor, solid defenses and so on -- in a variety of situations might also be those who following a severe trauma would "encapsulate" their experience -- attempt to keep it walled off, separate from the rest of life. (p. 112)

There is a discrepancy in the research about whether or not encapsulating trauma experience is adaptive. Nader (1996), who surveyed the literature on children's traumatic dreams, wrote that "one theory about repetitive re-experiencing of traumatic imagery attributes it to a failure of repression; another attributes it to a compulsion to repeat in the service of mastery.

Both theories imply a need to process traumatic material" (p. 15). She referred to Horowitz (1970), who suggested that trauma images are stored in short-term memory and the images repeat until they are translated into long-term memory. Or, the images can be inhibited, but then the trauma memories remain "unmastered" (p. 15). In her case study on a rape survivor, Muller (1996) described what can happen when an event is split off rather than integrated:

> The memory tends to intrude in the form of nightmares or isolated symptoms like migraine headaches, violent visual images or physical sensations disconnected from affect.... it is as if the psyche has cut the memory into pieces.... Making little sense by themselves, these snippets of apparently unrelated memories contain the trauma encapsulated and condensed as a means of avoiding intolerable affect. (p. 149)

Hartmann (2001) agreed, suggesting that when dreaming is working it prevents trauma memories "from remaining in a separate or 'encapsulated' state and integrates [the trauma] into the ongoing flow of the mind, so that one can better cope with it and with similar problems in the future" (p. 140). On the other hand, research into the dreams and coping styles of Holocaust survivors by Lavie and Kaminer (1991) suggested that encapsulating trauma might be an adaptive response. They found in their 1991 study that survivors who had adapted well had significantly less dream recall and higher denial of emotions toward their dreams than those who did not adapt well to the trauma in terms of ego strength, anxiety and PTSD symptomatology.

. In her review of the literature on dreams and trauma, Punamäki (2007) concluded:

> To understand the realities faced by trauma victims, it is crucial to bring together knowledge about trauma-related changes in sleep architecture and dream recall, content and structure. Some evidence shows that narrative and bizarre dreams incorporating symbolic, metaphoric and emotionally-loaded material are associated with good mental

> health and can even protect child development. Tragically, trauma deprives the dreamer of exactly those dream characteristics: the trauma dreams are typically mundane, fragmented, persecuting and emotionless. In other words, trauma constitutes a trap or vicious cycle for victims: the more they need bizarre and narrative dreams for their mental health, the more the very trauma prevents healing dreams. (p. 243)

Boulanger (2005) recounted the case of Beth, who survived the terrorist attacks in New York on September 11, 2011. Several weeks into their work together, Beth's dreams began to shift from concrete to metaphorical, and this led to a shift in her ability to mentally navigate the traumatic event. In her dreams, symbols began to emerge that helped her to mediate, make meaning, and finally integrate her traumatic experience. Boulanger suggested that these symbols indicated that his client "was no longer simply reciting the horrors she had suffered" (p. 26). Instead, she was able to reflect on her experience and make sense of it.

The above examples are case studies of the progression towards metaphorical thinking as a result of dreaming and dream work. Very little empirical evidence has been gathered on this particular subject. However, Kuiken, Chudleigh, and Racher (2010) found a possible connection between eye movements of both EMDR and REM sleep and resulting attentional flexibility and perception of metaphor for those who have experienced loss or trauma. Participants included 101 psychology students who had reported a significant trauma or loss within the past three years. Half were assigned to eye movement conditions and half were not. This was an extension of an earlier study in which Kuiken, Bears, Miall, and Smith (2002) found evidence that eye movements similar to those characteristic of the orienting phase of REM sleep facilitate greater openness to the metaphorical meanings of a distressing narrative. The researchers suggested that

studying eye-movement induced changes in metaphor comprehension and may enable them to extrapolate otherwise-inaccessible information about the metaphoric processes of dreaming.

Therapeutic Approaches to Working with Dreams and Nightmares

For some theorists, there is a clear difference between dreaming and the act of working with dreams to advance emotional processing or self-understanding. Flanagan (1997) called dreams a by-product of the sleep cycle, not mere nonsense, but an epiphenomenon that makes sense and expresses the dreamer's identity. He believed dreams are not always merely random noise, but sometimes worth working with, even though he did not consider them purposive in and of themselves. Hartmann (2001) saw dream function as operating on a continuum, where the dreams themselves are therapeutic, and working on them augments their natural integrative function. Gendlin (2012b) believed that the real benefits of dreaming are not realized until one uncovers the positive message hidden in them. He said, "a dream is code for a hidden life-energy that leads to solving life problems. It opens a direction that we cannot otherwise provide." This harkens back to Freud who called dreams the "royal road to… the unconscious" (1900, p. 647). Freud believed one needed the help of a skilled interpreter to glean the true meaning and benefit from a dream. Gendlin (1996) would agree with the former statement, but not the latter. He suggested that the body is the vehicle for the interpretation of dreams.

There is a difference between what dreams themselves do and what one might do with them. This section is concerned with therapy methods for working with dreams. The first section will describe the method of focusing-oriented dream (FOD) work in some detail, including a survey of the research into this method, and also the research covering general focusing work with trauma. The second section will cover imagery rescripting interventions for nightmares, since this is a key part of the intervention used in this study. The considerable empirical evidence

supporting (and also challenging) imagery rescripting techniques will be summarized.

Focusing Oriented Dreamwork

General introduction. Gendlin summarized his focusing oriented approach to dreams in *Let Your Body Interpret Your Dreams* (1986). Since then his approach has evolved in a number of ways (Gendlin, 1992, 2012b; Ellis, 2014), but his basic contribution remains the same. His dreamwork method priveleges the body and the dreamer's felt understanding of the dream. Gendlin stated that the main purpose of FOD is to enter into a direct experience of the "life-forward" (p. 85) energy that comes when a person directly and physically has an experience of their dream images. In this way, "dreamwork continues the living process" (p. 89).

For Gendlin, classic dream interpretation and insights gained were entirely secondary to the living forward that attending to dreams in a focusing oriented manner can bring. He believed only the dreamers themselves, by paying attention to the felt sense of their dreams, can identify what is valuable about what the dream brings.

Gendlin's most recent approach to working with dreams is summarized succinctly in a book chapter entitled, Body Dreamwork (2012b). In it, Gendlin suggested that his approach to dream work is compatible with, and builds upon the methods pioneered by Freud and Jung.

> The mere dream report cannot be interpreted without the participation of the dreamer. But the dreamer's interpretations are not reliable either. The purpose of Freud's free association and Jung's daydream was to engender something to break through directly from the 'unconscious.' Working with the body is a further development of their methods. (p. 84)

In general, Gendlin (1996) did not limit his ideas about dreamwork to a theory, but considered a focusing orientation as more of a general, experiential approach. Gendlin elaborated upon this point when he stated, "experiencing is much more intricate and multifaceted than

concepts and theories. Rather than remaining with the paucity and unreliability of a theory, we employ them all to open whole reaches of human experience" (p. 3).

Clearing a space: a self-regulation method. The first step in focusing (and in the FOD protocol used in this study) is called clearing a space (CAS). This involves inviting the client to sense inside about what might be impediments to a sense of feeling good in the present moment. Without engaging in any of these issues, the client is invited to imaginally set each one aside (Gendlin, 1978/1981). Research has shown that this simple process can be valuable in its own right, consistently bringing a sense of well-being apart from difficult life issues, reducing depression and trauma symptoms, and increasing self-care and a positive body image (Grindler Katonah, 2010). Klagsbrun, Lennox, and Summers (2010) conducted a pilot wait-list-controlled study exploring the effect of CAS on the quality of life of 17 women with breast cancer. They found CAS to be an effective stand-alone method for stress reduction. Both quantitative and qualitative results supported the authors' hypothesis that CAS is an effective method for improving quality of life of participants.

Elliott, Davis, and Slatick (1998) reviewed process-experiential approaches to therapy for PTSD. CAS was offered as an example of how to help the client create an inner safe place for clients to retreat to if needed during exploration of trauma. In their overview, Elliott and colleagues stated that a process-experiential approach to PTSD would characterize symptoms such as flashbacks and nightmares as "expressions of an underlying organismic need to finish some unfinished aspect of the trauma" (p. 252). Facilitating a therapeutic relationship is a key component of process-experiential therapy, not just for establishing trust and safety, but also to allow for a collaborative approach to the tasks of therapy. One of the end goals of this approach is the creation of meaning through the symbolization of intense emotional experiences. CAS can

be seen as a first step toward many of these goals, facilitating a safe and gentle way to begin the process of imaginally sensing inside.

The felt sense and carrying forward. Gendlin applied focusing-oriented therapy (1996) methods to working with dreams to bring a bodily felt sense of knowing that comes from the dreamers themselves in place of more traditional dream interpretation. "If one attends in the body and awaits a unique quality until it actually comes, the little steps come *from it*" (2012b). Gendlin (2012b) supplied a specific example. If someone dreams of a door, the therapist might ask where the dreamer has ever seen a door like the one in their dream. The initial response may be: nowhere. Yet if one then asks the dreamer for the body-quality the door brings, the dreamer will often pause, check inside, and then offer a different response, such as: it reminds me of my grandmother's door. "A whole field of information is implicit in that nameless body quality. Very strikingly, *what one answers from the body can be utterly different from what one has said before*…. The bodily quality [is] called the *felt sense*" (Gendlin, 2012b).

Gendlin believed that dreams do not come only to tell what is already known, but always bring new energy that somehow serves the dreamer in their waking life:

> People tend to interpret their dreams very negatively, but we find that a dream is <u>*code*</u> for a hidden life-energy that leads to solving life problems. It opens a direction that we cannot otherwise provide. The new energy is often invisible within the dream. It comes when the conscious person *lives bodily from the dream images*. (2012b)

As one can see, Gendlin incorporated dream theories and approaches from many different sources into his focusing-oriented approach to dreams, and most work quite seamlessly together. The unique ingredients Gendlin brought or emphasized are an orientation toward the bodily felt sense of what the dream brings, and the search for new energy or life-forward direction within

the dreamwork process.

For people who have disturbing dreams or who are not experienced in working with their dreams, engendering a safe relationship with their dreams is the most important place to start. Gendlin stated, “More dreams will come. We help them love the dream, admire its intricacy and uniqueness” (2012b). The research bears this out: Those who have a positive relationship with their dreams benefit most from dreamwork (Hill et al., 2001; Zack & Hill, 1998). Like Aizenstat (2009), Bosnak (1996) and many of the Jungian-oriented dream theorists, Gendlin said that a dream is alive. “Dreaming is a living process, not just frozen pictures. When we let the pictures bring their bodily quality, dreamwork continues the living process” (2012a).

The questions. In his original dream book (1986), Gendlin articulated 16 questions that can be asked of a dream. These were taken mostly from Freud and Jung (2012b) but there were also influences from an eclectic mix of scholars including Bonime (1962), Perls (1969/1992) and Berry (1974). “I provided only the new method, the bodily touchstone which lets us use many approaches in this way” (1986, p. 5).

The questions begin with associations to elements of the dream (emotions, material from the previous day), then ask about the dramatic structure of the dream (setting, plot, characters). The characters can be worked with in three ways: by asking what part of the dreamer is represented by the character, by asking the dreamer to imagine being that person and by seeing if the dream can continue. The latter instruction to dream the dream onward (which is not actually character-based), originated with Jung (1916) and his concept of active imagination. It involves imaginally re-entering the dream experience and allowing it to continue (and it is a central feature of the method used in this study to treat nightmares). The penultimate set of questions suggest three ways to decode the dream: symbolism, analogies to the body and attention to

counterfactual elements. The final four questions explore developmental dimensions: childhood, personal growth, sexuality and spirituality.

Gendlin originally proposed that FOD begin with trying out some of the various questions, inviting the dreamer to check in with the felt sense for a response. If there was no sense of response from the body, the therapist could simply try another question until the line of inquiry had an impact on the dreamer. Through this exploratory and unscripted approach, the dyad would arrive at the meaning of the dream. The process was meant to be fluid and open to where the felt sense of the dreamer would lead. Gendlin now advocates a slightly more systematic approach that begins with a detailed telling of the dream, and then an exploration of the dream setting or place, and associations to this. This is partly done to place the dream in context, and partly because it is usually a safe and non-threatening way to enter a dream (although this may not be true of replicative trauma dreams).

Finding help in the dream. The next step that Gendlin now suggests is very important is getting help from the dream:

> If we go to the most troubling spot right away, we work as if there were no dream. We want the help of the dream before we tackle the problem. In bodily terms, 'help' means anything that brings life-forward energy. In a dream, what sort of things bring help? Anything beautiful, also children, animals, anything living and green. Also, very odd objects unique just to this dream. We ask about those early on. (2012b)

If finding the body's sense of the help in a dream brings a good feeling, newfound energy and vitality, then Gendlin considered the dreamwork to be essentially done (2012a). However, he said that if the dreamer is curious, or if the process feels unfinished, dream exploration can continue. In this author's experience however, simply finding the help is not an ideal place to

leave the dreamwork because an opportunity is then missed to explore the experiential steps that will come from the new feeling. This good feeling, as Gendin has stated elsewhere (2012b), is what enables the dreamer to explore the darker, and possibly repetitive aspects of their dream experience from a vantage point that may allow something new to emerge.

Bias control and other steps. Further steps in Gendlin's focusing-oriented dreamwork take one back to the original questions, but there is no prescribed order. For example, a further step might involve working with dream characters, and especially those that feel most opposite or dystonic to the dreamer. This way of imagining into dream characters with foreign-feeling characteristics is an evolution of a method called *bias control* (1986) which Gendlin developed as part of his original dreamwork protocol. The basic idea comes from Jung (1948) and his sense that the main purpose of dreaming was to provide compensation for waking consciousness that had gone too far in one direction. Gendlin might suggest the person embody or become the character in the dream (especially one that feels foreign), a technique from Gestalt therapy (Perls, 1969). Gendlin recommended Stanislavsky's method for actors and suggested dreamers imagine how they would be in their body as they prepare to act that person on stage. According to Gendlin, one can ask about anything in a dream in this way, including objects. He was not suggesting the person adopt wholeheartedly the aspects of the person that the dreamer does not identify with, but just to imagine becoming a little bit more like them.

Additions to Gendlin's methods, for working with nightmares. Gendlin developed his body dreamwork method for working with normal dreams. For the purposes of this study, the author altered the protocol to make it both more succinct and more appropriate for working with trauma (see Appendix H). This was done by explicitly beginning with the step of clearing a space as a gentle way to introduce sensing into the body to provide a safe internal space to which

the dreamer could return if needed. Then, because finding help was not expected to be easy in the process of working with PTSD nightmares, a return to the cleared space was provided as an alternative if no help could be found. In addition, instructions were added to allow the therapist to ensure the dreamer stayed within the *therapeutic window* (Briere & Scott, 2006) necessary for working safely and effectively with trauma.

Focusing-oriented therapy for trauma treatment: gentle exposure. Focusing as a general treatment for trauma differs from the widely-accepted exposure-based approaches in two very important respects: It is gentler because it is client-centered, and it has a focus on engendering embodied experiencing rather than cognitive change. While exposure therapy has received considerable empirical support (Foa, Keane, & Friedman, 2009), it does have certain limitations, including high drop-out rates (Krakow, 2000; Lu, Van Male, Whitelhead, & Boehnlein, 2009). Exposure therapy asks the client to imagine their trauma experiences in great detail, focusing on the feelings of fear the memories bring up and to do so repeatedly until the fear response attenuates. This process can be very challenging and uncomfortable for the client. Current somatically-oriented therapies for trauma attempt in various ways to make working with trauma more tolerable than exposure therapy by attempting to ensure that the client's level of activation stays within an optimum therapeutic window (Briere and Scott, 2006) that is neither too activated nor dissociated.

Focusing-oriented therapy appears to enable clients to stay within the therapeutic window, but in a rather unique way. Focusing instructions allow for experiencing but not flooding because, as they process trauma material, the client is able to stay present and aware of body sensations but not flooded by emotion (Gendlin, 1991). This is because the process encourages the client to attend to the felt sense, which is about the whole of a situation and not

an immersion into the feelings about it. The focusing instructions, ask the client to be friendly and curious while observing their felt sense of the whole of a situation. In this unique stance, the client can process implicit aspects of the trauma memory while maintaining a space between the trauma experience and themselves. The focusing-oriented therapist provides the guidance and support to enable the client to achieve this, thus protecting the client from re-traumatization.

Research into Focusing-oriented Therapy

Focusing-oriented therapy has been empirically validated in numerous studies. Hendricks (2001) conducted a meta-analysis of 89 studies to determine if focusing correlates with therapy outcomes, if focusing can increase *experiencing levels*, and if higher experiencing correlates with therapy outcomes (Klein, Mathieu, Gendlin, & Kiesler, 1969). All three hypotheses were supported; 23 studies had findings that showed that focusing correlates with successful therapy outcomes. (A meta-analysis of focusing research since 2001 is currently under way.)

Experiencing refers to the ability to speak from one's inner experience in the moment. According to Gendlin's (1997) theory, such inner experience is not separate from the environment and implies ongoing process. Low experiencing levels are characterized by externalized and concrete thinking, while high experiencing is a moment-to-moment tracking of inner experience as it unfolds. High experiencing levels allow for what Gendlin would call *carrying forward,* the natural tendency of living things to grow, develop or progress, like a plant reaching towards light.

While there is considerable literature on the process and outcome of focusing-oriented therapy, there has been very limited empirical research into focusing-oriented dream work. What has been conducted is promising, but much more study is needed to validate this method. The following is a survey of relevant literature on focusing-oriented dream work, and on focusing-

oriented therapy specifically for working with trauma.

In a paper on trauma imagery and focusing, Coffeng (2004) stated focusing-oriented therapy is a "middle position between confrontation or relaxation" (p. 279) in working with severe trauma. Coffeng used focusing with complicated grief, and found that focusing brought manageable experiential steps rather than "stressful catharsis" (p. 280). In one case study, the focusing-oriented therapy client imaginally revisited a route he covered in wartime Yugoslavia, and this time he was able to bury the dead and say a proper good-bye. Coffeng reported that the process took eight sessions and evoked a lot of tension, but afterward the client reported reduced depressive and PTSD symptoms and fewer nightmares.

Kuiken, Dunn, and LoVerso (2008) conducted a study of the effects of different types of expressive writing instructions (factual, emotional or experiential) for 50 individuals writing about dreams following trauma and loss. The results generally supported prior research that shows expressive writing to be helpful following trauma, but not loss. The experiential instructions, taken from focusing, were found to accentuate emotional distress (as were the emotional instructions) for those writing about dreams following trauma. Only the experiential writing condition "distinctly facilitated the affirmation (or rehearsal) of a trauma narrative that emphasized unintentional responsibility rather than direct self-blame" (p. 77). The experiential condition also had unique effects on those who recently experienced loss, engendering significant shifts in self-perception.

In surveying the literature, Kuiken et al., (2008) acknowledged the studies showing that imagery rehearsal therapy is effective for treating trauma-related nightmares and that the Hill cognitive-experiential method "attenuates the impact of loss, facilitates insight, and initiates constructive personal change" (p. 78). However, the authors suggested that these results are

ambiguous and that the effective components need to be isolated. The experiential component is common to both imagery rehearsal and cognitive-experiential dream therapies. It also had interesting effects for both categories of participants in the Kuiken et al., (2008) study. The instructions for the experiential writing condition were based on Gendlin (1978/1981, 1996) and focusing. They included attending to the felt sense of the distressing event, finding words or phrases that resonate with the body to describe the felt sense, and recognizing what is new or different in what emerges from this process.

The exposure hypothesis (Sloan & Marx, 2004) suggested that fear extinction and habituation result from repeated exposure to the trauma memory. Effects from a single session cannot be accounted for by the exposure hypothesis. Even so, given exposure theory, Kuiken et al., (2008) said one would expect that the emotional and experiential writing conditions, which both intensified anger and tension, to show effects, and for the emotion group to show a larger effect due to increased emotional vigor engendered by their writing task. In fact, effects were strongest for the experiential writers. Kuiken and colleagues accounted for this by explaining that the specific instructions in the experiential writing condition encouraged participants to create a quiet, reflective and less emotional space and from there to wait for something fresh to arise, an alternative to their usual, often guilt-ridden, way of considering the distressing event. "By enabling affirmation (or what some would call rehearsal) of a cognitive alternative to entrenched self-blaming rumination, experiential writing may have provided modest benefit to members of the trauma group even during this single session" (p. 89).

This study highlights the key difference between working with a felt sense versus an emotion, a difference that makes work with intense emotional experiences potentially helpful rather than distressing. Gendlin (1991) saw emotions as an aspect of continuing to live the

pattern, whereas the felt sense moves one toward a new pattern. Emotional expression can engender re-experiencing rather than a working through. Finding the felt sense, which is often a quieter, more subtle sense around an emotion, requires the ability of the focuser to find the right distance from the sense of an issue so that there is space into which something new can emerge.

Another interesting finding in this study (Kuiken et al., 2008) that also counters the exposure hypothesis is that increasing how vividly the dream was recalled did not facilitate cognitive restructuring for the trauma participants, although it did for the participants who had experienced loss. In fact, for the trauma group, there was an inverse relationship between absorption (depth of imaginal involvement) and self-perceptual depth (the sense of something personal and important being freshly understood). The authors' conclusions drew attention to "the importance of the quiet and patient openness afforded within a phenomenological approach to dream work" (p. 91). They also reiterated the need to isolate effective components of approaches to dreams following distressing events.

Kan, Holden, and Marquis (2001) conducted a study on the effects of focusing-oriented dream interpretation and were able to support the notion that this method "facilitates constructive psychological change for the dreamer" (p. 106). The study was conducted in two parts. In the first, the authors developed and validated their own dream interpretation effects questionnaire (DIEQ) to assess seven aspects of focusing-oriented dream interpretation. These were: easing or release of emotional tension; increase in energy; increased self-understanding; movement, reconciliation or healing; development of a new step or direction; enhanced valuation of dreams; and enhanced understanding of dream's meaning. Their study found significant pre- to post-test improvement in scores for all seven categories "indicating significant beneficial effects" (p. 117). The researchers divided 20 participants into therapy or control groups and provided the 10

therapy group members with one 45-minute focusing-oriented dream therapy session, while the control group spent 45 minutes on personal activities. While the results were positive, the study had many limitations, including small sample size and testing on self-selected versus standard outcome measures. One finding of interest is that the largest pre- and post-test difference was the change in attitude for participants who presented with nightmares or scary dreams. All five participants who reported such dreams said that their experience was transformative, and their attitude toward the dream turned from negative to "very positive" after a single session of focusing-oriented dream work.

The neurobiology of focusing. Ozier and Westbury (2013) provide a detailed conception of the neurological underpinnings of Gendlin's concept of experiencing. They outlined their understanding of the differences in neural processing at low, medium and high experiencing levels, and also how chronically low experiencing levels may be associated with psychopathology. Their work provided a neurologically-grounded model that corroborated the considerable empirical evidence that depth of experiencing correlates with positive therapy outcomes.

To briefly summarize their model, Ozier and Westbury (2013) argued that the human mind has three interacting neural systems, aspects of which are unique to primates. Two of these systems are responsible for what they call *hot* and *cold* cognition, and a third mediates between the two. The first two systems to which the researchers refer appear to be the limbic system and the neocortical system, although they did clearly delineate the neural structures to which they were referring. According to their operational definitions, the hot cognition network generates automatic, affective responses from the lowest and phylogenetically-oldest parts of the brain, including the amygdala, while the newer cold cognition system employs higher brain structures,

including the prefrontal cortex, to assess situations using internal representation and memory. The mediating system between the hot and cold systems is the recently-recognized Lamina I afferent neural system, the least-studied and most important to the researchers' model. The researchers suggested that this latter system is responsible for the processes used in focusing.

Ozier and Westbury described three levels of experiencing as defined by the Experiencing Scale (EXP; Klein, Mathieu, Gendlin & Kiesler, 1969). They stated that their conception of low-level, (externalized) experiencing is analagous to Damasio's somatic marker hypothesis (SMH; Bechara and Damasio, 2005). According to the SMH, when faced with decision-making processes involving risk and conflict, the brain produces *somatic markers* or secondary emotions which provide fleeting, but influential impressions, based on past experience, that reduce a vast array of possibilities down to a manageable number.

However, according to Ozier and Westbury's detailed neural analysis, in low-level experiencing, somatic marker generation and emotional regulation are performed "while using a largely simulated touchstone with which to ground its assessments and reactions" (2013, p. 265). In other words, this process does not take into account current input or experiencing. "These top-down simulations are very fast because they are enacted entirely within the brain and do not rely on the much slower process of monitoring actual changes going on within the body proper" (p. 261).

By contrast, Ozier and Westbury stated that mid-level experiencing is different in two important ways. First, there is a reduction in top-down input from the cold cognitive system into the dorsal anterior insula (AI), lowering overall AI activation. This allows for "authentic, real-time Lamina I derived information to more strongly influence the right dorsal AI's computations" (p. 265). The Lamina I afferent neural system, which exists only in primates,

integrates and represents information from all the tissues of the body and terminates in the somatosensory cortex, the dorsal anterior cingulate cortex (ACC) and the posterior insula.

The other important difference between low and mid-level experiencing is that the neural network, which mediates between the hot and cold cognition systems, is more engaged. This allows for assessment and resolution of emotional conflict that includes input from current and emergent feelings of what is right and wrong. Ozier and Westbury (2013) suggested that this mediating network is what allows for high-level experiencing, which they conceived of as a detailed process: The person first constructs a mental mural of the situation as a whole, which activates related memories and simulates somatic changes which are relayed by Lamina I. During high-level experiencing, this information "emerges into conscious awareness. The tremendous richness of the homeostatic information being fed forward from Lamina I means that background feeling can only be consciously represented at low resolution, accounting for the inchoate, ephemeral quality of a felt sense" (p. 267). However, the use of guiding questions intensifies the most salient aspects of the felt sense and "its associated somatic profile will stand out" (p. 268), leading to tangible sensations, images, memories or emotions that typically arise from inquiry into a felt sense.

Within the model developed by Osier and Westbury (2013), psychopathology is conceived as an inflexible relationship between the hot, cold, and mediating neural sub-systems. The result is over- or under-regulation of emotion, or the inability to enter into higher levels of experiencing, but instead a quality of being "rigidly stuck in a low level of experiencing. This leads to a maladaptive, systemic dominance of the evolutionarily new cold cognition system over the mediation system" (p. 269). A major problem with this is that the cold cognition system is based on an *as-if body loop* that repeatedly bases its reactions and perceptions on the past versus

the here-and-now. Although not mentioned in this article, this conception has implications for those suffering from PTSD as many of their symptoms result from past trauma being experienced as if it were present.

The authors concluded that "a hallmark of psychopathology is a tonic under-representation of Lamina I input, relative to top-down input, into the insula" (p. 270), and that "*ameloriating psychopathology essentially involves helping clients to strengthen their mediation systems*" (p. 271). They advocated for clinicians to be trained in assessment of experiencing levels in clients, and in understanding how to deepen experiencing regardless of the therapeutic modality they practice.

Imagery Rescripting for Treatment of Nightmares

The method that has received the most empirical support for the treatment of the most distressing types of dreams -– the repetitive nightmares characteristic of PTSD – is a form of imagery rescripting called imagery rehearsal therapy (IRT). It is the only method unequivocally recommended by the American Academy of Sleep Medicine (Aurora et al., 2010) for the treatment of nightmare disorder in adults. (Lucid dreaming is also listed as a possible consideration, but with limited applicability, low-grade evidence of effectiveness and concern about how the treatment can be incorporated into therapy.)

The IRT method. Briefly, there are two main elements of intervention over four two-hour sessions. The first two sessions are educational, with the goal of cognitive restructuring so that participants can begin to see their nightmares as a learned behavior amenable to change. The second component involves education and training in the use of imagery. Following general information about the nature of the human imagery system, participants learn how to implement

a specific set of imagery-based steps to decrease nightmares. Simply put, they are asked to invent a new version of their nightmare and to rehearse this repeatedly.

In the imagery part of the protocol, IRT has adopted Neidhardt's model (Krakow & Neidhardt, 1992) that asks the dreamer to change the dream in any way that feels right to them. Krakow and colleagues (1996) said this open-ended approach is better than narrowing the scope of possible endings to "something positive or triumphal. We speculate that Neidhardt's broader instruction leaves open a psychological window through which the patient may intuitively glimpse multilayered solutions to other emotional conflicts in addition to or arguably as part of their nightmare resolution" (p. 61). They also stated that they would not be surprised if "a very important active ingredient of IRT were shown to be the ability to reconnect with the natural, human capacity to manipulate and change imagery in the mind's eye, beyond any specific changes of content within the new dreams" (p. 61).

Neidhardt and Krakow were not the first to use imagery rescripting as a way to work with dreams. Dreaming the dream onward is a technique that was pioneered by Jung, and adopted by many Jungian therapists and dreamwork specialists, including Bosnak (1996), Epstein (1981) and others. In his focusing-oriented dreamwork method, Gendlin (1986) included the simple instruction, "Can the dream continue?" (p. 181). He suggested that the dreamer "re-visualize the end, or any important bit of the dream. Then just watch it. Expect something to happen." This instruction is open-ended and non-directive, like Neidhardt's. The first treatment to specifically use rescripting asked dreamers to write out their nightmares and add a new, triumphant ending (Marks, 1978).

Research into the use of IRT. The base of empirical support for IRT is growing. Much of the earlier research was with sexual assault survivors with PTSD, and the method has more recently been adapted for use with combat veterans (Moore and Krakow, 2010). Over several controlled studies, Krakow and colleagues found that 70 percent of several hundred participants treated with IRT reported meaningful improvement in nightmare frequency, and "significant clinical change occurred in greater than 90% of patients" (2010, p. 48).

In an earlier study, Neidhardt, Krakow, Kellner, and Pathak (1992) compared IRT to a treatment that involved simply writing down nightmares. While nightmare frequency was reduced significantly for both groups, only IRT showed consistent reduction in distress scores across various measures. Krakow and colleagues (2000, 2001) conducteda randomized controlled trial with 114 women with PTSD as a result of sexual assault and found that IRT significantly decreased nightmares and PTSD symptoms while improving sleep quality. However, the study had a high dropout rate. This might be due to the fact that IRT protocols required participants to be highly self-directed after treatment. For example, they were asked to take responsibility for rehearsing the new dream endings repeatedly and consistently, and then doing the same work on their own with other dreams.

Germain and Nielsen (2003) found that disturbing dreams and related distress (though not sleep quality) were significantly improved after one session of IRT for 12 chronic nightmare patients. Another study (Germain et al., 2004) showed that it is the dreamers' mastery over negative dream elements that is important in the reduction of nightmares. Germain and colleagues collected nightmares and the rescripted endings of 44 female sexual assault survivors after one application of IRT. The researchers assessed mastery using the Hall and Van de Castle (1966) standardized coding system and a mastery scale developed for the study. In their

quantitative analysis, they found that the rescripted new dreams contained more positive and fewer negative elements and indications of increased mastery and concluded that "an increase in mastery over negative dream elements is a core process involved in nightmare reduction" (p. 196). An earlier study by Marks (1987) suggested that exposure and abreaction were the main processes leading to nightmare reduction. However, Germain and Krakow (2004) stated that IRT has minimal exposure and abreaction, and therefore posited that increased mastery over distressing dream elements is the key active ingredient. It bears mentioning, however, that IRT participants are asked to write down their nightmare, which is a form of exposure. Germain and colleagues (2007) also conducted a pilot study of a shortened version of IRT in which they administered a 90-minute intervention that including rescripting the nightmares of seven adult crime victims with PTSD. They found even this very brief intervention to improve sleep quality and reduce nightmares and PTSD symptoms in a "clinically meaningful" way (p. 627).

Krakow and Zadra (2006) found that directly targeting nightmares was a valid approach to solving the problem of trauma-related sleep disturbance. They suggested that further research was needed to determine specifically which elements of IRT account for its success. However, like Germain, they noticed that patients generally came up with versions that increased their mastery over the dream content, though not specifically instructed to do so. "The proper re-activation of patients' dysfunctional imagery system and associated increase in perceived mastery over negative dream elements appear to play a vital role in nightmare reduction" (p. 65). The IRT process involves minimal exposure to the traumatic material in the original nightmare. It is also a departure from the widespread belief that the best way of treating nightmares is a psychodynamic approach that targets the underlying issue (the trauma) that causes the

nightmares. Instead, Krakow and Zadra (2006) stated that treating the nightmares directly is "sometimes the best first step in treating posttraumatic sleep disturbance" (p. 51).

Recently Moore and Krakow (2010) adapted the IRT protocol for use with combat veterans, and although there are limited data about its effectiveness with this population, what has been collected is promising. In their study, the authors discussed what might be the most beneficial: treatment for underlying causes of PTSD or treatment for the nightmares themselves. PTSD nightmares are repetitive and realistic, suggesting the body may be engaged in its own version of exposure therapy. They suggested that IRT "should not work when nightmares are a secondary symptom while the primary cause [PTSD] is left untreated" (p. 233). In fact, they found that IRT not only reduced nightmares but also global PTSD symptoms, and follow-up studies showed the results were lasting.

A recent Dutch study (Lancee, Spoormaker, & van den Bout, 2010a) compared three 6-week self-help protocols: IRT, exposure, and diary recording with a wait-list control. The 399 participants were assessed 11 weeks post-treatment and both IRT and exposure were found to be significantly more effective than the wait list in reducing nightmare frequency and distress and improving sleep quality. However, there were differences: IRT was better at reducing anxiety and nightmare frequency, while exposure was more effective at reducing depression and nightmare distress. Simply recording dreams was more effective than the wait list in reducing nightmare frequency and distress, and improving sleep quality. IRT worked faster than other conditions. The authors concluded that exposure to nightmare imagery may be the main therapeutic agent.

The same group of researchers (Lancee, van den Bout, & Spoormaker, 2010b) included 278 participants in a study to compare the following self-help formats: IRT; IRT plus sleep

hygiene; and IRT plus sleep hygiene and lucid dreaming; and a wait-list control group. They assessed at 4, 16 and 42 weeks, and just 73 completed all phases. Contrary to expectations, IRT was more effective than the two other interventions, and was the only intervention convincingly better than the wait-list condition. Outcome measures included nightmare frequency and distress, sleep quality, anxiety, and depression. Authors suggest the results should be interpreted with caution due to the high dropout rate, which was attributed to the self-help nature of the intervention.

A few recent studies have challenged some aspects of the IRT research. For example Harb, Thompson, Ross, and Cook (2012) studied the characteristics of the nightmares and dream scripts revised through the course of imagery rehearsal therapy for 48 U.S. male veterans of the Vietnam War with PTSD. They found that while rescripting the nightmare generally reduced sleep disturbance, the new dream endings that still contained references to violence were related to poorer outcomes in terms of nightmare frequency. The authors concluded that IRT might be most effective for treatment of chronic severe PTSD when the rescripting excludes violent content. The findings implied that it may be helpful for the therapist to suggest the client seek more positive valence in imagining a new dream ending versus leaving the rescripting open to what feels right to the dreamer.

Lu, Van Male, Whithead, and Boehnlein (2009) conducted a study with 15 male U.S. veterans with PTSD and related nightmares. They provided participants with six IRT group sessions and followed up at 3 and 6 months. Immediately post-treatment, no benefits were observed, but at 3 months the number of trauma-related and general nightmares decreased significantly as did PTSD symptoms. Researchers found no effect on sleep quality, depression or impact of nightmares. In addition, the benefits were shown to have weakened at the 6-month

follow-up. The study was small, but raised several concerns with respect to the IRT intervention. Researchers found that participants who had problems either could not focus on a new dream or could not create a tolerable new dream. Compliance rates were low, with 53% of participants reporting they did not practice imagery rehearsal of the new dream outside of the group sessions. For 20% of participants, nightmare frequency had increased at 6-month follow-up. The researchers concluded that IRT has specific rather than general effects and may be best used in conjunction with other trauma therapy methods.

A recent review of PTSD nightmare treatments by Nappi, Drummond, and Hall (2011) summarized all IRT research findings and concluded that IRT has not been shown to be more effective than nonspecific therapy effects. In particular, they criticized the specific avoidance of exposure to nightmare content in this method suggesting it might perpetuate avoidance in those with PTSD. They also suggested that the IRT studies have been too few in number, and not standardized in terms of treatment protocols or sample characteristics, and therefore it is not possible draw firm conclusions about the efficacy of this method. Nappi and colleagues also reviewed a related nightmare treatment protocol, exposure, rescripting and relaxation therapy (ERRT). The main difference here is the addition of exposure to the nightmare content. The authors suggested that like IRT, the overall evidence is promising but limited, and that in both methods the specific components of the protocols that effect change have been identified but not systematically tested.

Cook and colleagues (2010) conducted a randomized controlled trial testing the effectiveness of IRT versus CBT on nightmare and sleep management for 124 Vietnam War veterans with recurrent nightmares and chronic, severe PTSD. Neither group experienced a reduction in nightmares, although they did show evidence of improved sleep quality and reduced

PTSD symptoms. There were no significant differences between methods. In reviewing this study, Nappi (2011) suggested that the nature of the participant group may have affected outcomes. Overall, Nappi and colleagues concluded that research in the area of PTSD should move away from looking at sleep symptoms in isolation and address them "more holistically within the framework of PTSD… by conducting more integrative studies that examine sequential or combined treatments" (p. 583).

Countering the challenges to IRT, Escamillia, LaVoy, Moore, and Krakow (2012) conducted a review of the recent studies of treatments for the management of post-traumatic nightmares. They concluded that IRT is featured most often in the literature on psychological treatments because of its "established efficacy" (p. 529). Casement and Swanson's (2012) meta-analysis of IRT studies confirmed this conclusion. They found 13 studies that met their inclusion criteria (with enough detail on outcomes to calculate effect sizes) and found that IRT had large effect sizes on nightmare frequency, sleep quality and PTSD symptoms and that these results were sustained over 6 to 12 months. They also found that combining IRT with cognitive behavioral therapy did not improve outcomes.

In terms of future direction, Moore and Krakow (2010) reiterated the need to dismantle the IRT protocol to clarify effective ingredients and best practices. To date, no studies have been conducted that separate the two main elements of IRT (psycho-education on nightmares as sleep disorders and imagery rehearsal). It is plausible that the experiential imagery component is the active ingredient because this component is present in other methods that have been shown to have a positive effect on PTSD nightmare symptoms. Moore and Krakow's statement that "IRT appears to jump-start a natural human healing system that was previously dormant" (p. 62) requires further exploration.

A recent meta-analysis (Hansen et al., 2013) compared psychological treatments that used imaginal confrontation for treating nightmares (ICNC) with imagery rescripting and rehearsal techniques (IRR) and concluded that dismantling studies are needed to determine which method is more effective and/or efficient. Both showed "impressively high" (p. 154) effect sizes, and both showed these effects over short-term treatment. Results of the meta-analysis showed that both of these methods were most effective on outcome measures of nightmare frequency, nights per week with nightmares and PTSD severity, and that ICNC effectiveness increased with longer duration of treatment.

ERRT, an Imagery Rehearsal Technique with Increased Exposure

Davis and Wright (2005) published a promising case series introducing the new protocol and demonstrating reduced nightmare frequency in all four cases. They suggested that due to the "vast literature" (p. 151) supporting the use of exposure for treatment of anxiety-related symptoms (Foa, Keane, & Freidman, 2000), they should modify imagery rehearsal therapy to increase the exposure component. They also added relaxation techniques and trauma education thus creating ERRT. In the new protocol, the authors allowed for discussion of trauma throughout the treatment and encouraged participants to write down, read out and rescript their most frequent and disturbing nightmare. In a randomized clinical trial for treatment of chronic nightmares for 27 trauma-exposed participants, Davis and Wright (2007) found that ERRT resulted in a significant decrease in PTSD symptoms, depression and fear of sleep while improving sleep quality and quantity. More recently, Davis and her team (2011) replicated and extended the earlier ERRT trial with 47 participants, and found similar support for use of ERRT in the treatment of chronic nightmares.

Lucid Dreaming and Narrative as Treatment for Recurrent Nightmares

Lucid dreaming is briefly included here because it is one of the imagery-based treatments included as a protocol for the treatment of nightmares by the American Academy for Sleep Medicine (Aurora et al., 2010). The research, though not extensive, supports the notion from IRT research that increased mastery over the dream content is a potential active ingredient in engendering positive change.

Zadra and Pihl's (1997) case study of five participants supported lucid dreaming as a promising treatment for recurrent nightmares. However, they cautioned, "It remains unclear whether the principal factor responsible for the alleviation of nightmares is lucidity itself or the ability to alter some aspect of the dream" (p. 50). In preparing to induce lucidity, participants were asked to relax deeply, to visualize a salient aspect of the dream in detail, and then to imagine carrying out a particular task, such as looking at their hands. If they were able to perform the task (i.e., look at their hands) while dreaming, it provided a cue to the person to wake up inside the dream and potentially to exercise control over the subsequent events of the dream. However, the reduction of nightmares was also achieved in two of the five cases where the dreamers did not actually become lucid, suggesting that lucidity itself is not the key therapeutic factor. The authors said the crucial aspect is likely the dreamer's ability to exercise some control over their dream, whether they become lucid or not.

Spoormaker, van den Bout, and Meijer (2003) reported very similar results. They conducted a case study and found nightmare frequency was reduced for six of the eight participants who tried a single lucid dream treatment, although state and trait anxiety were not. Of the six whose nightmares were reduced, only three were able to alter their nightmare while dreaming, and for three others, the dream changed by itself. One dreamer was able to become

lucid, but not able to alter the dream. Nightmare frequency was reduced by an average of 60%. The authors suggested it was not lucidity but a sense of mastery that made the difference. Zadra (1996) found when dreamers were able to alter their dreams, a constructive solution, such as engaging peacefully with or fighting the attacker was preferable to a less constructive reaction, such as running away. He suggested the dreamer's ability to alter something in a repetitive dream could be a key factor in eliminating it.

In a narrative approach to working with nightmares, Shalev, and Ursano (2003) found that the dreams of veterans with anxiety content were amenable to change, those with trauma content less so, and dreams associated with trauma re-enactment were chronically recurrent. The authors suggested that the latter category may involve sub-cortical brain structures and be detached from areas of the brain accessible to therapy where speech and thoughts are the vehicles for change. In their qualitative study, the authors found that dreams of traumatic events persisted long after the end of therapy, but that reducing fear associated with such dreams, facilitating the development of control and power over the dreams and identifying concurrent adversities to the dream content all promoted improved adjustment. The therapy used in this study consisted of working directly with dreams, developing emotionally-manageable dream narratives, collaborative interpretation and linking dream material to related current limitations.

Spoormaker (2008) developed a cognitive model of recurrent nightmares that has implications for treatment methods. In the model, he differentiated bad dreams from nightmares and stated that the latter are "examples of failed fear extinctions" (p. 15) and that awakening in the middle of the nightmare strengthens the fear and distress response. This leads to avoidance, which Spoormaker stated makes the dream script more likely to recur because it "prevents

emotional normalization of the script" (p. 18). This, he suggested, is why exposure and rescripting are effective means of treating nightmares.

Background, Current Theory and Approaches to Working with PTSD

While a thorough survey of current trauma theory and approaches to treatment is beyond the scope of this literature review, this section will briefly review current research into the neurobiology of PTSD as these discoveries have implications for the screening and treatment protocols used in this study. Also included is a brief review of what are understood to be current best practices for PTSD treatment, and their limitations.

A Brief History of Trauma Theory: Amnesia and Contradictions

A diagnosis for the effects of trauma (PTSD) was not made official by an entry into the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association until as recently as 1980. However, there has been sporadic investigation of the effects of trauma since the late 1800s when Charcot began investigating hysteria. This line of inquiry was picked up on by Charcot's two rival students Freud and Janet, who both concluded, independently of each other, that hysteria was caused by trauma. Janet found that trauma produced an altered state he called *dissociation*, a term that has lasted into contemporary discourse. Freud presented his theory in 1896 that the origin of hysteria was found in early sexual trauma, but soon after, he reversed this, suggesting instead that the problem came from repressed sexual fantasies, not actual events. Due to Freud's dampening influence, Janet's work on trauma, largely in agreement with modern views, was forgotten until recently (Bacciagaluppi, 2011).

Study of trauma has gone in and out of fashion over the course of history. Until recently the advancement of trauma research depended more upon world events and political pressure than on scientific curiosity. Herman wrote that "the study of psychological trauma has a curious

history – one of episodic amnesia" (1992, p. 7). As a researcher and member of the womens' movement, Herman played a major part in bringing the widespread violence toward women to public attention, and out from under a veil of secrecy and denial.

War veterans also suffered from varying levels of support and denial, depending on world events. In World Wars I and II "traumatic neuroses were the object of concern as long as the war lasted and traumatized soldiers had to be reclaimed in order to be sent back to the front lines" (Baccagaluppi, 2011, p. 531). The term *shell shock* was used to describe the effects of trauma in WWI, and soldiers who suffered from it were either seen as malingering and treated punitively, or were given treatment (usually with hypnosis), and sent back into service. By WWII, there was less stigma attached to those suffering psychological trauma, and a briefly renewed interest in trauma treatment and theory. However, it was not until the soldiers returning from Vietnam organized and garnered public attention that sustained public and academic attention was given to the effects of psychological trauma.

Leys (2000), who summarized the history of trauma theory beginning with Freud, offered a possible explanation for the variability of interest in trauma over the past century. Her central thesis was that trauma theorists have oscillated (or vacillated) between two contradictory ideas about how to work with trauma. The first is *mimesis*, or the idea that trauma victims cannot recall the actual traumatic event, but instead are doomed to re-enact it in various ways. Along with this idea, therapy (often hypnosis) is focused on recovering and articulating these memories. The second major idea is *antimimesis*, or the notion that trauma survivors *can* accurately recall their trauma experience, although this may entail an arduous process.

Ley also discussed Janet, who she said has been misinterpreted to advocate for therapy that converts trauma memory into narration by means of hypnosis:

> In actual fact Janet not only recognized the therapeutic value of forgetting or altering the past, but also called into question the entire opposition between remembering and forgetting on which the psychotherapy of the trauma victim is now largely thought to depend. (p. 302)

Ley believed that this dialectic, which has been evident between and within trauma theories throughout history, will continue. She concluded that "the soundest basis for practice would be an intelligent, humane and resourceful pragmatism" (p. 307).

Studies quoted in this literature review also show evidence of contradiction: In some cases, recovering and processing trauma memory appears to provide symptom relief, while in other cases, encapsulating the memory and forgetting affords trauma victims better long-term adjustment (i.e., Lavie & Kaminer, 1996).

Pragmatism is one way to proceed: When in doubt, follow what appears to work for the client. However, ideally there would be a more definitive prescription available. The recent neurological studies of PTSD by Lanius and colleagues (2011) showed that there are at least two qualitatively different responses to trauma; possibly the optimal treatment protocol for each may differ as well. In any case, the focusing-oriented approach to trauma treatment presented in this study does not focus on either remembering or forgetting the actual trauma event but on processing the experience as it is brought up in repetitive dreams. Ideally, this moves a stuck, repetitive process forward in a way that feels authentic and therapeutic to the client. The goal is not to determine what really happened but to alleviate symptoms that cause distress by following what the body appears to be trying to accomplish in its persistent activation of aspects of the trauma memory. This is not a focus on remembering or forgetting, but rather a new way of experiencing so that one can move forward without persistent and intrusive symptoms.

PTSD: Theory and Approaches

As noted earlier, the diagnosis of PTSD is a relatively recent one, officially added to the DSM in 1980 after mental health professionals successfully lobbied to include a diagnosis to account for the after-effects of Vietnam War trauma. Van der Kolk (2002a) noted that a major difference between those who developed PTSD and those who did not was the specific nature of the trauma memory. As time passes, trauma memories are naturally altered and diluted. However, those with PTSD continue to recall the event, or specific fragments of it, in precise detail as intrusive images and nightmares that keep the memory as fresh as if it were current. In PTSD sufferers, the memories are not stored as if they were past. "Their 'implicit' (sensory and emotional) memories of the trauma are 'dissociated' and return not as ordinary memories of what happened but as intense emotional reactions, nightmares, horrifying images, aggressive behavior, physical pain and bodily states" (p. 37).

Van der Kolk (2002a) has extensively researched the neurobiology of trauma and has contributed to the understanding of how the human brain functions under extreme stress. His work (and related research) has implications for the treatment of PTSD. We now know that people with PTSD have lower levels of the stress regulation hormone cortisol (Yehuda & LeDoux, 1996), and so are less able to modulate their natural stress responses. Their brain's alarm system, the amygdala, becomes overactive (and van der Kolk suggests this may not be reversible), and consequently those with PTSD are easily triggered into states of arousal and the fight-or-flight response. This high arousal level leads to "state dependent memory retrieval [which] precipitates flashbacks and nightmares" (p. 38).

Lanius and colleagues (2004) found that trauma memory is stored in different parts of the brain for those with PTSD compared to those without it. Using functional magnetic resonance

imaging (fMRI), the researchers observed functional connectivity in the brains of 11 people with PTSD and 13 people without PTSD as the participants focused on the experience of a traumatic event. In their subjective reports, all PTSD participants experienced the trauma memory as though it was happening in the present, while the non-PTSD group recalled it as an ordinary memory. The authors noted that flashbacks differ from ordinary memories in that they can be experienced as fragments of various sensory components: images, smells, sounds, sensations (van der Kolk, 1996b). Unlike ordinary memories, flashbacks do not change over time, and in this respect, they are similar to PTSD nightmares.

Lanius and her team (2004) found significant differences in memory storage location; those with PTSD showed connective activity primarily in several locations on the right anterior hemisphere, while those without trauma showed more connective activity on the left side of the brain and generally more balanced lateral activity during trauma recall. The researchers concluded that these significant differences may account for the non-verbal nature of traumatic recall for those with PTSD: The areas of the brain that were active during trauma memory recall for the PTSD group corresponded with the regions associated with nonverbal memory retrieval.

Van der Kolk (2002a) suggested that effective trauma treatment must be body-oriented rather than insight-oriented because PTSD is largely a physiological response. “To overcome a traumatic experience, one must have a physical experience that directly contradicts the helplessness and sense of the inevitable defeat associated with the trauma” (p. 41). Revisiting dream states, which access implicit memory, and ideally offering a new response that is more empowering may be an effective ingredient in revision work with PTSD nightmares. Van der Kolk noted that those who had feelings of powerlessness, and who dissociated from the trauma

event were the most likely to develop PTSD. Reversing this and instilling a sense of control and ability to stay with the trauma experience has the potential to facilitate recovery.

Van der Kolk (2002a) suggested that exposure to the trauma memory can be effective, although many PTSD sufferers drop out of such therapy because it can be too traumatizing. He advocated for exposure to trauma memory, but in a form that includes mindfulness, the calm sensing of internal states and facilitation of experience that is more constructive than mere repetition. He wrote that effective PTSD treatment

> must promote awareness, rather than avoidance, of internal somatic states…. Mindfulness, awareness of one's inner experience, is necessary for a person to respond according to what is happening and needed in the present, rather than reacting to certain somatic sensations as a return of the traumatic past…. *Imagining new possibilities*, *not merely repetitively retelling the tragic past, is the essence of post-traumatic therapy*. (p. 42, emphasis added)

Van der Kolk (2002b) recommended focusing-oriented therapy as an effective approach to therapy because paying attention to the felt sense allows feelings to be known in a mindful, aware state helps those with PTSD to experience their bodily sensations as something other than signals of threat. "Such awareness allows people to introduce new options to solve problems and not merely to react reflexively" (p. 390).

Key Distinctions in the Presentation of PTSD Symptoms

While valuable knowledge was developed in the first two decades after the diagnosis of PTSD was introduced, recent advances in the understanding of the neurobiology and physiology of PTSD have the potential to change how the disorder is now conceived of and treated. Although the diagnosis and criteria for PTSD initially came mainly from the study of war

veterans, researchers and clinicians are now delineating a difference in the constellation of symptoms for those with simple PTSD brought on by single-incident trauma events in adult life versus those with PTSD who have a history of complex developmental trauma (Van der Kolk, 2013; Widom, 1999).

In addition, for those with PTSD, there are two distinct categories of responses to trauma stimulus: 70 percent show symptoms of hyper-arousal such as increased heart rate and re-experiencing, while 30 percent exhibit dissociative symptoms and no change in heart rate (Lanius et al., 2001). Lanius and colleagues (2002) conducted a small controlled fMRI study on just the 30 percent of PTSD sufferers with dissociative responses. Their results suggested that hyper-arousal and dissociation are two distinct reactions to traumatic stimulus. The authors noted that the DSM-IV does not have a dissociative symptom cluster for PTSD although there is an emphasis on dissociative symptoms for Acute Stress Disorder. (However, this was rectified in the DSM-V which includes a specifier for dissociative symptoms of depersonalization and derealization.) Based on the fMRI images, the authors found functional abnormalities in the medial prefrontal, superior and middle termporal gyri and in the anterior cingulate cortex in those with dissociative PTSD versus control subjects. These areas of the brain are responsible for multimodal sensory integration.

A New Paradigm: PTSD as a Failure of Affect Regulation

Frewen and Lanius (2006) more recently began a line of research to provide support for a model in which PTSD is considered to be a disorder characterized by affect dysregulation rather than anxiety. The authors noted that those with PTSD are typically unable to both down-regulate and up-regulate their levels of arousal, especially those who have experienced long-term developmental or interpersonal trauma.

> We conceive of the PTSD re-experiencing response as an instance of deficient neuroregulatory control over emotional arousal, whereas at the other extreme, we consider the PTSD dissociative response to be an enhanced neuroregulatory suppression or inhibition of traumatic memory-related emotional arousal. (p. 111)

The authors summarized neuroscientific research that shows how the anterior cingulate cortex (ACC), dorsolateral and ventromedial prefrontal cortex (PFC), and the orbitofrontal cortex (OFC) are associated with the ability to deliberately regulate negative emotion and autonomic arousal (so-called *top-down* regulation). Individuals with PTSD show reduced activation in the PFC and ACC compared with controls, accounting for their reduced ability to regulate or articulate affect during trauma memory recall.

> In brief, whereas healthy controls demonstrated significantly greater activation in multiple areas of the left hemisphere in concert with right ACC response during traumatic memory recall, consistent with a verbally mediated pattern of recall, individuals with PTSD evidenced significantly greater coactivation with right ACC primarily in structures of the right hemisphere, including the inferior frontal gyrus and posterior cingulate gyrus, consistent with a negatively valenced and primarily nonverbal pattern of recall. (p.113)

The authors suggested that the dissociative states often found in a subset of those with PTSD may not be the result of protective repression, as popular psychodynamic theories suggest, but of the immobilization response seen in animals when more active responses fail. In terms of treatment implications, the authors suggested that helping those with PTSD to manage emotional responses should take place before trauma processing. The idea of a phased approach to trauma treatment has been presented by others as well (e.g., Courtouis, 2004).

Therapy for complex trauma requires engendering a sense of safety before the client can

begin to benefit from the helpful presence of the therapists. This idea is supported by Porges' (2011) influential polyvagal theory, which added another branch to the behavioral strategies of the autonomic nervous system. The immobilization or parasympathetic response depends on the oldest (unmyelinated) branch of the vagus nerve, while the mobilization response of the sympathetic nervous system affects heart rate and metabolism, quickening to ready the body for fight or flight. The fight, flight or freeze stages of response are well-known. However, another response, less well understood, depends on the myelinated vagus; it inhibits the sympathetic nervous system and allows for social engagement. According to Porges, all of these responses happen outside of conscious awareness, and "a neuroception of safety is necessary before social engagement behaviors can occur" (p. 17).

The polyvagal theory has implications for psychotherapy for clients with PTSD. Those with a history of relational trauma may be more likely to react in social situations with one of the first two defensive strategies of the nervous system: fight/flight or freeze. In either case, the client is then not able to use the very social engagement system that enables them to make use of the therapy relationship. Porges stated that if therapists are not able to instill a sense of calm and safety in the client, they may not be able to access the social mechanisms that enable therapy to work. So he believes that effective therapy begins with connection, often at the very basic level that fosters early-attachment security: prosody, somatic mirroring and facial expression.

Therapy Practices for PTSD: A Multi-faceted Approach

Current research suggests that PTSD may not be an anxiety disorder, but a failure of emotional regulation. Lanius, Bluhn, and Frewen (2011) proposed a new paradigm called SCAN (social cognitive and affective neuroscience) for understanding and treating complex PTSD. They recommended an approach for assessing, treating and conducting studies on those with

complex PTSD that includes working with emotional/self-awareness, emotion regulation, social emotional processing and self-referential processing, all of which are impacted in those who have suffered chronic developmental and interpersonal trauma. Their ideas may influence and change the way PTSD is now conceived of and treated. At the very least, it suggests tailoring the approach to the specific sub-type of PTSD a client may be presenting. To date, many overviews of PTSD treatment have not been able to clarify why proposed treatments are not universally effective, but have generally flagged this as an area for further study.

Foa, Keane, Friedman, and Cohen (2009) researched a comprehensive overview of effective practices for PTSD and concluded that exposure therapy was the most reliable and powerful currently available treatment for PTSD. They found that it was more effective provided individually than in a group. They also found that therapy for PTSD had a protective impact: Those who recovered naturally (without therapy) were more likely to develop PTSD from future exposure to traumatic events. Foa et al., also found that CBT in its various forms was the most studied therapy for PTSD and was clearly effective, but not for everyone. The authors noted that CBT is demanding on both patient and therapist.

The authors (Foa et al., 2009) also found EMDR to be a recommended evidence-based treatment for PTSD. Shapiro (2002) wrote that the name eye movement desensitization and reprocessing has caused confusion, and it would be more aptly named reprocessing therapy. The approach is based on reprocessing perceptual information that has been maladaptively stored thus causing psychopathology. In several comparative studies, EMDR was found to be as effective but more efficient than prolonged exposure therapy (Shapiro, 2002).

EMDR is based on Shapiro's adaptive information processing (AIP; Shapiro and Maxfield, 2002) model that suggests "adaptive processing occurs when associations are forged

with previously stored material, resulting in learning, relief of emotional distress, and the availability of the material for future use" (p. 935). This theory suggests that trauma memories are not processed fully and are stored in isolation without the benefit of associative links to related thoughts, images, emotions and sensations. EMDR's eye movement desensitizes the patient to the trauma memory, enhances processing, and enables the patient to access adaptive and new connections within their memory network.

EMDR is supported as an evidence-based treatment for PTSD, although Foa and colleagues (2009) are not convinced that it is the eye movement that accounts for its effectiveness, stating there is evidence that EMDR without the eye movement appears to be as effective. The mechanism of action has not been isolated, and the authors suggest it might be the exposure element, the reprocessing mechanism proposed by Shapiro, or "a unique combination of proven, client-centered approaches (2009, p. 627) that account for the success of EMDR treatment. They noted that several components of EMDR overlap with other PTSD therapies including the establishment of a therapeutic relationship, psychoeducation about PTSD, assessment, identification of maladaptive beliefs relating to the trauma, and imaginal exposure to the trauma memory.

It may be that successful therapy for PTSD generally requires more than one mechanism of action because PTSD itself can present in several different ways. There are several common elements in FOD and evidence-based PTSD treatments that might contribute to their effectiveness. First, a sense of safety and therapeutic alliance must be in place for the trauma client to be open and available for trauma work. Without this basic condition, the social engagement system is not active and the client is unavailable for the process of therapy (Porges, 2011). Second, the fear memory must be active, but within a window of tolerance that limits

extremes of hyper- or hypo-arousal. FOD and EMDR are among the body-based approaches that encourage clients to be aware of their inner state, and to actively maintain their equanimity as they process trauma memory. This may be providing new emotional regulation skills that Frewen and Lanius (2006) deem crucial to the recovery from trauma, especially for those who have experienced complex developmental trauma.

Third, there must be a revision of the trauma memory that integrates its various aspects, as the hallmark of PTSD memories is their fragmented, often non-verbal nature. As Shapiro (2002) suggested, trauma memories of those with PTSD are not processed fully and so are stored in isolation, without the benefit of associative links to related thoughts, images, emotions, and sensations. The FOD protocol builds associative links by rekindling the dreaming process using the very dreams that the patient's mind and body appear to be attempting repeatedly to integrate.

The end result is not simply that the trauma memory is reprocessed and subsequently stored in explicit memory as Shapiro (2002) suggested, but that the client effectively processes the associated emotion and comes to terms with the trauma event. As they do so, they can begin to articulate this emerging story of their trauma. This will include felt sense impressions that are carried forward by the whole of the therapy situation so that the trauma memory will be contaminated by the novel sense of experiencing the event from a safe distance, in the company of someone, while in touch with their own body, and while thinking metaphorically. The sum of this new experience becomes part of the trauma memory, which is then forever altered. As Gendlin (2011) stated, "Present living changes how the past functions now."

Special Considerations for Treating Survivors of Torture

This section briefly reviews the literature specifically on the study and treatment of survivors of torture because those who have experienced torture or political oppression were part

of the participant group. The following research shows that this group can safely participate in research studies, but that cultural sensitivity is required.

According to the International Rehabilitation Council for Torture Victims (IRCTV), in 2011 there were more than 15.5 million refugees worldwide and of these, approximately 35% are victims of torture. In addition, there are more than 27.5 million internally displaced persons and although accurate statistics do not exist on the extent to which these people have experienced torture, statistics suggest that this is a serious global issue. Those who have undergone long-term, repetitive and/or extreme experiences of trauma often have a different symptom presentation and a more complex path to recovery than those who experience brief or single-incident traumatic events (Courtois, 2004). However, this brief survey of the research finds that people can be resilient in the face of torture, can tolerate diagnostic interviews about their trauma experience, and can benefit from trauma-focused therapy.

For those working with survivors of torture, it is important to be sensitive to the cultural background of the client. According to Schubert and Punamäki (2011), "culture shapes the subjective and collective meaning of trauma and expression of pain" (p. 176). The researchers examined the role of culture, gender and refugee status in the mental and somatic health of 78 torture survivors who sought help from a centre in Finland. They found group differences in PTSD and depressive symptoms as well as somatic complaints, and concluded that those providing treatment to survivors of torture should consider cultural influences in terms of symptom presentation and expression.

Johnson and Thompson (2008) also stressed the need for cultural sensitivity for diagnosis and treatment of people who have suffered from torture, as Western-based models of trauma symptomatology may not accurately apply. Johnson and Thomson reviewed 48 studies on risk

and protective factors for PTSD for survivors of war and torture and drew several conclusions. First, there is evidence that the more trauma events one suffers, the more likely they are to develop or maintain PTSD. Women and those over 65 years of age are more likely to develop PTSD. Poor living conditions and uncertainty with respect to relocation are additional risk factors, while social and family support, preparedness for torture, and religious beliefs provide some protection against PTSD.

Steel and colleagues (2009) conducted a review and meta-analysis of torture sequelae to assess the prevalence of PTSD after torture. Most studies surveyed used the Harvard trauma questionnaire (Mollica et al., 1992). In a regression analysis of 181 studies and a total of roughly 82,000 participants, the researchers found a prevalence of 30% for PTSD and 31% for depression. While these figures may seem low, Maercker and Forstmeier (2011) suggested that protective factors for survivors of torture include its collective nature and the fact that victims maintain an oppositional attitude. Risk factors were identified as trauma history, features of the torture, general political climate and length of time since the torture. Steel and colleagues (2009) also found that those who permanently resettled in another country had lower rates of PTSD than those displaced or in refugee camps.

Neuner and colleagues (2010) conducted a study to determine if asylum-seeking populations with PTSD could be successfully treated using exposure-based techniques. Earlier studies suggested this is the case. For example, Paunovic, and Ost (2001) found that trauma-focused treatment (exposure therapy alone or combined with cognitive therapy) significantly improved the PTSD symptoms of 16 Swedish refugees. The authors quoted several other studies that supported the use of trauma-focused treatment for this population. Neuner et al., wanted to determine how well-tolerated exposure-based trauma therapy would be. The research team

sampled 32 asylum-seekers, with PTSD that was severe in some cases, and found significant overall improvement in PTSD symptoms at a 6-month follow-up. The intervention used, narrative exposure therapy, was found to be well tolerated and effective.

Another study (Kolassa et al., 2007) showed that diagnostic interviews about torture and other extreme trauma events are generally well tolerated and not re-traumatizing. The researchers compared the stress response levels of male refugees with severe PTSD. A group of 17 were given a diagnostic interview about war, detention and torture events, while 16 were interviewed about absorption behavior. It has been suggested that detailed diagnostic interviews about traumatic events can lead to re-traumatization, but the results of this study found no difference in cortisol levels in saliva samples taken at four points in the interview process between the study and control group. The authors concluded that a diagnostic interview that includes detailed questioning about the trauma events themselves "does not trigger an HPA-axis based alarm response or changes in psychological measures, even for persons with severe PTSD, such as survivors of torture" (p. 54). The researchers stated that exploring trauma experience with empathy and sensitivity does not appear to add to the burden of those who have experienced severe trauma.

Metaphor and Imagery

Having an experience that helps to make sense of trauma events that appear senseless and destructive may be what differentiates memories that continuously repeat from those that are integrated into a person's larger sense of self. According to Johnson (2007), human beings are inherently meaning-making creatures and begin the process of making meaning from the day of birth. He suggested that meaning is grounded deeply in the body:

> Our experience of meaning is based, first, on our sensorimotor experience, our feelings, and our visceral connections to our world; and second, on various imaginative capacities for using sensorimotor processes to understand abstract concepts. Any adequate explanation of meaning must avoid attributing it either to 'body' or 'mind.' (p. 12-13)

The following sections briefly explore the way metaphor and imagery may be implicated in the process of making meaning and beginning to recover from PTSD.

Metaphor, the Body and the Transformation of Trauma

Lakoff and Johnson (1980) espoused a cognitive-linguistic theory that suggests metaphor is much more than a poetic way of linking two disparate elements so that our mind creatively connects them. They argue that metaphors are, instead, the very foundation of the way human beings perceive and think.

Levin (2009) stated that metaphors have a basis in multisensory experience and as such, they are not only powerful vehicles of communication between people but also between parts of the brain. He observed the research of Niels Lassen in the late 1970s and noticed that when people are very interested, they activate their sense of touch, hearing and sight simultaneously, whereas when they are less engaged, they use only one sense perception at a time. He thought this intense interest was potentially creating new neural networks. For him this was analogous to how metaphor can engage several levels of meaning at once for therapy clients: sensorimotor schema from childhood, concrete thinking, logic and symbolic thinking. He noticed his use of metaphor in a session could lead quickly to moments of deep insight for his patients.

Borbely (2008) explored the relationship between metaphor (where something is viewed *in terms of* something else) and metonymy (where something is *equated* with something else) in

the psychoanalytic process. Metaphor is considered a healthy mode of functioning because it allows for a flexibly vague way of holding meaning, one that can be modified by other, related experiences. Borbely said that trauma "destroys the possibility of registering an experience with appropriate ambiguity" (p. 417). This reduces the metaphor's potential to bring new perspectives. Trauma leads to the freezing in time of the meaning of an experience, to "literality" (p. 417) in which the meaning of an experience is inflexible. Past and present are seen as the same and therefore can't metaphorically inform each other. Borbely said this "precludes an optimally resilient, autopoetic self-organization. Absent such resilience, the individual's responsiveness to the present and openness to the future are severely restricted" (p. 418). Metaphor allows for the ability to differentiate experiences of the past and present allowing for flexibility of interpretation and response, and sensitivity to context. Borbely added that metaphor is on the zone between primary process (unconscious) and secondary process (conscious). He called the metaphoric process "imaginative rationality" (p. 421) and associated it with psychological growth, which he stated mostly occurs via primary process, that is, in the unconscious. Metaphor integrates the conscious and unconscious "as they coalesce in the optimal functioning of the mind" (p. 421).

According to Modell (1997), there has been resurgence in interest in the concept of metaphor from a number of disciplines, including cognitive science and neurobiology. He wrote that metaphor is now seen as "an emergent property of mind" (p. 105). He stated that metaphor is "rooted in the body" (p. 105) in the sense that the mind uses it to organize bodily sensations, especially those with affective valence. As well, metaphor is somatic in the sense that it "rests on the border between mind and brain" (p. 105). He suggested that somatic capacity for

metaphorical understanding begins very early and is present in preverbal children as a way to categorize emotional memories.

Modell (2000) stated that metaphor is an unconscious process of detecting patterns and has a major role in the organization of emotional memory. He wrote that when there is trauma, metaphor becomes "fixed and frozen in that it loses its playful 'as-if' aspect… In the face of trauma, metaphor loses its capacity to create a new understanding" (2000, p. 143). Modell suggested that "*metaphor is an essential element in the transformation of traumatic memories* and, further, that the metaphoric process provides the necessary bridge between the past and the present" (2000, p. 137, emphasis added). According to Modell, when trauma occurs, there is a narrowing of the space between present and past, and thus a compulsion to repeat the past as it is undifferentiated from the present. He called this a freezing of the metaphorical process and saw the goal of psychoanalysis as "convert[ing] these frozen metaphors into fluid, generative metaphors" (2005, p. 555).

Metaphor research has developed the concept of *emergent properties*, which may explain how novelty can arise from metaphor. It would be natural to think that metaphor interpretation is mainly based on what the two elements of a metaphor have in common, however, this may not be the case. Tourangeau and Rips (1991) compared participant responses to the shared features that arise from the two items being related to each other in a metaphor with responses to emergent features that characterize neither item taken separately. In a three-part study, the researchers found that participants clearly had a preference for interpretations of metaphors that were wholly novel and not based on shared features of the two elements of the metaphors used in the study.

Counter to this, Hartmann (1998) discussed how dreaming makes use of metaphor to note similarities. He saw the mind in terms of networks or *nets* and suggested that metaphor brings *subnets* together. According to Hartmann's theory of dreaming, dreams function to contextualize emotional images, and they do this using the vehicle of metaphor. Hartmann believed dreams make connections more broadly than our waking mind does and depict these connections as visual metaphors.

Hartmann (1998) used a visual metaphor to explain nightmares following trauma. He wrote that when a person has experienced trauma, it is as though there is a hole torn in the net of the mind, and the dreaming process weaves connections in an attempt to repair the net. The dreamer who is recovering from trauma will have frightening dreams interwoven with details from life, broadening the memory to include emotionally related events and calming the stress. Hartmann differentiated these helpful types of nightmares from repetitive PTSD dreams, although he said under careful scrutiny, even the so-called replicative dreams of those with PTSD often have slight alterations from the actual trauma event. If their trauma dreams are truly stuck in a repetitive pattern, they do not have the healing properties characteristic of most dreams, and such clients are not often helped by psychotherapy either. Hartmann has observed a progression of emotion in dreams following trauma from abject terror, to fear, and then to guilt or grief. These emotions are often depicted not as the actual event but as *contextualizing images* such as a tidal wave to express the overwhelming feeling of being trapped in a fire, in other words, as metaphors.

The initial development of the capacity for metaphor may be related to early interactive experience. Wilkinson (2010) likened metaphor, the ability to allow one thing to stand in for another, to Winnicott's (1971/1996) notion of the transitional objects infants use to represent the

primary caregiver during her absence. Schore (2003) has demonstrated that early infant-caregiver attunement is crucial for early right-brain development associated with affect regulation throughout life.

The right hemisphere is also implicated in processing novel metaphors. Language processing takes place primarily in the left hemisphere but Mashal's research shows metaphor, particularly novel metaphor, to be a right-hemisphere function, particularly in the "right posterior superior temporal sulcus, right inferior frontal gyrus, and left middle frontal gyrus.... suggesting a special role for the right hemisphere in processing novel metaphors" (Mashal et al., 2007). Wilkinson (2010) noted that evolving symbolizations, such as those that emerge in dreams, have long been considered hallmarks of progress in therapy. "The activation of the implicit in this way requires connection at a deep emotional level" (p. 108).

Language combined with empathic attunement is essential to the therapy process (Cozolino, 2010). Wilkinson (2010) suggested that proto-metaphorical thinking is made possible through interaction, through the first relationships one has with one's caregiver, and the need for the development of an ability to have one thing stand for another in their absence. This ability to use what Winnicott (1971) dubbed a *transitional object* is what Wilkinson suggested is the genesis of metaphorical or imaginal capability. She stated that nowhere is the blending of words with feelings "experienced more powerfully than in the realm of emergent metaphor, when a patient haltingly struggles to express feelings that have emerged in picture, dream or image" (p. 108). This halting struggle to find the right words for an internal somatic sense that conveys more than one can initially say about it perfectly describes an essential part of the focusing process. Wilkinson's ideas suggest why the focusing process, which encourages the articulation of a felt sense, may be a vehicle for change. "Emergent metaphor helps us to understand the

emotional truth of our inner experience while still tolerating uncertainty. Most importantly, emergent metaphor heralds metamorphosis, the capacity for healthy change in the mind, enabling a more coherent sense of self" (Wilkinson, 2010, p. 120).

Clinical Approaches to Restoring Metaphorical Thinking

Clinicians working with the victims of trauma observe that intensely traumatic experiences frequently result in impaired metaphorical thinking. Grubrich-Simitis (1984) found that the impairment in metaphorical thinking as a result of severe trauma can even affect the subsequent generation. She worked with children of Holocaust survivors and was impressed by the characteristic *concretism* of these particular patients in her psychoanalytic practice. She speculated that the lack of metaphorical thinking she found in the second-generation victims of trauma was related to their parents' need to deny their extreme traumatic experiences. "The patients frequently regard what they have to say as thing-like. They appear not to regard it as something imagined or remembered…. The open-ended quality of fantasy life is missing."

Grubrich-Simitis (1984) suspected that what prisoners had to do in their minds in order to survive in a concentration camp "impaired the ego capacity for metaphorization and the related psychic ability to structure time in past, present and future." To treat this condition, she felt what was needed was to help the patients "to overcome the concretism and to restore the metaphoric function." She made a point of noting that she was not using the term metaphor in the limited linguistic sense, but rather in a general sense that allows the fixed meaning of the word used in the metaphor to be "loosened" from its actual, literal meaning "in order that the word's much wider, more variable, indeed limitless metaphorical potential can unfold."

Grubrich-Simitis (1984) envisioned the analytic process with Holocaust victims and their children as beginning with acceptance of the reality of the event, which she believed would

enable them to begin to make use of symbols that naturally emerged in psychoanalysis in a way that would allow for:

> … the finest gradations, for ambiguity, for the playful and the paradoxical, indeed for wit and humor… to wrest, out of despair, a confirmation of the truly human dimension, which in the twentieth century, in the most brutal form ever, has been cast in doubt by the crime of the Holocaust. (p. 319)

Boulanger (2005) also observed that those who have experienced severe trauma "frequently experience deficits in symbolic functioning affecting the capacity to dream and to think productively" (p. 21). He suggested that what might be happening in the minds and psyches of highly traumatized individuals is that the psychic space that allows for reflection is not available. "Catastrophic dissociation is characterized by a narrowing of perception and rigidity of mental processes; thoughts lose their elasticity in order to ward off annihilation anxiety, and symbolic thinking is compromised" (p. 22). In direct contrast to the cultivation of mindfulness that is prevalent in current approaches to trauma treatment, Boulanger called response to major trauma "the state of mindlessness" (p. 22). He suggested that during times of trauma, thoughts that are "free to roam associatively… can lead to terrifying meanings and untenable anxiety" (p. 23). He cited van der Kolk (2002) who has shown that the traumatized brain cannot effectively form thoughts because the hippocampal function required for consolidation of memory is disrupted.

Boulanger (2005) referred to Bion's 1967 book, *Second Thoughts* to describe his sense of how thinking is disrupted (and can be repaired) after trauma exposure:

> Thinking, in Bion's sense, requires that words be used symbolically, as signifiers, implying that there is a distance between the experience of the word and what it signifies.

> Finding meaning depends on being able to make associations between different thoughts. Making meaning of an experience implies that the linked thoughts are resilient and flexible…. Meanings give rise to metaphors that yield new perspectives. Affects inhere in meaningful experiences, and they too can withstand inquiry, varying and deepening as understanding grows. (p. 23)

This process can take time, and Boulanger observed that literal and confused thinking often arise long after the trauma, especially as the victim attempts to recall the traumatic event. He believed that "the endless and unproductive cycle of the survivor's fragmented thoughts and feelings is best captured in the repetitive dreams reported by survivors of massive psychic trauma" (p. 24). He also suggested that it is the therapist's ability to enter into the traumatic experience, in all its confusion, and to be a true witness rather than a voyeur, that enables the client to adopt this more flexible stance toward their own trauma experience.

Agarkov (2011) wrote about how exposure to trauma can cause "impairment in symbolic functioning that affects capacities to entertain fantasies and to think productively" (p. 55) and he is among those who suggested that this impairment is also apparent in the dreams of trauma survivors. Agarkov used the term *operative thinking* to describe the state of mind of trauma survivors as concrete, with little or no fantasy or dream life and an impoverished use of metaphorical expression. He observed that "dreams of individuals with operative thinking are exact description of an action… connected with what happens to the individual in reality" (p. 56). However, he noted that the recovery of the capacity to symbolize manifests in dreams in this order: first, the dreams remain realistic but depict different aspects of the traumatic scene than those in the recurrent nightmare. Second, the traumatic scene is reproduced but with a positive

resolution. Third, the traumatic scene has *day residue* or elements from the dreamer's current life woven into the content.

In the case example presented, Agarkov suggested that interpretative therapy was not effective until the dreams started to shift, which began to take place after about 20 sessions. Until then, the therapist's suggestion of possible symbolic meaning was rejected. However, as the traumatic experience gradually moved from being experienced as in the present to a sense that it was in the past, the client was more open to finding meaning in the experience. After 6 months of therapy, the client had his first symbolic dream. This vignette suggests that the movement from concrete to symbolic dreaming in the recovery from trauma can take time; results may not be apparent after just a few sessions. However the movement echoes Wilmer's (1996) three stages of PTSD dreaming.

Focusing Theory and Metaphor

Focusing as a therapeutic approach to working with impaired metaphorical functioning is appropriate because it echoes the process of articulating bodily felt sensation which Lakoff and Johnson (1980) suggested is the very basis for metaphor. Gendlin (1962) conducted a detailed philosophical exploration of the functional relationships between experiencing and felt meaning. Metaphor is viewed in this theory as "novel symbolization" (p. 113). In other words, Gendlin saw metaphor as the vehicle for achieving new meaning because it draws on familiar symbols but employs them in novel ways.

However, to really understand how Gendlin (1962) conceived of the creation of meaning, one must go back a few steps to the basics of his explication of how felt meaning functions (or refer directly to the original text). Felt meaning can be initially accessed through direct reference to the unique feeling or *felt sense* it brings even though at this point, one may not be able to

articulate what this unique feeling is. “Direct reference is a relationship between symbols and felt meaning. The functions of symbols and felt meaning depend on each other… the symbols depend on felt meaning for meaning… The felt meaning depends on symbols to mark it off as a referent” (p. 100). This type of relationship applies when the symbol does not have meaning independent of its relationship to felt meaning. However, symbols and felt meaning can have a different relationship: when the symbol is recognizable to us, it can engender or call forth felt meanings. This function of symbols can apply not only to words, but also to people, situations, objects and actions. A third functional relationship is one of *explication* in which the felt meaning guides the search for symbols that bring a feeling of recognition or apt fit for the direct referent. If there is no symbol available to fully express the felt meaning, a new felt meaning can be created and symbolized through metaphor:

> A metaphor achieves new meaning. It does this by drawing on old experience and by using symbols that already have some other, old familiar meaning. Metaphors differ from ordinary meaningful symbols in that they do not simply refer – as ordinary symbols do – to their habitual felt meaning. Rather the metaphor applies the symbols and their ordinary felt meaning to a new area of experience, and thereby creates a new meaning. (p. 113)

A step from here is what Gendlin calls *comprehension* or the act of articulating the new meaning that has emerged from metaphor. To do this, one must find new symbols, which may take some trial and error, and repeated reference back to the felt sense. Even when the process yields an accurate symbolization of the direct referent, it will also change it: it will become “richer, more explicit, more fully known… Only through such a process of specifying aspects and telling ourselves what we mean can we *comprehend* and experience meaning” (p. 120).

The above briefly explains how metaphor is implicated in the process of change. Dreams often provide symbols that call forth felt meanings that can lead to transformation. However, in repetitive trauma dreams, this process appears to function poorly, if at all. Gendlin's process steps offer a guide for the development of a protocol to engender experiencing that creates new meaning, and these form part of the rich theoretical foundation for focusing-oriented therapy.

Imagery: A Common Thread at the Intersection of Waking and Dreaming

A particular area of interest that crosses many aspects of this review of the literature is imagery: a zone in the mind where waking and dreaming intersect. Several lines of current research (cited in Domhoff, 1999) suggested this intersection may include larger areas of overlap than was previously supposed, demonstrating strong support for the theory that there is continuity between dreaming and waking life concerns. Domhoff cited evidence that "waking cognition is more 'symbolic' in terms of the pervasiveness of metaphoric thinking than previously has been realized…. The overlap between thinking and dreaming may be extensive."

Domhoff (2001) cited a telling instance of parallels between waking thought and dreaming, reporting that in Solms (1997) studies of the dreams of schizophrenic patients who were leucotomized, he found most of them completely lost the ability to dream and there was a corresponding lack of "initiative, curiosity and fantasy in waking life" (p. 4). In the same paper, Domhoff (2001) suggested that the forebrain network that is critical for dreaming may also explain the phenomenon known as lucid dreaming. Lucid dreams are more common during the latter stages of sleep and when dreamers are closer to being awake, what Domhoff suggested is simply "a 'lighter' stage of sleep closer to waking fantasy life" (p. 6). He also referred to people who exhibit more dream-like cognition and experience more vivid imagery while awake, suggesting there is a continuum between sleeping and waking consciousness that is linear, and

not either/or.

In their 2006 study on imagery rehearsal therapy (IRT) Krakow and Zadra included a section on imagery skills, which they described as a behavioral therapy component although it has been used in experiential and other forms of therapy as well. They listed several attributes of imagery including that it is a natural mental activity, that daytime imagery can be a bridge to dreaming, and that it can be used safely and effectively with those with PTSD, who are often "surprised at their healthy capacity to image things" (p. 55). While visualization should not be equated with symbolization, it is a step in that direction.

However, Krakow and Zadra (2006) found that there are some people who have clear deficiencies in their ability to imagine, or who cannot keep distressing images from forming. These patients are directed to practice rehearsing pleasant imagery, and are possibly provided with an individual session focusing on developing some control over their imagery process. Krakow and Zadra suggested that those who experience "constant barrage of nightmares or disturbing waking images (e.g., traumatic memories) could easily… think too much as a natural, self-protective mechanism. This imbalance, however, diminishes or distorts the nightmare patient's natural capacity to work with his or her imagery system" (p. 57). They said it helps to show patients that their imagery system is a normal, useful part of everyday life, used, for example, whenever one thinks about making changes or envisions things they will do in the future. The authors suggested that IRT may revive the capacity for imagery.

Gendlin has written several articles on imagery including a book chapter (1980) that describes how imagery can be much more powerful if one incorporates focusing. Gendlin stated that the body and imagery are "inherently related" but that it is "much more powerful when one not only works with the body and imagery, but devotes specific attention to the formation of the

body's holistic sense of the issue." This is focusing, letting a felt sense form. By paying attention to a felt sense, images form and emerge into consciousness. When imagery comes from a felt sense, and this sense is allowed "to engender a felt shift, that is when working with imagery is most powerful" (p. 73). Gendlin (1980) viewed the body as a complex, living interactional system. This view is grounded in a complex *philosophy of the implicit* (1997); Gendlin's was not the usual concept of the body in its purely physical form. Images, as well, he considered to be alive and symbolic, not flat and one-dimensional. When working with imagery, he advocated "a constant return to the body between each image and the next." In Gendlin's opinion, "real change in people does not come to any great extent from the mere having of images as such. It comes if one works directly with the bodily change that image-formation makes. If this is ignored, the most important effect of imagery is ignored" (internet). Therefore, in designing our method, the focusing-oriented intervention specifically included particular emphasis on the bodily felt change that comes from working with participants' newly-imagined dream images. Using the FOD protocol to experientially change the nature of participants' trauma-replicative nightmares was expected to bring about a shift in participants' dreaming experience, ultimately toward more metaphoric and healing dreams. The literature reviewed above supports the idea that a shift toward more typically imaginative dreaming could potentially lead to a concurrent improvement in PTSD symptoms and an enrichment of the metaphorical thinking function in waking life.

Chapter 3: Research Design and Method

Chapter Overview

This study is a qualitative analysis of five participants' experience of a focusing-oriented dreamwork treatment protocol for PTSD-related nightmares. The data were initially collected for a quantitative study designed by the author to be carried out at the Vancouver Association for the Survivors of Torture (VAST). However, that study was cut short due to a major and unforeseen funding cut at VAST. The initial data collection process included the protocol developed for the treatment of PTSD nightmares. Therefore it is relevant to this qualitative study and will be described in detail below. Most of the original data was in the form of clinical interview sessions that were audio recorded and could be transcribed to allow for a qualitative analysis of the intervention process and dream material. A brief summary of the quantitative results is also included in the results section.

This chapter begins with a brief justification for the use of interpretative phenomenological analysis (IPA), and its philosophical relationship to focusing-oriented therapy. A reflexivity section briefly outlines the biases and experiences the author brings to the analysis. Data collection procedures for the initial study are outlined in detail. There is a section describing participants and sampling which includes justification for the sample size used in the qualitative analysis. Additional sections cover the screening and data collection procedures, measures, dreamwork session protocols and ethical assurances.

The chapter concludes with a detailed description of the analysis process itself. This analysis goes beyond thematic analysis to provide detailed descriptions of convergences and divergences within the data for the main themes. These themes, listed below, cover both dream content transformation, and the process of the study (intervention protocol and study design). A

benefit of the qualitative approach to the data analysis is that it allowed detailed information about the content and process of working with nightmares to be fleshed out in a way that more traditional hypothesis testing would not have. As Willis (2001) stated, "The quest for what one has decided to look for can cloud the researcher's gaze so that significant elements of the human activity that is being researched can be overlooked" (p. 1). Although initially the data was gathered with a specific purpose in mind, much of the detail that would have been lost in the initial quantitative approach was available and included in the phenomenological analysis.

Why IPA?

For the qualitative analysis of the data for this study, interpretative phenomenological analysis (IPA) was chosen as the best fit for examining in detail how participants experienced changes in their nightmares as a result of working experientially with them. IPA is a fairly new but increasingly popular approach to qualitative inquiry for research in psychology and health (Smith, Flowers, & Larkin, 2009). The method focuses on how people make sense of their experiences using a phenomenological approach; by this its authors mean "exploring experience in its own terms" (p. 1). The phenomenological approach also explicitly includes the body. Finlay (2009) wrote that the central concern of phenomenological researchers is "to return to embodied, experiential meanings aiming for a fresh, complex, rich description of a phenomenon as it is concretely lived" (p. 6).

Why use IPA as opposed the more established and somewhat similar method, grounded theory? Both qualitative methods involve developing a map of participants' experience grouped into themes and clusters. However, where they differ, IPA is clearly more aligned with the goals of this study. Grounded theory was developed to allow researchers to identify and understand basic social processes, while IPA was designed to garner insight into an individual's

psychological experience of a specific life situation or event. In addition, following the advice of Willig (2001), one may choose to avoid grounded theory because it is the subject of considerable debate and controversy.

IPA is also more philosophically aligned with the study material than grounded theory or any of the other well-known qualitative approaches. IPA is grounded in phenomenology, and as such, is a good fit for this study because phenomenology is the "primary philosophical home" (Krycka, 2014, p. 57) for the focusing-oriented approach used in the study's main intervention. Participants were invited, in working with their nightmares, to allow the dreams and their responses to them to unfold in the moment, while being encouraged to stay present with their experience. The post-treatment questions flowed naturally from the style of the intervention because they also invited reflection and embodied exploration of experience.

There is another way in which phenomenology is focusing oriented: according to Willig (2001), "It makes no sense to think of the world of objects and subjects as separate from our experience of it… the appearance of an object as a perceptual phenomenon varies depending on the perceiver's location and context, angle of perception, and importantly, the perceiver's mental orientation" (p. 51). This is compatible with Gendlin's (1997) major philosophical work: He argued that all living things as inseparable from their environment, and that interaction is primary. Gendlin (1973) stated that it is impossible to study *pure* experience as Husserl had intended because there is no such thing. "Experience is always organized by the evolutionary history of the body, and also by culture and situations organized partly by language" (p. 292). Gendlin made the point that situations, feelings, and language are already inherent in experience, and the explication of these connections is an additional way of organizing experience. He argued that people do not structure situations with their explication of them, but rather structure

them further (p. 292). How this is done involves several complex steps beyond the scope of this paper, but described in detail in *Experiencing and the Creation of Meaning* (1962).

A final reason for choosing IPA is that it is a new and emerging approach that affords the researcher some flexibility and creativity in its use. According to Smith, Flowers, and Osborne (1997), there is no single, definitively right way to do IPA. The overarching goal is one of understanding, but in two respects: first, to understand by empathically entering into the world-view of participants to get a sense of their lived experience; and second, to understand in terms of trying to make sense of a phenomenon using inquiry and knowledge beyond just what the participants are able to articulate (p. 53). Smith, Flowers, and Osborn suggest that, "IPA is particularly useful when one is concerned with complexity, process or novelty," (p. 55) all of which are present in the data for this study.

Reflexivity

Transcendental phenomenology, as developed by Husserl, suggests that one focus on the world as it presents itself, and return to "the things themselves." In this study, I have adopted the IPA approach because it recognizes both the impossibility of truly setting aside what one already knows about a particular phenomenon and also questions the wisdom of attempting to do so as the researcher's knowledge and experience can add value to the inquiry provided it does not cloud judgment or prevent the researcher from being open to new ideas that emerge from the data. To engage phenomenologically, we cannot simply take for granted our experience of the world, but rather attempt to step outside of our everyday experience so that we can actually observe it and reflect upon it. To *bracket* is "to put to one side the taken-for-granted world in order to concentrate on our perception of that world" (Smith, Flowers, and Larkin, 2013, p. 13).

The developers of IPA ground their approach to analysis in the philosophy of Heidegger, who linked phenomenology with hermeneutics, the theory of interpretation or analysis, and the notion that fore-conception (assumption based on prior experience) is an intrinsic and iterative part of the analysis process. IPA advocates "a more enlivened form of bracketing as both a cyclical process and as something which can only be partially achieved" (Smith, Flowers, & Larkin, p. 25).

According to Willig (2001), IPA is based in part on the recognition that the exploration of research participants' life-worlds "must necessarily implicate the researcher's view of the world" (p. 53). Later, Willig wrote, "The researcher is necessarily implicated in the analysis. As a result the analysis is both *phenomenological* (that is, it aims to represent the participant's view of the world) and *interpretative* (that is, it is includes the researcher's own conceptions and standpoint). IPA requires a *reflexive* attitude from the researcher" (p. 67), in other words an awareness and acknowledgement of inherent biases, as much as this is possible. Her criticism of the method is that it does not actually spell out how the researcher's views are implicated in the analysis.

I will attempt to make my views as transparent as possible, clearing stating the biases I brought into the study, and noting where the data has surprised me, or added something new. My personal, direct experience with nightmares is very limited. I do not experience nightmares. With the exception of a few vaguely recalled nightmares from childhood, I have been fortunate to never have been plagued with terrifying dreams. I have had disturbing dreams, classic anxiety dreams and emotionally powerful dreams, but not nightmares. My interest in the study of nightmares evolved from a confluence of my deep interest in dreams and my work with people who have suffered from severe trauma. In designing the initial study, I had a general desire to work with dreams in a measureable, impactful way, and to develop a treatment protocol to

alleviate the suffering of those who have experienced trauma. Hartmann's (1999) idea that nightmares are the most useful dreams for study struck me as true: In working with deeply frightening, memorable and repetitive nightmares, it is much easier to track changes than in a less dramatic course of treatment and dreams because nightmares are so clearly recalled, and any changes in their nature are both evident and welcome.

As a clinician with 15 years of experience working with trauma and dreams, I have developed and adapted a method of working with dreams that draws from both Jungian and focusing approaches to the dream. In developing the protocol for the initial study, I simplified the approach I have come to trust as a gentle yet highly effective way to work with and transform the nightmares of my clients. In particular, inviting clients with trauma-related nightmares to engage in embodied active imagination to dream their nightmares forward in an experiential way has been particularly effective at shifting recurring dreams into something more like normal dreams. As well, I have noticed that those clients who continued to experience nightmares developed a more open and constructive relationship to them once they had worked with nightmares over time and could see the metaphorical nature of many of their most dramatic dream events. The latter insight and development of metaphorical thinking appears to take place over time, and although it is something I thought study participants might move toward, there is also the recognition that these deeper changes may not come in just the session or two allowed for in the study protocol. Still, I consider the move toward metaphorical dreaming and thinking an important goal in dreamwork. These are the biases, hopes and expectations I brought into the initial study design and subsequent analysis.

Data Collection Method

The data used for the qualitative study were existing data collected originally for a quantitative nightmare treatment study at VAST. It was transcribed (and translated as necessary) for the purposes of the qualitative analysis. The following is a discussion of sample size for the IPA study followed by a detailed description of the data collection process for the original study.

Participants and Sampling

For IPA, small sample sizes are advised and can range from a detailed analysis of a single case to a comparison of convergence and divergence in a small number of cases. Data collection is typically via semi-structured interviews that invite participants to reflect at length on a particular experience. For this study, a two-session treatment was implemented first, and then participants were asked to reflect on their experience.

For an IPA study, typically a small and purposive sample is chosen. Smith suggests there is "no right answer to the question of sample size" (p. 51), but that because IPA is concerned about detail and depth, sample sizes are generally getting smaller. In terms of student research projects, Smith suggested a sample of three for a Masters-level study and four to 10 for a doctoral study. More is not necessarily better. What is more critical is the quality of the data and the analysis. Qualitative research projects seek sample sizes that are large enough to reach a saturation point where themes begin to repeat across samples, and where all essential variations appear to be included. The sample in this study was not large enough to reach the point of saturation; however, it was not possible to add more participants, so this is a limitation in this study.

However, it is possible to glean general information from small samples if they can be shown to represent the norm. Case study research design requires just one participant, and this

single sample can be sufficient if it has the attribute(s) required for inclusion in the class that is the target of the study, and the sample can be shown to exemplify this class. Choosing an exemplar is simple if the class has a single defining feature, but more complicated if defined by many variables, especially if these are continuous. In this study, participants were defined by three continuous variables: frequency of nightmares, degree to which the nightmares replicate trauma incidents, and level of PTSD. Participants were chosen if they reported moderate to high levels in all three categories. At initial screening, members of the sample differed in many respects, but were very similar with respect to all three defining features: nightmare frequency (mean = 5.4 per week, SD = 2.07), the degree to which the dreams replicated trauma, as measured by section one of the dream imagery questionnaire (mean = 32.2, SD = 5.89) and PTSD scores, as measured by the PDS scale (mean = 37.6, SD = 4.72). The variation across participants for all three defining features was low enough that the sample can be considered a multivariate monothetic class representative of those who experience replicative PTSD-related nightmares. The sample had many differences (countries of origin, language, and length of time experiencing nightmares) and other similarities (high depression levels, low income, and refugee status) but these were not directly relevant to the study questions. The gender distribution (four females, one male) was not representative, and may positively skew the results because women tend to benefit more than men from therapy for nightmares (Hansen et al., 2012). Overall, the sample is a small but tidy example of the phenomena in question. The study would have been stronger if more participants and/or more variables were included in the analysis.

Participants of the original study were adults (age 18 years or over) drawn from the clientele of the Vancouver Association for the Survivors of Torture (VAST) and were pre-screened to determine if they met the requirements to participate. To qualify for the study,

participants must have experienced a traumatic event as defined by DSM-IV criteria A for PTSD (the person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others, and their response was one of intense fear, helplessness or horror), but not within the past three months. (According to Davis & Wright, 2007, most of the natural recovery process is likely to happen within a 3-month window.) The second main criterion was that participants suffered from chronic nightmares (at least three per month) that were related to their trauma. Nightmares were defined as dreams that cause significant fear and distress that awakens the dreamer, as at the time this was the generally-accepted defining criteria for nightmares (DSM-IV, 2000).

Exclusion criteria included suicide risk, or severe depression. (However, the study was conducted by VAST under the direction of the clinical director, and she exercised some discretion with respect to the inclusion criteria because so many of the participants had high depression levels.) Also excluded were those participating in psychotherapy directly related to their nightmares or those whose medication regime was not stabilized. In addition, exclusion criteria included those with severe cognitive impairment, current or historic psychotic disorder, a diagnosis of substance abuse or dependence or severe childhood trauma. Participants were not excluded based on gender, race, income, or education level.

Recruitment of participants was conducted through referrals from VAST, as screened by the director of clinical services. To minimize risk to the participants, only those who were already in therapy, or who had participated in therapy for their trauma and had access to a therapist, would be included in the study. In addition, the participants' own therapists at VAST conducted the data collection and intervention. There is some evidence that direct attention to trauma-related nightmares may be most efficacious as an adjunctive treatment after trauma

victims have had some initial therapy (Cook et al., 2010; Lu, M. L., Van Male, L., Whitehead, A., & Boehnlein, J., 2009). VAST therapists were trained to administer the intervention, and the intervention was also manualized (see Appendix H).

Screening and Measures

Screening measures and questionnaires included a brief initial screening (Appendix A), the suicidal behaviors questionnaire (SBQ) and the posttraumatic diagnostic scale (PDS). After the screening process, participants who qualified for the study were given a demographic survey, an adapted trauma related nightmare survey (TRNS-A), a brief questionnaire on dream type and a dream imagery questionnaire (DIQ) developed specifically for this study. Participants were asked to keep a dream log throughout the duration of the study, which covered dream content and frequency of their dreams, although only one participant actually kept a dream log. Safety was monitored using a brief version of the suicidal behaviors questionnaire (SBQ) and direct inquiry into any adverse effects of the previous session at the start of each session. A standardized safety protocol was followed as the need arose, based on the crisis intervention plan already in place at VAST.

The initial study consisted of four individual sessions: an initial screening and data collection session, followed by two intervention sessions with data collection and de-briefing as part of the second intervention and, a follow-up semi-structured interview and data collection at one month post-treatment. Express written permission (or implied permission in the case of purchased instruments) was acquired for all measures.

Suicidal behaviours questionnaire – revised (SBQ-14; Addis & Linehan, 1989). Participants were asked to complete an abbreviated version of the suicidal behaviors questionnaire as those at with current risk of suicide were generally not to be included in the

study. The revised SBQ-14 is a comprehensive self-report assessment of suicide ideation, suicide attempts and suicidal acts without intent to commit suicide. The five SBQ-14 behaviors have internal reliability with coefficients ranging from .73 to .92 (Addis & Linehan, 1989).

Beck depression inventory – II (BDI-II; Beck, Steer, & Garbin; 1988, Beck, Ward, Medelsohn, Mock, & Erbaugh, 1961). BDI-II is a 21-item self-report measure that assesses symptoms and characteristics of depression. Beck, Steer, and Garbin (1988) report internal consistency ranging from .73 to .92 and a split-half reliability coefficient of .93. PTSD is often co-morbid with depression; so the presence of depression was to be expected in the study candidates. In fact, in the DSM-V (APA, 2013), "negative alterations in cognitions and mood" have been added to the diagnostic categories for PTSD.

Demographic survey. A survey was conducted to capture basic demographic data including age, gender, race, occupation, income level, marital status, level of education, and list of current medications.

Dream log. A dream log was administered to assist participants in tracking and recording the occurrence and frequency of nightmares, and the nature of the dream content. As there is often low compliance to keeping dream logs, the questions were brief, simple, and mostly in the form of a checklist. Participants were asked for similar information at weekly sessions (using TRNS and session recordings) to formally record data from the dream log.

Trauma related nightmare survey – adapted (TRNS-A; Davis, Wright, & Borntrager, 2001). The TRNS was used to measure frequency, duration, severity and reaction to trauma nightmares, as well as to track the nature of the nightmares and the degree to which they replicate trauma events. The instrument uses a Likert scale to assess various aspects of nightmare experience including fear of going to sleep, feelings upon waking, hours of sleep, and nightmare

type, frequency and severity. Davis and Wright (2007) report test-retest reliability over a 2-week period for nightmare frequency of $r = .64$, and for nightmare disturbance of $r = .63$. Convergent validity with the modified PTSD symptom scale – self report (MPSS-SR; Resick, Falsetti, Resnick, & Kilpatrick, 1991) for nightmare frequency was $r = .64$ and for nightmare disturbance $r = .45$. (Permission granted to use this instrument.)

Posttraumatic diagnostic scale (PDS; Foa, Cashman, & Kevin, 1997). The PDS provides both a PTSD diagnosis and a measure of symptom severity. Foa and colleagues surveyed 248 participants who had experienced a wide range of trauma events. They demonstrated that PTDS showed good internal consistency for each of the three PTSD symptom clusters with an alpha of .92 for total symptom severity, .78 for re-experiencing, .84 for avoidance and .84 for arousal. Test-retest reliability using 110 participants over a 2- to 3-week interval was .83 for total symptoms, .77 for re-experiencing, .81 for avoidance and .85 for arousal. In terms of convergent validity, they found 82% agreement between PDS and SCID (First et al., 1996) and the sensitivity of PDS was .89, and specificity .75.

Dream imagery questionnaire (DIQ). This questionnaire was designed specifically for this study to capture the degree to which the participants' nightmares literally replicate the original trauma event, or other life events. It was also designed to capture the degree to which the dreams or elements of the dreams are symbolic representations of the trauma and/or life events as well as the degree to which considering the dream metaphorically leads to new insight or understanding. This questionnaire had not been used before and proved to be too challenging for many of the participants.

The CAS checklist (Grindler Katonah, D., & Flaxman, J., 2003). The CAS checklist was used to assess the level of engagement with the clearing a space part of the protocol, which also

provided an indication of experiencing process in the overall session. This scale also measured whether or not the subject experienced a felt shift, which is a goal of focusing-oriented interventions. In a study with breast cancer patients (Klagsbrun et al., 2005), it was found to correlate significantly (0.7) with the experiencing scale. In its initial use with 18 cancer patients, reliability was .84.

Data Collection Procedures

Clinician-administered. Qualified clinicians employed at VAST administered the data collection, intervention and semi-structured interviews. The clinicians had experience working with trauma, with translators, and with multi-cultural clientele. They had access to two supervision sessions per week, and were also able to consult with the staff physician who specialized in mental health and immigrant populations. In addition, they have all received, at minimum, basic training in focusing-oriented therapy and specific training in how to conduct the data collection and FOD intervention itself. Where possible, the therapist guided each assigned participant through all stages of the data collection, intervention and interview process to maintain a sense of safety and continuity for participants. In the last two cases, the clinical director completed the final stages of data collection. The two intervention sessions were recorded to ensure the protocols were followed as prescribed, and also to record the dream and session content for qualitative analysis.

Session Protocols

The study was comprised of four sessions, with the assistance of a translator if needed. Sessions one and four were mainly for collection of pre- and post-intervention data and participants' reflections on the experience of working with their nightmares, while sessions two and three were for the intervention.

Initial data collection session. Informed consent and administration of the measures was carried out as described. Participants were informed about the dream log structure and were asked to track their dreams as of this date.

The dream logs were to be used as a tool for the dreamers to track their dream content, type and frequency, but they were not intended to be part of the data collection process. This is because dream logs are rarely reliably kept by all participants, but without them, dream frequency is often underestimated and dreams are more likely to be forgotten. In fact, only one participant kept a dream log.

Intervention session one. The session began with a brief assessment of risk, and a structured set of questions about dream frequency and impact. This session included orientation and establishment of a sense of safety in the client by directly addressing any questions or concerns they had, by suggesting they do what they need to do to be physically comfortable, and by beginning gently. When the client was ready to start, they were led through a brief version of the first step of focusing, clearing a space, aimed at enabling the participant to create an inner resource, an internal sense of distance between themselves and their trauma. They were encouraged to stay with this focusing approach, attending to the felt sense of the cleared space as a resource, as needed as they recounted their nightmare.

Participants were asked to tell their recurrent dream in detail, and were encouraged to also describe any concurrent physical sensations and/or the general felt sense the dream brought. If needed, instructions to help guide the person to finding a felt sense were offered, although often dreams bring a felt sense with them. Care was taken to modulate the level of activation so the sessions were not re-traumatizing to the client. For example, clients were asked to slow down, contact the inner resources established early in the session, and attend to physical

sensations. The re-telling of the nightmare brought some exposure to the original trauma. A controlled, manageable level of arousal while experiencing some aspects of the original trauma afforded some protection to participants from traumatic re-experiencing. Gendlin also suggests finding help in the dream, which may be challenging with the material in repetitive trauma dreams, but if any aspect of the dream brought a positive felt sense, therapists were encouraged to reinforce this as to do so could bring an expanded sense of how the dream might continue (Gendlin, 2012a). Specific instructions were provided to therapists on ways to find help in a dream if it is not easy to find. Gendlin (2012b) suggests one can even ask for the positive valence directly and that finding the help is a necessary step to accessing the dream's "hidden life-energy."

The crux of the session comes after telling the dream when the client is asked the focusing-oriented dream question: Can the dream continue? (Gendlin, 1986). The clients were encouraged to allow their bodily felt sense of what was the right next step guide the dream forward. The dreamer was encouraged to continue dreaming, but with the active participation of their body's inherent tendency to move in a life-forward direction. According to Gendlin (1996), "These dream-continuations can come from sensing in the body. *Let it well up* from attending *in the body*; don't invent it" (p. 181). As the dream was allowed to continue into new content and toward resolution, the dreamer was encouraged to attend to their inner felt sense of the dream, and the shift in the felt sense as they experienced the new dream content. They were encouraged to mark and receive the felt shift, and to say whatever came to them in relation to this new felt sense. Unlike IRT, they did not then need to rehearse and repeat the new dream ending. Instead, participants were encouraged to mark the new felt sense, and to internally ask themselves how they might be able to anchor this feeling and keep the new felt sense with them.

Intervention session two. The session began with a brief assessment of risk, inquiry about any adverse effects, and a structured set of questions about their dreaming (TRNS). Participants were guided through a brief version of clearing a space and then the dreamer was asked to recount their dream again using the same safety precautions as in session one. The ensuing steps depended on what type of dream the participant brought. If there was no change, the basic steps of session one were repeated. If there had been any change at all in the content or felt sense of the recurrent nightmare no matter how small, particular attention was paid to what had changed. To assess whether the felt sense of the nightmare had changed, participants were asked directly whether their response to the nightmare had shifted, for example, whether it had engendered the same level of distress. The participant was asked to spend time with the new content, to see if they could get a felt sense of the change, and then to follow this felt sense in a client-centered, focusing-oriented way. If the nightmare had stopped altogether, the client was given the option to work with another dream, and to choose the most representative and impactful dream if they had several to choose from. If they had no other dreams, or none they could remember, then this significant change was discussed, as was the question of how this change might also have manifested in the client's relationship to the trauma incident.

Follow-up session. The participants attended a follow-up data collection session one month after the previous session. At the follow-up session, they were again assessed for PTSD and depression levels, and completed the trauma-related nightmare survey a final time. The clinician administering these tests determined if they required any follow-up care. They were asked specifically if they had experienced any adverse effects as a result of their participation in the study.

Ethical Assurances

Confidentiality

Identifying data such as name, address and contact information were gathered initially by VAST, but kept separately and not included in the study data itself. Each case was assigned a code number and for this dissertation, participants were given a pseudonym. Only the principal researcher at VAST and the therapists working directly with the participants had access to identifying information. Data were stored electronically in a secure location. At VAST, therapists and translators were all required to sign confidentiality agreements, and these agreements covered all of the activities in the study, which took place solely at VAST.

Ethical Protection of Participants

The Chicago School of Professional Psychology Institutional Review Board gave this study exempt status as the use of the original data posed minimal additional risk to participants. The Vancouver Association for the Survivors of Torture provided permission for the use of the data from the initial study. The VAST board conducted a review process and deemed their study proposed no greater risk to participants than the normal activities at VAST. As a trauma counseling clinic, VAST has formal measures in place to protect the mental health and well-being of their clientele including assessment and medical services, risk management and emergency response protocols. The participants were ongoing clients of VAST. They were provided with a written informed consent process outlining the risks and benefits of participation in the study (see Appendix A), as well as the understanding their participation was voluntary, and that they were free to leave the study at any time with no repercussions. They were also informed of and provided a consent process for the change in how the data they initially provided would be used and analyzed.

Risk/benefit analysis

Any work with trauma-related material involves some risk. Steps taken to ensure the risk was minimized included: the use of a protocol with well-established practices for working safely with trauma material, careful screening and ongoing monitoring of participants, adequate follow-up and a safety plan which included counseling support. Participants were recruited from VAST, ensuring they already had access to known and trusted sources of professional support that is ongoing throughout the study.

Potential risks. One risk identified was that the assessment process included questions about trauma history that participants might find distressing. In addition, the therapy sessions themselves might cause anxiety or escalate PTSD symptoms. However, these effects are usually brief and often ultimately beneficial. Controlled, manageable exposure to trauma has been shown to improve resilience and ultimately reduce anxiety and trauma symptoms.

Potential benefits. Treatments using imagery rehearsal are considered best practice by the American Academy of Sleep Medicine for therapy-based treatment of trauma-related nightmares. Imagery rehearsal methods have been found to reduce nightmares, improve sleep quality and reduce overall PTSD symptoms. Other potential benefits to participants of the particular version of imagery rehearsal used in this study (FOD) included an improved understanding and relationship to their dreams and a positive shift in the nature of their dreams.

Treatment was provided free of charge and was based on a protocol with core elements similar to IRT, which has been recommended by several recent studies as an effective adjunctive therapy for PTSD. In some ways, FOD may be an improvement on IRT. For example, it was delivered in an individual rather than group format; research has shown that individual therapy is more effective than group therapy for treatment of nightmares (Spoormaker, & van den Bout,

2006). The results of this study will add to the knowledge base of treatment for PTSD and related nightmares.

Qualitative Analysis

The interpretative phenomenological analysis was focused broadly on transformation, and specifically on the changes in the dreams from the initial recurrent trauma dream to the next dream participants brought to the session following the initial intervention. The transformations between dream one and dream two were examined within and across participants, and as they related to the new dream endings participants imagined, experiential depth, and signs of change in PTSD symptoms.

Although there were some individual variations, for each participant there were data captured about: their PTSD symptoms before and after the intervention using the Foa et al., posttraumatic stress diagnostic scale (PDS); basic history and demographic information; information specific to their nightmares using the trauma related nightmare survey (TRNS), such as impacts prior to sleep and upon waking; and their assessment of the degree to which these nightmares replicate their original trauma using the dream imagery questionnaire and TRNS. All of this information was considered in light of the changes in the dreams themselves to explore whether changes across dreams coincided with changes in the participants' ability to manage their nightmares and their levels of PTSD in general.

Each participant had two intervention sessions in which they recounted their most typical nightmare. Then they were asked to imagine a new dream ending for this dream. (Some required only one intervention session because after the first intervention, their dreams changed from nightmares to normal dreams or they stopped remembering their dreams.) In the final exit interview, participants were also asked to recount a typical dream and provide their assessment

of the entire process and its impact on their dreaming. (However, some participants did not remember or recount a final dream, and some did not complete the final session due to the closure of VAST so there was not always a third dream to include in the analysis.)

There were several ways in which transformations were tracked: first, within the post-intervention dreams themselves, and across the dreams of each participant. One area of particular interest was the nature of the new dream endings that the participants imagined, and the level of imagination and experiential depth they were able to achieve. The Hendricks' (1986) simplified experiencing scale was used to gauge experiential depth, providing a rating of high, medium or low for the new dream endings. Part of the inquiry was directed at how dream transformations might relate to the experiential depth and types of changes participants invented as new dream endings.

To answer the latter question, observed changes in the dream material were focused on the themes that came up most often in the initial thematic analysis of the dream transcripts. Themes or content areas that transformed most often included: the dream villain: known/unknown, weapons; dream settings (both time and place): trauma scene vs. safe place or home; and the actions of the dreamer: asking for/receiving help, finding a voice, standing and fighting vs. flight or freeze response, and level of fear.

The detailed data analysis focused on transformations *across* dreams in order and *within* the dreams recorded after the first intervention session, noting any progression from replicative, concrete material from the trauma events toward dreams with more diverse elements from the dreamer's life, and more dream-like, symbolic or surreal elements. Once the transformations were identified within each participant's dream series, convergences across participants were

examined systematically, and attention was focused on the data where the experience was common to the greatest number of participants.

The goal with respect to the intervention was to facilitate change in the dreaming experience of those who frequently experienced concrete, frequent, repetitive trauma nightmares. For the participants, who complained that they always dreamt the same dreams and that nightmares were their most troublesome PTSD symptom, almost any kind of change might be considered welcome. Symptoms of PTSD and nightmare frequency and distress were tracked as these are concrete indications of change. However, changes within the dreams themselves and the nature of dreaming is related to clinical change and is not as well understood, so attention to the details of the changes in the dreams themselves was an important part of the analysis.

If dream researchers and clinicians begin to understand the most common pathways from nightmares to healthy dreaming, they could use this information to facilitate more effective dream therapy with nightmares, and/or use nightmare change characteristics to track clinical progress. For this particular study, one of the goals was to begin to identify patterns of transformation within the nightmares of those with severe PTSD. This information could be used to pinpoint areas that might be fruitful to ask about when trauma survivors recount their nightmares in a therapy setting, and also to direct further study.

Thematic Analysis

Initial analysis of the transcripts produced the following themes. They were grouped into two broad categories: themes with respect to the process of the therapy and the study, and themes related to the dreams themselves. The following table lists the themes and subcategories that initially emerged for each main theme.

Table 1.

Table of themes from initial thematic analysis of transcripts

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1. Analysis of Process

1.1 FOD protocol
- 1.1.1 Clearing a space
- 1.1.2 Finding help in the dream
- 1.1.3 Dreaming the dream on
- 1.1.4 Experiencing levels

1.2 Elements of the study
- 1.2.1 Data collection
- 1.2.2 Instruments
- 1.2.3 Screening
- 1.2.4 Participant factors

1.3 Participant themes
- 1.3.1 PTSD symptom relief
- 1.3.2 Changes and perception of changes in sleep and dream experience
- 1.3.3 Benefits identified by participants:
  - 1.3.3.1 Restoration of identity
  - 1.3.3.2 Self-regulation and control
  - 1.3.3.3 Bodily felt shifts
- 1.3.4 Adverse reactions: Remembering vs. forgetting

2. Transformational dream elements

2.1 Villain or Attacker
- 2.1.1 Shifting identity/level of threat
- 2.1.2 Use of weapons

2.2 Actions of the dream ego
- 2.2.1 Finding a voice
- 2.2.2 Help: giving/asking for/receiving
- 2.2.3 Standing up for self

2.3 Setting: Time and place
- 2.3.1 Known/Unknown
- 2.3.2 Movement from danger to safety/home
- 2.3.3 Movement from past to present

The two groups of data were analyzed differently. Observations and issues with respect to the process of the study and the focusing-oriented dreamwork process were presented in a descriptive manner, followed by a discussion of relevance to changes in the protocol or future research design. The transformational dream elements were analyzed using IPA as described

above. Out of this, two main categories of experience emerged and the differentiating factors were summarized.

Chapter 4: Results

Chapter Overview

This chapter begins with a summary of the data from each of the five participants followed by a two-part qualitative analysis of the transformation of the nightmares of participants. First, changes within and across the dreams of individual participants are itemized briefly. Second, transformations of dream content across participants are examined in detail using the main themes identified in the initial thematic analysis. There is a detailed examination of the dreams themselves, and the ways they responded to the intervention, with a focus on specific details and unique or noteworthy aspects of individual experience. A discussion section includes a summary of dream transformation findings and implications and compares these to Germain's (2004) categories of mastery. Relevant quantitative data collected as part of the initial study, and additional outcomes from the initial grouping of themes round out the analysis. This section concludes with a discussion of additional themes, adverse reactions, remembering versus forgetting trauma, and a brief chapter summary.

Findings

Participant Summaries

The following summaries begin with a brief description of the participants' stories and a summary of relevant quantitative data. The FOD sessions and the dreams are presented in more detail, as well as initial analysis of each case study.

Participant 1: Flora. Flora is a 44-year-old Congolese woman who moved to Canada in 2008 and has been granted refugee status. Her trauma experiences in her native Congo included political persecution and torture (rape, illegal apprehension). Her most recent trauma was within the past year, though more than three months prior to participating in the study. She had been in

an abusive relationship, and had left her partner. She was pregnant at the time of the study, and recently had a baby. For the study, we did not collect details of participants' lives, and, for privacy purposes, this brief sketch is all we will say about her life.

The following data were collected from four sessions: initial data collection and screening, two sessions of dreamwork and a final data collection and exit interview. The quantitative data are summarized later in this chapter, and will be referred to here only if worthy of note.

Flora had been experiencing nightmares for three years, one to three times per week on average, and she found these nightmares to be extremely disturbing. In fact, they were her main reason for contacting VAST. Her nightmares were always the same, always about someone trying to kill her, and always replicative of her trauma. It would take her up to an hour to fall back asleep after a nightmare, and she would often pray as a way to help soothe herself.

In the first intervention session, she brought a typical nightmare, which was reconstructed here using the therapist's detailed notes: *She is being chased by people who want to kill her, and they fire a gun. The setting is her step-brother's family house (her father had two wives). In the dream one of the men is saying, "I had to kill her because she knows it all and she will try to kill us. She is threatening to us." In fact, Flora is frozen in the dream, she does not know anything and can't find the voice to tell them this.* This dream is very much a replica of her trauma. She was chased by men who wanted to kill her because of the political work done by her father and their fear that she had incriminating information about them.

She completed a dream imagery questionnaire that asked about how closely her nightmares replicated her trauma. She said the setting, her actions and her feelings were exactly

or almost exactly like the traumatic event, but that the other characters and their actions only partly replicated the event.

In dreaming the dream onward, Flora was able to engage deeply in this process in an authentic, experiential way. In this new imagined version of her nightmare, she stood up, defended herself and found her voice. She was able to answer back to her attackers, and she felt empowered by this. The therapist rated her level of experiencing in this phase as very high.

The dream Flora brought a week later was quite different in character from her usual dreams. *In the dream, she was in her bedroom, cleaning something. She saw a cat with some white markings, mostly black. It was a female, a kitten and too small. She was curious about it. To her surprise, the cat began to speak. It said, "Do not chase me, I want to help you." Flora responded, "How can a cat help me?" The cat started to fall and she started chasing it, saying, "I do not need your help." She used a broomstick to shoo the cat away, but it did not want to leave. With the broomstick she had somehow broken the cat badly, the contents of its head were coming out. Finally it left the room and she saw it was not going to stop her. She wanted to go 'far away' and at this point, she saw the cat turning into a woman she worked with. She followed her to a cemetery. Flora was afraid and started to pray.*

In dreaming this dream on, *she started at the end of the dream. She was afraid and was praying. She felt like she needed to go home and asked her best friend to come help her. She started to move, to crawl like a baby, and then she was able at first to stand, then to run, and she made it home.* At first she was afraid, when she took time to sit and think, she began to calm down. At the end of this sequence she said she was "not afraid inside" but calm. Again her level of engagement with focusing was high.

Although there was a plan to follow up with participants after a month, there was no follow-up session with Flora for four months because in the interim, she had a baby. In this time period, her nightmares essentially stopped. Her score on the PDS scale dropped significantly, changing from severe to moderate PTSD. She did have three or four nightmares when the baby was one month old, and possibly this was a stress-related response (Zadra, 1996). Other than that, she had no nightmares at all. She had been aware of dreaming, but was not able to recall her dreams. One might expect she would be excited by these positive changes, but she was more pragmatic about it. She spoke about missing her dreams, despite the fact that for three years they had been extremely disturbing.

In her final session, Flora did report a dream, one of the ones she had during the brief period when her nightmares returned. Even though these were similar trauma nightmares, they were not quite the same as before. From the transcript:

We were somewhere where there were many trees. It looked like I went with children to play and then a group of men was there. They were chasing me trying to kill me. And I saw another man who saved me say, I'm taking your kids so go to that house and go hide yourself with your kids. But I couldn't remember who were those men.

In the final interview, Flora reported that she no longer had nightmares, and in fact, could not remember her dreams at all. She spoke about feeling disturbed by the brief period when her nightmares returned, and speculated that her fear memories had returned. She did, however, recognize that the dreams had changed in one key respect: "The fact of being saved. The fact of having someone stand there and say, go hide yourself and your children. I think it's safe."

Flora also spoke about how her confidence had returned as a result of the work with her nightmares. "I revived my confidence. I see that this is me, I am here in Canada, I am not there

anymore. I am here and healthy. I am here to find a new life. That's really positive. And I wasn't, like if I have a nightmare I would wake up and be jumpy. You taught me, even if I have a nightmare, if I am awake in the nightmare, you taught me what to do... this is very positive."

Flora spoke about feeling empowered, better able to make decisions without fear. "I know what I want, I know what I don't want. If I can't stand it, I have a voice to say no, I don't like it. Before I was like being frightened, like no, I am not going to say anything. I am not like that anymore. Now I have a voice. I can say yes or I can say no." The therapist related this back to her dreamwork, to the way she stood up to her attackers when she was dreaming the dream on, and found her voice.

When asked about the best and worst parts of the treatment, Flora said it was difficult to work with the memories of her trauma. At first, it disrupted her sleep and she said it was "like I'm reliving again those things. Flora said the best part was that ultimately the work helped restore her identity. "That's the best part of it. It gave me again my... I found my real identity. The one that I had before experiencing these trauma. I found my real identity."

Analysis. The most striking thing about this case is the (almost) complete cessation of nightmares after the brief treatment. Something was clearly working, but what? The re-telling of the nightmare was activating and provided some exposure to the trauma, but at a moderate level, so exposure might be part of the mechanism of action. Also, Flora was successful at engaging in the process, and re-entering the dream. She was empowered by the new dream she created, and spoke of having choice, finding her voice. It was moving for her to take a stand against her attackers in an imaginal way. In the dream itself, this appeared to be effective at saving her from further abuse. Imagining that she found her voice, and returned to safety seemed to have brought

help into her subsequent dreams, as though her new dream ending was incorporated into her subsequent dream life.

Did her dreams become more symbolic? She did not really think so, but she dreamt of a cat changing into a woman, a cat that came to help. This was very different from her recurring nightmare of being chased by a man who wanted to kill her. Her relationship to her dreams had transformed. In her closing session she said she "very much" enjoyed her dreams and missed them. She was disturbed that she could not remember them better. Yet her answers to the TRNS clearly indicated her dreams were unwelcome. Initially, she rated her nightmares as extremely disturbing, and was very much afraid to go to sleep. Somehow, over the course of the study, she had forgotten how bad her dreams generally were, and wished some form of dreaming would come back. There was dramatic change, yet a low level of recognition of this.

In the final session, she was very tired, and the therapist was not able to complete all the elements. She noted that the client was usually much more talkative – so the comments may not be reflective of her usual mood. She was getting very little sleep at that point because of the baby.

The biggest change, in addition to her nightmares stopping, was reflected in her PDS score. She was optimistic about her future, endorsed fewer symptoms, and had reduced symptom intensity across all three clusters. The therapist noted that this client in particular was very much able to engage in the clearing a space and dreamwork process.

The case raises the question about whether it is the ability to engage imaginally that enables change. Does the degree of change depend on the degree of engagement in the experiential nature of the protocol as designed? This client was a natural focuser, so was able to use the dreamwork protocol as intended. It is possible the change in her PTSD diagnosis could

have been the result of life changes or therapy, but the timing would suggest that FOD was the catalyst because the therapy had been ongoing with minimal change until immediately after the intervention.

Participant 2: Jose. Jose was a 25-year-old man originally from Ecuador who moved to Canada and applied for refugee status because he was being persecuted for his sexual orientation in his native country. During the study, his citizenship application was still in process and a significant source of stress. He was educated (BA degree) and spoke both Spanish and English. At intake, he reported having nightmares every other day for the past 1.5 years. These were recurring nightmares related to his trauma.

At intake, his depression score was high, as was his score on the suicidal behaviors questionnaire, so he was monitored carefully for suicide risk. Over the course of his participation in the study, his suicide risk and his PTSD both decreased. His trauma-related nightmare symptoms changed a little over the first measurement period. He reported taking less time to fall asleep but he also reported slightly more frequent nightmares that he found moderately disturbing. At the exit interview three weeks later, he reported no nightmares and said he did not find his dreams from the past week at all disturbing.

Jose was the only participant to keep a dream log, and he found the process initially challenging but ultimately helpful. He completed the first intervention session, and then did not return to the study for two weeks, in part because he was very busy, and in part because he initially found working with his nightmares to be challenging. He said he returned to the study because he noticed that his dreams were changing.

In his dream log, he said, “Writing my dreams down has helped me out. I realized many of my current insecurities, fears and frustrations.” A brief sample of the dreams from Jose’s dream log (see Appendix G) provides a sense of his dream life prior to the intervention.

The following is a transcript of the initial dreams Jose brought to the FOD sessions, including the new dream ending.

One of the most recurring dreams that I have is that I see myself laying on my bed and after a while I see myself going out. Suddenly I feel like I’m being dragged, I’m being pulled out from my bed by my leg. And then I go to a place where there is despair and sadness. I realize that it’s a dream inside a nightmare, I realize it’s not real but I start panicking. I see demons around me and in the middle of the dream, Satan is in front of me and he shows me men, different men that I will be with during my life. All men are naked, people from different skins, different backgrounds. But the last one is a blue-eyed one. From that dream comes to a second dream. These two dreams are recurring dreams that usually come together.

In the second dream I am in an unknown city. Everything is dark. I’m escaping from some people, but I don’t know who they are. What I know in the dream is that I am escaping. Then it comes a building in front of me while I’m running and I get into the basement. And that is when I see that I cannot escape and I open sort of a closet or small room down in the basement and I lock me up. Then it’s all dark again and I feel someone raping me. I hear the voice of my dad sometimes, sometimes it’s the voice of my brother. But for sure it’s a male figure. I know that they are recurring dreams because they always come. And that’s the end. I woke up, my heart starts beating fast.

New dream ending: *Since the beginning what I see my body laying on my bed, instead of someone dragging me out down, I would like actually to fly away, to look over the cities, fly over*

the oceans, the mountains. Probably being on a sand beach where I can relax. Sometimes I dream that too, the dream continues in that way. I would like instead of being in a city, when is the next part, when I'm in a city, I would like the scenario to change to being on a beach, and I am riding a bicycle. And instead of going into a building escaping from someone, I would like to go back to my bed and wake up. And when I wake up I would like to feel rested, energized, and happy.

The work with the dreams in the sessions themselves was not recorded, just the dreams and the new dream ending. For the second intervention session, Jose told a dream that began in the same way as one of his main recurring nightmares, but within the dream itself, the ending was transformed:

This dream is actually a recurring dream I have been having. However, in the last two weeks, has had some change. It's again me in an unknown city and for some reason I feel horror and sorrow in my heart like someone is following me and I need to escape. So I try to find a place where I can be safe so I start running as usual, however instead of going into a door and going downstairs into a basement and locking me up, it happened that actually I was with a guy that I'm dating right now. A key change. I was with a guy that I'm dating right now, and I was selling clothes, like my ordinary work, one of my work. He was passing me some clothes to sell, some garments, don't remember. I was selling them and I was making fun of the outfit. And we were start laughing and then I woke up, and instead of being awake and feeling desperate, this time I'm feeling happy when I woke up.

In his final session, Jose described a typical dream that he had been having, and was apologetic that it was not a nightmare. The following is a transcript from that interview:

Well it is pretty simple. Like it starts in I think it's Vancouver, somewhere, I don't know where it is. I'm walking with (my partner) and we are talking. It looks like a park. And then we go to his house, or apartment and then finally I have sex with him because until now he was not having sex.

When asked for other relevant details, Jose said, "Comfort is really relevant. I found pleasure in the dream, and I woke up very happy about it." He noted that the dream setting had shifted from reality. "The room is different. The room is not like his room. The room is a white bedroom and the blankets are white. And it's a wooden bed. Pretty cute, the whole scene. I'm completely naked. Yes, it an amazing dream."

Jose said the hardest thing about working with his nightmares was not the content but the emotions that the dreams brought up. "It's a vivid way to experience again those events." However, it did enable him to exercise conscious control over the material, "to understand that it is something that's disturbing me, but it's not something that can define me at the end."

Jose found the creation of a new dream ending to be one of the most helpful aspects of the process because he said after doing this, he would remember the new dream ending more vividly than the dream itself. "It gave me like mind-peace at the end."

At the end of the study, Jose felt that he had greater control over his own dreaming process, and over how his nightmares affected him: "I feel like I can have more control probably in how much they can hurt me. So if I can feel like how much they can have power on my feelings like trying to feel like, trying to realize it's just a dream or maybe try to find a new resources, like the felt sense, or trying to not make the dreams define me or have some certain control on me."

Paying attention to the dream material and the increased awareness this brought was one of the major benefits of the therapy sessions for Jose: “I become aware of what I’m dreaming. Before it was like, yes I have nightmares. The problem is there, but I don’t know what to do. Right now I’m more aware of what I’m dreaming. I’m more aware of what I should do, like relax and try to find like the question in me, like why I’m dreaming this, and like what I should be doing not to dream that. And try to imagine I’m find a new ending at the end of the dream like so I can be less stressful… it’s like a resource. I find it helpful because I realize I can have control on the dream, not the dream on me.”

As Jose felt more in control of how his dreams impacted him, and because he had new tools to work with his nightmares when they happened, he had less fear going to sleep and less fear when the nightmares occurred. As a result, he was more likely to confront his nightmares rather than avoiding the trauma material they brought:

“Eventually they have decreased the anxiety of going to sleep. Probably I’m kind of anxious… when I’m going to sleep. But if by chance I have a bad dream or a nightmare I feel I’m more conscious after I woke up, let’s saying like okay, what is this about, why am I dreaming this? I’m questioning more. I’m trying not be reluctant or refuse to analyzing the nightmare or just getting scared paralyzed. Rather than that I try to say to myself, let’s see, why should I have these? Or sometimes I even wake and try to get up like some tea and try to relax and say like, why am I having this kind of dreams? So trying to reason and then to analyze it more. In that way that’s changed. Like I’m not that fearful to have the dream itself or to have the nightmare. But I find like I’m more… since I wrote them down I think that it’s a way for me to fight against them. So it’s not only I know they are there, but I’m doing something to decrease them or to have more control over them. That is the way they have changed.”

Because this client was being monitored for suicide risk and was an ongoing VAST client, one more follow-up was conducted. In the interview, Jose described how he was able to reduce his use of sleeping medication. He reflected back on how his nightmares used to cause him to 'explode' awake at about 2:30 am and it would take him up to an hour to fall asleep again. Several times a week, he would wake up in a sweat, with his heart pounding. In the month prior to this final interview, Jose could recall only one nightmare that produced these symptoms, and he could identify the trigger. He was now living with his partner, who was a great comfort to him, and the nightmare occurred on the last night before his partner had to go away on a trip:

"That was the only one really bad one I had. I've had others, but I've tried to think them through a little bit more and they're not related to the trauma, but that one was sort of… was ugly because it was a man coming into the room… I didn't see a face or anything, it was as if he was totally black… and so he came in and it was as if he wanted to take us both so that… I sort of opened my eyes and it's like I see this figure, this entity, there, beside the bed, and that was when I screamed."

At first when he woke up, Jose was confused about whether or not the dream was real because this dream was set in his then-current bedroom, while previously, his nightmares were set in their original location, back in Ecuador. Jose said, "That was the difference, because before, my dreams were always outside, they were always like… in the street, and I'd go into a place, and things would happen in that place. And this time instead, it was sort of… like in my place, in my apartment… A man comes through the door, he's there and it's as if he wants to take us."

To help himself go back to sleep, Jose said he now always imagines a new dream ending, and he described this to the therapist. After having this dream, he imagined the man leaving the

room without hurting anyone and he was able to calm down and go back to sleep. Jose said he used to rely on sleeping pills to get back to sleep after nightmares and now rarely needed sleep medication. He talked about how well he was sleeping, often seven to eight hours without interruption, which he called an "achievement" for him.

Later in the conversation, Jose recounted a dream from that morning:

"*It was about some birds that were flying… and at one point one bird joins the other and the other one falls and dies. And I am passing under them so I get up… I'm below the flying birds and I see that one falls to the ground and he's dead. And it wants… and then comes another bird, it wants to pick him up and take him, the dead body of this other bird. And I am passing by there, and so I wake up*… and it disturbs me. Why am I seeing these things so like death? …a dead bird, what does it have to do? But dreams like these, yes, I've had them but… they're not in the category of the trauma, in the category where someone comes and tries to hurt me."

The therapist suggested this dream might be more metaphoric, not as replicative as his former typical trauma dreams. Jose spoke instead about his emotional reaction to this kind of dream. He found it disturbing, but not terrifying. He said it did not alienate him the way the other dreams had. Jose went on to explain how he could manage his suicidal thoughts in the same way they he had learned to control the thoughts and feelings that arose from his nightmares. He was able to calm himself and find something else to do. At the time of the interview he was awaiting his immigration hearing and was managing the stress of this in the same way. Jose heard back from the immigration committee after he had completed his part in the study and sadly, his claim was not accepted.

Analysis. Like Flora, Jose found the process of working with his nightmares difficult at first, but he continued with the process because he could see the changes in his dreams. Jose was

primarily concerned with the emotional impact of his dreams, and drew a clear distinction between the terror of the recurrent nightmares, and the mildly disturbing dream of the birds.

The FOD protocol was something Jose incorporated into his way of managing his nightmares, and this was empowering for him. He described feeling much greater awareness and control, and as a result, less fear going to sleep, less fear of the dreams themselves, and a greater ability to settle after having a nightmare. There was greater ability to differentiate between the trauma event and his current situation, and as a result, less of a sense of re-experiencing the trauma.

Those who suffer from recurrent PTSD nightmares seem to be caught in a vicious cycle of fear. They remain in a hyper-aroused state even as they are sleeping (Germain, 2014) and their dreams appear to reflect this state. For Jose, the FOD process appeared to have interrupted this cycle. As he was able to feel more aware of his nightmares as dreams and not reality, and to effectively calm himself when he did wake up from a nightmare, he became less afraid to fall asleep, and the reduction of fear appeared to carry over into the emotional tenor of the dreams themselves. Their content became less disturbing, their impact less distressful. It is also important to note here that Jose's nightmare frequency appeared to vary throughout the duration of the study, at times increasing during stressful life events.

Participant 3: Mitra. The data for Mitra was collected over a 7-month period, reflecting the fragmented nature of the sessions and her life. She was physically disabled from the extreme beatings she suffered, and often sick and tired in her adult life. Her brother beat her regularly when she was a child, nearly killing her more than once. Her mother was present during these assaults, but never intervened on her behalf. She left home to marry at age 17 thinking this would

be an escape, but her marriage was also abusive. She recently (within the last two years) left her husband and escaped to Canada, claiming refugee status.

Mitra was born in Iran in 1984. She divorced her first husband and was recently engaged to be re-married. She has a Masters degree (physiotherapy/computer science) and speaks Farsi. At the initial screening, she reported having repetitive nightmares almost every time she slept for the past eight years. She had been diagnosed with PTSD, and while electroshock therapy was prescribed, it was not done. She received a minimal amount of therapy from a neurologist in Iran, and had been in therapy for several months at VAST. Her most recent trauma was being choked about two years prior.

Mitra entered the study and began with sessions in October 2013, but found the process, especially the questionnaires, very taxing. She decided to leave the study in the beginning, but returned to the study after a few weeks because the process kindled an interest in her dreams, and she noticed they were beginning to change. She completed the study process in May 2014. She usually took two sessions to complete the material designed to fit into one session. Both her fatigue and the use of a translator slowed the process considerably.

The dreams she worked with in detail were recounted in this order:

1. Brother with bulldozer destroying the ruined houses.
2. In her own bedroom, attacked by Taliban men; Imam Ali in the ending.
3. A messy place, from which she escapes by bus with her sister.

Mitra had high scores at intake on measures of depression, suicide risk and PTSD. For the PDS scale, she indicated experiencing every kind of trauma listed except for natural disaster. The ongoing assaults by her brother were the experiences that continued to bother her the most. Notable from the final trauma-related nightmare survey was that she took less than an hour to fall

asleep where she used to take four hours, and she was no longer at all fearful to fall asleep. Her PTSD diagnosis changed from severe to moderate.

Mitra reported several dreams during the course of the study. The dreams included here and for analysis are the ones that were recorded in detail and worked through using the FOD protocol. The following is the first of these dreams:

She is at her mother's, and there has been an earthquake. All the houses are in ruins and she is alone. Her brother (who is 17, the age he was when he beat her) is driving a bulldozer, helping the government demolish the houses. She has an empty thermos, is trying to find water. She takes her sister to safer, higher cement houses, and then goes back to try to find her mother. She knows her mother is upset, but can't find her. She falls down and then she wakes up.

In her imagined new dream ending she is looking for her mother, who comes up to Mitra by herself and holds Mitra's hand. She is dusty and muddy. Her mother is eating, happy and Mitra doesn't know why. She continues to look for water. First she sees water at the construction site (no longer a destruction site) *but it is not drinkable. Then she sees some new immigrants who have both food and water, but she is too shy to ask for some. Her brother is nowhere to be seen. She feels good.*

The following is a summary of the second dream that was worked with in detail:

I was laying in my bed (her current room). There was a lot of men that were dressed like Taliban, dressed in Afghan clothes. My friend has bought some knives as a gift for me. One of the knives is very sharp and I saw one of these guys holding the sharp knife. It's a big, long knife. He is sitting on my chest, has put his hand on my throat. He wants to do both – he wants to choke me and he wants to cut my head off. And the rest are all there as well, just around the room. I don't see any faces. I am both choking and I am afraid of the knife. He is heavy on my chest. I

was choking. There is nobody to hear my voice and I can't make a noise. I want to scream but I can't. For a second I manage to scream, and I woke up. I called my mother. Still in my dream, I called her, 'Mom,' and I woke up. After I woke up I felt like it was dark in the room even though the light was on. I was choking, I couldn't breathe. I called them downstairs and asked for help. When they came up, I realized that there is nobody in the room. The person who had come upstairs to help me tells me it's a dream, it's finished. But I couldn't hear him very well. My ears were clogged.

After this, she was left with the felt sense of a stone in her chest that she literally wanted to cut out. The therapist tried to help her remove it in an imaginal way, but she insisted on being literal about it. She was not suicidal, and understood the implications of what she was saying. Yet she said, "I want to open my chest. It's like a lump that has been torturing me all my life. I just want it out. But it's always there. And I always have this feeling of wanting to open my chest." In dreaming this on, she was transported to the house of Imam Ali, a spiritual leader. The feeling of being seen and touched by him transported her to a better place. Her chest lightened, she felt "light, light, light."

The next dream Mitra brought began in a setting similar to that of her original nightmare, but the outcome was different. The following is a summary in her words:

My dreams are back to the time that, they have become similar to before. They are all again messy, like in a ruined place. And I'm being followed… There was a big group of people. I was fleeing from them, like from one city to another city. Again there was this place that was full of all half-built houses, or like houses in ruins. They were being reconstructed, or repaired in a way. So I go to a guy in one of these houses and I ask him to give me refuge, give me shelter. So at first he gives me refuge in his place but after a few minutes he comes back with the head of

that group that is following me, so I have to flee again. There are many people, a lot of women who were being abused. I could see them being abused, but I couldn't do anything or say anything… None of those people could see me. I was in a sitting position. A friend was giving me a hiding place and there was this opening in the wall so she had me sit there… So I see myself moving from one building to another through certain back ways and finally get myself to a bus loop where I catch a big bus. These are like buses used for traveling from city to city, the long-distance ones… So while I'm fleeing I try to help my two sisters escape as well. And one of those people following us who looks like my brother has somehow figured out where we are and has come to the bus loop. Anyways we got on the bus, and that person was in the bus. At that moment I'm thinking he is only one and if his group is not with him, he has no power over us.

In the ensuing discussion of the dream, Mitra said that she had no fear of her brother in this dream. She was trying to get away from him because she expected him to do something she would not like, but the fear of him was gone.

The final session included an exit interview and a brief description of her current typical dream. These dream notes are brief and cryptic: *She dreams something about her wedding, and there is fear/anxiety but through the session she regains a sense of power. The meaning she takes from it is that she is to stand firm. There is some jewelry in the dream, a gold ring and bracelet and she thinks gold is a good thing to see in a dream. She says, "I have to be strong."*

In the exit interview, Mitra said she was recently engaged to be married, and had been spending a lot of time on the phone with her fiancé, who lived in Iran. She felt hopeful, less alone, and attributed a lot of the good feelings to this major change in her life. She also expressed a very strong desire to put her past behind her, to forget her brother and all of the pain of her childhood. She said she felt the FOD process was not successful because she still had dreams

about her brother. She had expected the process to erase her nightmares, and facilitate the process of forgetting her painful childhood.

She said, “I still have these dreams, and these dreams are the constant reminder that my brother has done this harm to me. And I never feel good about my brother and I feel like he’s trying to hurt me again. But because I have tried to get rid of this a lot and I wasn’t successful, I will try a different approach… Maybe by not talking about it, by not having any reminder of him around me, I am kind of like deleting him from my life.” Mitra said even the mention of her brother’s name brought back bad memories, and that she would follow her husband’s advice to get rid of all pictures and reminders of her brother, to erase him from her life. Mitra called her childhood “a lost piece that I will not be able to find again… The years that I could have lived happily were spent in sorrow and sadness. I can’t go back and recreate those childhood years; they’re all gone. That’s why I don’t want to talk about them.”

Mitra found some effects of the FOD intervention helpful. She had significantly reduced her use of sleep medication, and had no more fear of falling asleep. She still dreamt about her brother, but in those dreams, she had no fear of him. In general, her nightmares had decreased, and her recall of dreams had decreased significantly. She still woke up screaming sometimes but with just a vague sense of a struggle with her brother or family, and usually, no details. She no longer felt the lump of stone in her chest. Along with this significant shift, she felt that when she had negative sensation or emotion, she had the ability to move it out of her body by crying, breathing or sleeping. She no longer felt she needed to literally remove it.

Analysis. Like, Jose, Mitra initially had an adverse reaction to being in the study. The lengthy process of answering questionnaires was taxing for her. There was also, for all participants, more exposure to their trauma material than was comfortable, especially in first

session. Working directly with nightmares is a turn toward the trauma, a deliberate facing of the experience and the feelings it engendered. This is different from the IRT process where the dream material to work with is specifically not a replicative nightmare. The brief exposure to the trauma material in the FOD process was not for the purpose of desensitization but rather for integration of the trauma memories contained in the nightmare. Mitra's case raised the question of whether it is better to remember and integrate trauma events, or to forget them as much as is possible. A study of the coping styles of Holocaust survivors (Lavie & Kaminer, 1991) showed that in the very worst trauma situations, effectively forgetting is an adaptive response. The study showed that those who adjusted better post-trauma had less dream recall, and actively repressed their trauma memories, just as Mitra had proposed doing with her memories of childhood. Integration and making meaning of trauma history is the key to healing for many, but not all survivors of trauma. Desire to avoid the trauma memory is not an indication that one falls in the latter category; avoidance is a classic symptom of PTSD. However, it would be useful to establish criteria for when it helps trauma victims to work through their memories, and when it is best for them to forget.

Participant 4: Gina. Gina was included in the study with some reservations. She was a fairly recent client and was not doing focusing-oriented therapy prior to participation in the study, so some of the terms and exercises were new to her. In addition, her trauma was recent (she was raped within the past 6 months) and her life stress ongoing. She escaped Honduras with her partner and son, coming to Canada via the United States. Traversing the U.S., the family was thrown from a train and got separated. They were leaving Honduras because of repeated attacks on their home. Her partner was shot on their front doorstep and both Gina and her son witnessed this. She was attacked and raped. There was no sense of safety in the family home. In Canada,

Gina's life had not settled. She was awaiting immigration proceedings and not optimistic. There was a question about the whereabouts of her partner. Her son was experiencing nightmares and other PTSD symptoms. In addition, she had been hospitalized recently for surgery to remove a tumor from her ear/face area that was suspected to be cancerous. It turned out to be benign. These events clearly impacted her stress levels and dream life, so it is difficult here to separate these from the effects of the intervention, which appeared to be negligible.

At initial screening, Gina reported many trauma experiences, including childhood sexual assault, imprisonment and torture. The trauma that troubled her the most at the time was the recent sexual assault. She entered the study with severe PTSD, with especially high re-experiencing symptoms. Post-treatment, the clinician assessed that her PTSD level had not changed appreciably since the intake session. There was a long break between sessions and the final exit interview because of the cancer scare and surgery. In the meantime, Gina was not receiving therapy. She is an example of someone who would likely need more therapy to build resources prior to engaging in direct work with her nightmares. Resourcing and calming techniques were the main focus of the therapy she did receive at VAST.

Gina's trauma-related nightmare symptoms first worsened and then were improving at the final session. She was starting to sleep longer again, experience slightly less fear falling asleep, and fewer nightmares. At intake, she was having four nightmares per week, then at session two, seven nightmares a week, and by session three, she was back to having four per week. She reported feeling better able to manage the emotions brought up by her nightmares than before the treatment. Yet she also spoke about how difficult she found it to work with the material depicted in her nightmares. She was generally in a highly activated state, and although

various calming techniques appeared to work for her in session (and sometimes she found relief doing these on her own as well), the calm state did not appear stable or lasting.

She had two intervention sessions. In the first, she reported the following dream: *I'm at my mom's house in Honduras when suddenly some guys break in. I want to see their faces but I cannot. I feel that someone from my family was crying because he or she is in fear. I feel a hand on my shoulder, grabbing me. Voices, a shot. I cannot see anything, I could just hear. My pants are all covered with blood. Again a hand on my shoulder. Children are screaming. I can recognize A's voice (her son). One of the guys pulls my hair. I start to cry but I couldn't scream. It was dark. I couldn't see anything. I kept hearing screams, others crying. I couldn't see anything. I was trying to move, I was trying to get rid of the guy but I couldn't. My pants are covered with blood. I start to scream… and then I wake up in panic.*

The therapist made a note: scream, not cry. Or cry, not scream. They were pulling her hair. She had very long, beautiful hair. The following questionnaires and the therapist herself confirm that this dream is an exact replica of what happened during her trauma. Upon exploring the elements of the dream, the therapist noted that this dream took place at the house of her mother in Honduras where she and her partner experienced trauma. She had a very strong sense in the dream that they were going to hurt her.

New dream ending (recounted by the therapist):

She resumes the dream at her mom's house. There is this push and pull. A struggle in the new version. In the first dream, she can't do anything. (The therapist wrote luca in Spanish – a mix of fight and struggle, a component of internal, not just physical struggle. Luca for human rights, is a powerful word used by activists.) She mentions the hair. But in the new dream, these guys don't hurt her. She can hear her son's voice crying. He and the other children were

screaming. She did not recount the new dream smoothly, but was assisted by prompts such as, how would you like to change this? Then Gina said: "Not to hear him cry. I don't hear him cry. I don't feel fear." Gina mentioned the pressure on her shoulder lessened.

According to the therapist, re-entering the dream was not an easy process for the client. The process was also interrupted by her therapist's use of the calming technique of visualizing a safe place, something they had practiced in sessions prior to the study. When invited to visualize something in her mind, Gina imagined being on an island where it was calm and resort-like. (However, this may have detracted from the FOD process by encouraging a kind of invented fantasy.)

According to the therapist: "We first had to re-enter the dream, really pinpoint certain elements and details such as her son's voice, the cries, because at first, she got nothing. Gina wanted her son's inconsolable-sounding cry to stop. Gina spoke of fear, nervousness, pressure on the shoulder, and her hair being pulled.

In the new dream ending, Gina set herself free. She said, "I go to my son's rescue. I comfort him, I help him feel calm. We are together and close." (What do you do?) "I hug him. We are in a different room, we are now in the living room… I am also soothed."

Seeking help in the dream, Gina named her mother's house as a source of comfort, yet this was also the site of the trauma. She did not exit the house, but went to a different part of the house in order to escape her attacker. The focusing step of clearing a space, took some time and was calming, although Gina was mostly silent throughout the process, and her voice was very faint. She was able to engage in some parts of the process, but it was clear from the transcripts that the bodily felt sense often eluded her, and she took the process too literally at times. However, she has continued the practice on her own.

Dream session two: In the second dream session, Gina said she had a hard time discerning whether she was dreaming or re-experiencing a trauma memory.

"I'm in a house where I lived (in mother's house in Honduras)… there's no one in the house… and suddenly I see that someone opens the door… and they start to grab me… here, by my neck. And after this person grabs my neck, I feel like… like I fall on the floor… and then it is as if I lost consciousness… after that, I feel as if someone is hurting me… like I'm not conscious but I can… it's like I'm being hurt. After that, I sort of get up, crying. And… just like when I have this dream, I wake up… I wake up very frightened… I also wake up crying…

Gina said this dream is an exact replica of her trauma experience, but when prompted, she noted a small difference. She heard someone "laughing in a very ugly way, like a clown, grotesque… in the dream I can hear that ugly laugh, and it scares me."

Finding help at first did not succeed because the therapist asked for what caught Gina's attention. In being careful to avoid being too leading, or forcing an easy solution, the search for help was left too open-ended. What caught Gina's attention were the menacing details of the dream/memory: the guns the men carried, and the presence of the person who hurt her.

When Gina was asked to imagine a new dream ending, it was as though she needed extra permission. She asked, "Now?" and, "Is it like… what I wouldn't want to happen in the dream, or how do you mean?" The therapist answered: "What you would want… you can change it in whatever way you want…" In the new dream ending: Gina removed the hands from around her neck so that she could scream or speak. She wanted to change the feelings so there was no fear or sadness, but instead a sense of safety. This sounded hypothetical at first, but the therapist asked for more about this using the present tense. Gina picked this up, and her language became more immediate, indicating a shift to a deeper level of experiencing.

T: You said, “I feel safe.” Is there anyone around?

C: My son, my family. My mom. My husband is also there… he has always been there with me… We are sitting there, outside of the house, talking. We are happy and safe.

The new dream ending brought a felt sense of happiness in Gina’s chest, which she was able to anchor in her body. Gina smiled as she did this and let out a long sigh. Later in the session, when Gina felt fearful again, revisiting the sense of the new dream ending again brought a feeling of calm and safety.

At the exit interview, Gina did not provide a dream but said that in general, her dreams were exactly the same as before. She had the particular dream that she recounted in the first session three times in the previous week and said she woke up very frightened each time. She said she had tried imagining a new dream ending to her nightmares at times, but found it “a little bit difficult.” She elaborated on this, “When… I dream about these bad things, that upset me very much and to go back to remember it, makes it alive again.”

Although very little changed for Gina in terms of her dreams or her symptoms, she did mention that she had more resources to calm herself when nightmares woke her up: “It did change a little bit because at first I would wake up very scared and sometimes I would scream and now, I still wake up frightened and from time to time screaming… But now when I wake up, I start doing what you taught me and it calms me down.”

At the close of the interview, Gina mentioned that she noticed some slight changes in her recurring nightmare. Some of the people had changed, and there were new people that had not been there before, but she did not say more about this. Something also began to change about the setting. Although the dream still took place in her mother’s house, there was a sense of loneliness, as if there were no other houses around, which was a departure from how things were

in actuality. She also said her attitude within the dream had changed 'a little' but again did not elaborate. The time allotted for this session was very short. Gina had just 45 minutes, and the process usually required about 90 minutes, so there was not enough time to probe for further detail, and Gina volunteered very little. She was very soft-spoken and sounded timid.

Analysis. Gina's case provided an example of the need for stages of therapy for working with complex trauma. Courtouis (2004) said that before helpful trauma processing can take place, clients need to feel safe and settled, have trust in their therapist, and possess basic self-regulation skills. Gina was in the early stages of many of these processes, and her life continued to be stressful and unsettled throughout the time she spent as a participant in the study. The case reinforced the notion that good trauma therapy requires time, patience and sensitivity to the client's life situation and their available internal and external resources. Although the timing for FOD was not ideal for Gina, there were some hints of change in her dream content post-intervention, some slight loosening of the rigid repetition of her nightmares. The client also expressed an interest in continuing with the therapy, and could possibly have shown improvement over time. For the purposes of the study, the FOD intervention was brief. However, in a regular therapy situation, FOD would likely be used more frequently (or as needed when nightmares occurred), over a longer period of time and as part of a course of therapy that included other aspects of trauma work and resource building.

Participant 5: Katherine. Katherine is from Nigeria where she and her children were subject to ritual abuse related to traditional religious practices. She had been having recurring, replicative trauma-related nightmares for 20 years and had been diagnosed with PTSD. She received some therapy through the court system, and had some resettlement support through VAST, but her therapy had been fairly minimal. She provided few details about her life. She had

some college education (nursing), was married, and left her husband to bring her children to Canada. In Nigeria, children become the property of one's husband, and she lived in constant fear that her husband's family would take her children and harm them. Katherine was physically disabled and visually impaired.

At intake, measures indicated moderate to severe PTSD and a very high level of depression. Katherine's trauma experiences included serious accidents, sexual and non-sexual assault by family members, living in a war zone, and experiencing life-threatening illness (she was pronounced dead as a child). The trauma event that still disturbed her most was sexual assault, although the nightmares she recounted for the study had more to do with potential harm to her children.

There were a number of changes in her trauma-related symptoms after the first intervention session, some positive, some negative. She became slightly more afraid and it took her longer to fall asleep. Her sleep duration stayed the same at just 2-3 hours of sleep per night. A positive change was that previously she would not fall asleep at all after waking from her nightmare and after the first treatment session, she was able to fall asleep quickly after waking from a nightmare. Katherine completed the first two intervention sessions, but not the final data collection and exit interview. The following are summaries of the transcripts.

In the first session, Katherine said she had lots of dreams but that she did not remember them. She typically woke up in distress within two hours of falling asleep, and with little or no dream recall, so was actually experiencing night terrors rather than nightmares. When prompted for details about her dream life, Katherine said she had loud conversations in her sleep that her daughter told her about later. Sometimes she saw her ex-husband or her sister try to enter her room. Sometimes it was her current bedroom, and sometimes she thought she was back in

Nigeria. She felt intense fear and a desire to fight for her children, but she felt helpless as though she could not scream or move.

As the therapist prompted her, more details of her typical dream emerged:

I'm with my family. Sometimes it's here in Canada, sometimes it's back home, and it's my ex's family and we are at their place. There are lots of people. There's a meeting going on, the family's there, and there's a circle of meeting, all the elders are there and some rituals are taking place. I recognize my ex husband's sisters and brothers. We were tricked into the place. My kids are there. These people are trying to get the kids, to take them away. In the nightmares, they put the little one in the car. I know that they want to steal them and I'm crying. I'm crying and I cannot scream. Sometimes I can cry out loud. I cannot move.

Katherine was asked to reflect further on the dream, and said, "I don't know what comes. Just the only thing I will say about the whole thing is… (laughs) just the mention of his name, of my ex's name terrifies me. I still have the name. I still have the last name and I don't know how I can get rid of it because I have it on all my documents. Just that last name terrifies me… so I keep having nightmares of him and I wonder if there will be one day, just one day that I don't have nightmares of what happened to me because 18 years was not a joke and 18 years of torture it was torture and of living hell and into witchcraft and of living and seeing voodoo stuff all around… so if I can be seeing all those voodoo stuff all around and those images… so it terrifies me so I don't know how I can lift my head."

In finding help, Katherine was asked what she found striking or incongruous, and she recalled telling her daughter not to expose herself, but to go into the bathroom to pee. Another difference between actual the trauma event and the dream was that the aggressors had guns.

When asked what stood out most about this dream, she chose the setting, which was highly evocative for her: "The environment of the house. It's actually the house… the rituals were in my ex's father's house. They had all those rituals in it and they were scarier when they were in his father's house. So much rituals. It was like they were going to, um, do human sacrifice… if you go further inside, there were tons of rituals inside. That's what drew my attention. And my friends that took me there, they were in on it, so it was a kind of well-planned something, so that's what distrust an issue also…" She recounted being tricked by a cousin to go to that house, and at that time her ex-husband's brother tried to perform some kind of ritual with her son.

When asked to dream the dream onward, it took some time for Katherine to understand what was being requested. She asked, "Turn it into something good you mean?" The therapist said not to necessarily put a value judgment on it, but to allow it to unfold. She repeated the dream, and that helped Katherine find this ending: *"(Long pause) I get it right away I see. Right when we were dropped off. I sensed it right away. I call a cab… right away I call a cab. I turned around, head back home. We turn around, we head back home before they could see us. I sneaked."* This scene brought "a sense of peace" to Katherine.

In session two, Katherine brought a snippet of a dream that filled in more with some prompting, although it was still very brief: *Her two daughters have been lured away to a party, but Katherine suspects this is a ruse. She is frightened and is calling her eldest daughter's name. "The more I called the more they were being led far, far away from me… I can't remember. I saw. I was screaming, calling the eldest one's name… because like they were being led to danger, to unknown people leading them far, far away." When she calls, the daughter looks at her strangely, as though she does not hear, and she does not respond.*

When the therapist asked for more details, looking for help in the dream, Katherine began to talk about another dream instead: "A long time ago I dreamt of carrying a newborn baby. I kept dreaming of a newborn, and that newborn is like an angel. It was a long time ago. And I kind of save the newborn." When asked to return to her recent dream, Katherine spoke about screaming and not screaming. She then related this to a recent trauma incident she experienced while in Canada, another time she screamed for help. The therapist brought her back to the cleared space, and again back to the original dream. She imagined the following new dream ending:

"I called up her brothers (her own two sons). I got hold of her brothers and I told them what was happening and some of my family members. And we traced the steps of where they went. And they followed the people, before they could leave the building, went after them and we caught them and brought my daughters, retrieved them from the people and they came with me and my brothers and my family and they ended up being with us and we dealt with those people. We called the police and they arrested those other people. They arrested them. They finally confessed that it was… they were sent by their uncles and their dad's family. So that's what happened." This brought a felt sense of peace throughout her body. The therapist asked her to mark this feeling and keep it with her. The study ended before a further session could take place with Katherine to determine the impact and her sense of the experience of the intervention.

Analysis. It was clear from the transcript that the focusing process did not come naturally to Katherine, but that she was picking up the skills as the sessions progressed. She was early in the process of working through her trauma, so, like Gina, it would be expected that more changes in her dreams and symptoms might take place given more time. It was also clear from the transcript that Katherine did not find it easy to stay with the dreamwork process, but kept

tracking off into associations of other traumatic events in her life. There was a sense of agency about Katherine that was promising. In her dreams and in her imagined dream endings, she demonstrated strong desire to fight for herself and her children. She took the initiative to move away from her ex-husband to the safety of Canada. In her dreams, the setting reflected that her sense of place was shifting, "Sometimes here in Canada, sometimes back home." The setting and temporal shift in dreaming content was common across participants and will be examined in detail. It is possible that in this particular type of transformation, the dream is beginning to do the work of integrating fear memory by weaving elements of current life into the dreams that replicate trauma memory (Hartmann, 2001; Levin & Nielsen, 2007).

Post-Intervention Within-Subjects Analysis of Transformations

This section is a brief analysis of the nature of changes in the dreams within the individual case studies with particular attention on the dream reports post-intervention. Included in the analysis are relevant observations about the nature of the new dream ending (NDs) and its relationship to the subsequent dreams (SDs). Comparison is made between the pre- and post-intervention dreams because a major goal of the intervention is to effect change in what has been (or perceived as being) an unchanging, ongoing nightmare.

1. Flora. The dream Flora brought following a deeply-experienced new dream ending was strikingly different from her usual replicative nightmares. It was not about the trauma event at all, but about a cat that could speak, a cat that came to help her. In it, Flora became the aggressor rather than the victim when she attacked the cat. The cat itself transformed into a woman, a surreal and magical event. The setting of the dream changed twice, from home to a cemetery and back home again. The emotional experience of the dreamer shifted several times, from incredulity that a cat could help her, to aggression, to disgust at what she had done to the

cat, to fear when she was at the cemetery, to a sense of gradually becoming stronger and ultimately feeling safe. The final event of the dream was a transformation of Flora herself. At first she was afraid and crawling on the ground, but then she was able to stand, and then to run home to safety. So within this dream, there were transformations on several levels. The characters changed (both the dreamer and the other character), their actions changed, the setting changed, the emotions shifted several times, and the dream also had a resolution rather than ending abruptly with an awakening.

This transformation bears some relationship to the new dream ending Flora imagined. In her new dream ending, she *stood up* to her attackers. Following her typical trauma dream, in which men were chasing her and wanted to kill her, she imagined herself finding the voice to confront them. This effectively stopped them, and moved the dream forward from the place where it usually ended.

At the final interview four months after the second dream session, Flora reported she had stopped having nightmares or any dream recall. However she did have a few nightmares about six weeks post-intervention that were similar to her original trauma dreams, but with a key difference. The dream she reported from this period continued on past the point where it usually ended, with her frozen and terrified. Instead, it incorporated help within the dream in the form of a man who pointed the way to safety for her and her children. She took action in this dream to get herself and others to safety. The dream moved beyond the place where it usually was stopped by fear so intense it woke her up. It is possible that her increased mastery over her fear (which came in the form of a new character, a man that could point the way to safety) enabled her to keep sleeping and complete the dream. Since that time, the dream has not recurred.

2. Jose. Jose's post-intervention dream was also strikingly different from the recurring nightmares he had been experiencing. It began in much the same way as his recurring nightmares, with him in an unknown city trying to escape from someone who was following him. He ran to a building and found himself with his current partner. In his typical nightmare, he would then go into the basement, lock himself in a dark room and re-experience his rape trauma. In this dream, the ending of the dream from this point was completely different from his trauma dream in several ways. He was with someone he knew and trusted rather than with an unknown attacker. The action of the dream took a decided turn as the setting became his current workplace. He and his partner were making fun of the clothes Jose was selling. There was laughter and he woke up feeling happy.

Within the dream, there was transformation of emotion. It began with Jose feeling "horror and sorrow in my heart" and ended with him feeling happy. The setting changed from an unknown city to his current workplace, from past to present. The characters with him changed from an unknown attacker to a known and trusted friend. The action changed from being a victim of rape to participating in playful activity.

Jose's new dream ending did not appear to be deeply experienced, as his use of language did not indicate immediacy. In the new dream ending, Jose changed the setting to a beach, changed the action to something playful (riding a bicycle) and changed the mood from despair to happiness. The subsequent dream he brought appeared to incorporate many aspects of these changes: setting, playfulness, and a shift from despair to happiness.

3. Mitra. The analysis of change for Mitra's dreams was complicated by the fact that she completed portions of the study over a seven-month period. Many of the sessions were broken up or aborted because of limited time (due to translation) or her limited energy. Throughout the

process, she brought several dreams, but not all were recorded in detail and worked through. For the purposes of this analysis, the dreams she worked with in detail following the protocol of the study were chosen for further analysis. There were three such dreams: the initial recurrent nightmare and new dream ending, the subsequent nightmare and new dream ending, and a final dream that, like Jose's, began like her typical nightmare, but ended quite differently.

Because dream one and three began in the same setting, it was useful to compare how they played out differently. The first dream took place in the city in Iraq where Mitra's mother lived, and there had just been an earthquake. Her brother, the main aggressor in her nightmares, was driving a bulldozer, furthering the destruction. In the final dream, Mitra said the location was just like her previous dreams but in fact, the ruined houses "were being reconstructed or repaired" rather than destroyed. This was a key difference, and one Mitra equated with her own personal development. At the last interview, she said, "I am still reconstructing."

The interim dream was an intense and terrifying nightmare, but very different from her typical nightmare. In it, she was in her own current bedroom under attack by a group of men (not her brother). One of the men sat on her chest intending to kill her. She was being choked and could not find her voice until the end of the dream when she called for her mother and woke up. This dream replicated her most recent trauma, which was an experience of being choked. It left her with the feeling of a stone in her chest.

In dreaming the first two dreams onward, both times, Mitra was able to engage deeply in a waking dream process, allowing it to unfold without directing it consciously. In the first, her dream continued with a search for water, and was moving toward the goal, but not in the direct, easy way that one would invent. Instead, first she found undrinkable water, and then water belonging to someone else. In the second new dream ending, she was transported to the house of

spiritual leader Imam Ali, famous for crying into the well, absolving others of their sorrows. Mitra said this vision dissolved the stone in her chest freeing her from an intolerable sensation she had carried all her life. Her own tears became capable of softening her after this. She said, "After that dream this thing that I felt was in my chest that I wanted to stab it with a knife and take it out… that thing went away totally. So now I feel that when I am crying or screaming, I can get rid of the thing inside."

The new dream ending had a clear effect on her waking life. The changes to her dream life were apparent as well, but not as direct. In her final dream, the villain was both her brother and a group of attackers, amalgamating the aggressors from the first two dreams. However, they were less frightening for two reasons. First, they did not see her or target her directly. Rather, other women were the target of their abuse. Second, she was successful in fleeing from all attackers except her brother, and by himself, her brother no longer frightened her. Within the dream, she was able to escape, and this time, to a new city, a completely different place. Her emotions were calmer, and her actions effective.

4. Gina. Gina is the participant whose dreams changed least through the course of the FOD process. Her recurrent nightmare replicated an attack she experienced at her mother's home in Honduras in which her partner was shot and she was attacked and raped. She had difficulty engaging in the active imagination of a new dream ending, and with prompting, changed the dream so that she escaped from her attacker to a different part of the house where she and her son were safer. After this, she continued to experience the same recurrent nightmare, and the FOD process was repeated. In the second new dream ending, she imagined being outside the house with her family and this brought a felt sense of community and safety. After this, she continued to experience the same nightmare, but reported a new ability to calm herself upon

waking. There were also a few small changes about the dream. She became more aware of the person who was attacking her; he was no longer faceless and vague. She could hear clown-like, disturbing laughter that had not been part of her real-life experience. As well, the setting for the house was lonely, separate and different from its situation in reality.

5. Katherine. Katherine's typical nightmare was set in the house of her ex-husband's family where rituals were conducted. In it, she was trying to save her children from his family, afraid they would be harmed. This was in fact her experience in Nigeria. In imagining into a dream ending, Katherine stopped the dream before entering the house, essentially turning back time to the place where she and her children were safe. The dream ending was reported in past tense, indicating a low level of experiencing. However, after this, Katherine's dream life shifted. Although she still reported having nightmares, her dreams became more characteristic of night terrors, and she had little recall of the content. Due to this, and because the study ended prior to final follow-up with Katherine, further analysis of her dream changes was not possible.

Overall, the level of change in dreams following the FOD intervention was quite variable, although all participants did experience some change in the nature of their dreams. There was also a great deal of variability in the properties of dreams participants began with. Although all of them suffered from recurring nightmares related to their trauma, and all indicated on the questionnaires that their dreams were highly replicative of their original trauma, in fact, only one participant (Gina) appeared to have the same purely replicative trauma dream repeatedly, and her dreams appeared to be the least amenable to change. There did appear to be some relationship to the level of experiencing of the new dream ending and the magnitude of change in subsequent dreams. To firmly draw this conclusion would require further study.

Table 2

Summary of post-intervention dream transformations within individual dream series

Flora	
Dream as a whole:	Completely different dream from ID, some trauma elements
Dream ego actions:	Becomes the aggressor, then afraid, and then able to run to safety
Other characters:	Completely different, cat changing into a woman, friend present, no attacker, vague sense of threat
Actions of others:	Cat and friend both come to help
Emotions:	Incredulity, disgust, fear, triumph
Setting:	Home, graveyard, home (safety)
Elements from ND:	Attackers become ineffectual, their presence fades
Jose	
Dream as a whole:	Begins like ID, but ends differently
Dream ego actions:	Begins with running away from attackers; ends with play, laughter
Other characters:	Begins with someone chasing him; ends with his partner present
Actions of others:	Attacker takes no action; partner is laughing and joking with him
Emotions:	Moves from fear to happiness
Setting:	Begins in 'unknown city' and ends at his current workplace
Elements from ND:	Dream ends with sense of freedom, feelings of happiness, rapist not present
Mitra	
Dream as a whole:	Begins like ID, but ends differently
Dream ego actions:	Asks for help, is invisible to attackers, flees successfully, helps others escape
Other characters:	Attackers are a group that includes her brother. He is not a threat.
Actions of others:	Unknown men attack other women. Her brother follows her, but does not hurt her
Emotions:	Begins with fear, but by the end the fear is gone
Setting:	A ruined city (like in ID), but ends on a bus to a new city
Elements from ND:	Fear is no longer present; brother not a threat; she helps her family
Gina	
Dream as a whole:	Almost exactly the same as ID
Dream ego actions:	She is attacked, falls to the floor, loses consciousness
Other characters:	Attackers, and family present, same as in ID
Actions of others:	Attackers grab her by the neck, they hurt her; clown-like laughter a new element
Emotions:	Fear, loss of consciousness
Setting:	Home in Honduras, same as ID; sense of loneliness new
Elements from ND:	No
Katherine	
Dream as a whole:	Different from ID, but very similar trauma theme
Dream ego actions:	She is calling for her daughter who is being lured away
Other characters:	A sense of the presence of the usual aggressors, but not their actual presence
Actions of others:	Aggressors lead her daughter away; daughter does not respond to her calls
Emotions:	Fear, desperation
Setting:	Unclear
Elements from ND:	She is trying to save her children from abuse

Analysis of Transformation of Dream Elements Across Participants

With the series of dreams participants in this study provided, it is possible to examine in detail the convergences and divergences in dream content changes across participants, which is the purpose of the following analysis. This section examines the way the dreams change from the initial trauma dreams (IDs) reported by participants to the subsequent dreams (SDs) following the FOD intervention. During the intervention, participants imagined new dream (ND) endings to their nightmares, and the relationship of the new dreams to the subsequent dreams is a secondary focus of this analysis. There appears to be a relationship between the type of ND imagined, how deeply it is experienced and the subsequent dream content. In the following analysis, themes within the dreams that transformed across participants are highlighted. Table 3 summarizes the presence of changes common across dream reports.

Table 3

Summary of Changes in Dream Content

Participant	Flora		Jose		Mitra		Gina		Katherine	
1. ID vs SD	Y		Y		Y		Y		Y	
2. ND-SD										
a. Aggressor	Y	Y	Y	Y	Y	Y	Y	N	N	Y
b. Dream ego	Y	Y	Y	Y	Y	Y	Y	N	Y	N
c. Time/place	Y	Y	Y	Y	Y	Y	N	N	Y	Y

Definitions

1. This indicates whether or not there were any content changes from the initial dream (ID) and subsequent dream (SD) after the FOD intervention.
2. Changes made to the ID to create the ND were tracked with respect to the three main content areas shown to change across participants (villain, dream ego, time/place). Column 1 indicates change from ID to ND. Column 2 indicates whether this particular change also occurred in the SD.

Identity of the aggressor/attacker

One of the common transformations across dreams was the identity of the main aggressor in the nightmares. Four of the five participants specifically noted (at varying points in the

dreamwork process) that they did not know the identity of the people who were threatening them in their dreams. Three specifically stated that they could not see the face of their attacker, and this detail appeared to be important to them. The initial dreams were generally replicative. The dreamers who were attacked by strangers in real life were the ones who could not see the faces of their attackers in the initial dreams they brought. Those whose aggressors were well-known to them, initially dreamt of the known aggressor. In most cases, the identity of the attacker was one of the ways the dreams began to change after the FOD intervention.

In his first dream, Jose said, "I'm escaping from some people, but I don't know who they are." And in an earlier dream from his log, he wrote, "Someone was chasing after me. I could not see his face."

In Gina's first dream, she said, "… suddenly some guys break in. I want to see their faces but I cannot."

Mitra was well aware of the identity of her attacker. In her dreams it was always her brother who was the aggressor, and it was his attacks that were the main trauma in her life. Her initial dream was of her brother as aggressor, but after the intervention session, the next dream she brought had unknown attackers: They were men "dressed like Taliban, dressed in Afghan clothes," and, "I don't see any faces."

In this second dream, Mitra's brother also made an appearance, but he was no longer such a threat, not nearly as threatening as the group of Taliban men who wanted to kill her. She said, "I don't see my brother, who was following me. I don't feel the fear, I just don't want him to find me."

The aggressors in Jose's dreams changed in the opposite way. In his life, he was raped and beaten by an unknown group of men. His initial dream replayed this scenario. However, in later dreams, his attacker/rapist was his father or his brother, or sometimes Satan.

Gina's second dream more clearly identified her attacker. Initially the attack in the dream was described as being carried out by an unknown group of men. In speaking about her second dream, she was able to single out the person who attacked her on the day the men broke into the house and attacked both her and her partner. There is more detail available to her in this second dream. When asked to reflect on this nightmare, what caught Gina's attention was the particular person who would come to the house 'to deliver threats or to do something… throw things in the house… it was almost always the same person." This was also the person who hurt her.

The most dramatic transformation of the dream aggressor took place between the first and second dreams of Flora, whose initial dream was a typical replay of her trauma event where she was being chased by a group of men who wanted to kill her. In the second dream she brought, there were surreal elements, and she became the aggressor. There was a cat in the dream that said it wanted to help her, and she attacked the cat with a broom. Later, this cat changed into a woman. At the end of this dream, Flora was at a cemetery on her knees on the ground and wanting to flee home to safety. There was no sense of an actual aggressor, just a general sense of threat. It is worthy of note that Flora, who experienced the greatest change in the nature of the dream threat, was also the participant who experienced the greatest change in her dream life. After the sessions, her nightmares essentially stopped.

In comparing the participants, Flora, Jose and Gina were all attacked by unknown groups of men, both in real life, and in the initial, representative nightmares they brought to their first dreamwork session. All three experienced a change in the identity of the aggressor in subsequent

dreams, but there was considerable difference across these participants in the degree and nature of these changes.

For Gina, the attacker was the same person in her initial dream as in her later dream. It was just a little bit clearer to her who the specific attacker was in her second dream. Her new dream ending was also the one with the least amount of change compared with the other participants, and she had the lowest level of experiential connection with the new dream material. She changed her initial dream by moving herself and her son into a different part of the house where it was safer, but she remained in the same house in which the trauma took place. In her life, her trauma symptoms also changed little.

Jose experienced greater change in the nature of the dream aggressor, but in his case, the shifting identity of the attacker (to become his father or brother) was not necessarily a change that could be seen as a step forward. Instead, the symbol of the attacker is collapsed, is overdetermined. In Jose's life, he experienced persecution from several fronts, not only from the unknown group of men who raped him, but also from the church and from his family. His father and brother often berated and beat him because of his sexual orientation. So the dream villain became an amalgamation of many of the threatening forces in his life.

Mitra and Katherine were both traumatized by known family members, so the nature of the identity of the dream aggressors and their transformation differed from the other three participants. Mitra said she always had nightmares about her brother, who beat her and nearly killed her when she was a child. In her dreams, he was always a threat, and always the same age as he was when he beat her. Her initial dream was of her brother driving a bulldozer, and she noted that he was always armed. However, in her second dream, there were other women under attack by a group of men that may or may not have included her brother, and she was safely out

of sight. Later when she brought her sister and herself to a bus to go to another city, her brother followed, or someone "who looks like my brother," but she felt no fear of him. After this, her nightmares dropped in frequency, as did her general dream recall. She brought one exceptionally vivid nightmare, however, and in this dream, she was attacked by a Taliban man. Although the dream was extremely frightening, the main attacker was unknown to her. Notably, it was not her brother.

For Katherine, the aggressors were also well-known to her, and the threat was more towards her children than herself. Her husband's family practiced voodoo ritual that involved children, and she lived in constant fear that her children would be taken and harmed. In her initial dream, she was at her ex-husband's family home where much of the ritual had taken place, and the people were trying to take her children away. In her subsequent dream, the villains were much more shadowy and in general her dream recall was not as sharp. There were unknown people trying to lure her daughter away to a party but she knew this was a trick and she was trying to call for her daughter to come back. As in Mitra's dream series, the dream villain shifted from known to unknown, or at least lesser-known.

Also worthy of note is the weaponry carried by the villains in the dreams of the participants. For both Mitra and Katherine, the villains in their initially-reported dreams carried weapons even though these aggressors did not have weapons in real life. In fact, Katherine noted that this was the one element that differed from an otherwise exact replication of her original trauma. "The thing that I see that doesn't match, that they didn't do, was the guns, using guns to chase me." Mitra said, "My brother was always armed, once with a gun, once with an ax, once with a bulldozer." Later, when the Taliban man attacked her in her dream he wielded a long,

sharp knife. (In Flora's dream as well, the attackers fired a gun, but there is no information about whether they in fact had guns.)

The general nature of the main threat appeared to change after working directly with the nightmare. The degree of change seems to have a relationship to how well the dreamer was able to work with and face their dream material. Flora, for example, who had the best results from this process, was able to stand up to her attacker in a deeply experiential way in her work with her repetitive, replicative nightmare, and subsequently she experienced these changes within her dream life. They also appeared to translate into her waking life in ways that seem relevant to the dream content. She reported feeling more empowered, better able to make decisions, and in general, less afraid.

Implications for working with nightmares can be gleaned from this. When asking into a nightmare, a helpful line of questioning might be to encourage curiosity about the dream aggressor. In some forms of dreamwork (Aizenstat, 2009), dreamers are encouraged to turn and face, and even develop a form of relationship with the dream aggressor. The latter might be a considerable challenge to work up to for those with PTSD nightmares, but some study participants instinctively seemed to take the initial step of standing their ground and engaging with the dream aggressor rather than avoiding the confrontation. Germain's (2004) study on increased mastery elements in IRT is relevant to these findings, and will be covered in more detail in the discussion section.

Dream Ego Actions: Standing Up, Finding a Voice, Help

The actions and experience of the dream ego in the nightmares of participants also shifted in the dream series in ways that showed some commonality across participants. These centered around three related and interconnected themes of finding or not finding one's voice, asking for,

receiving and/or giving help, and standing up for oneself. There appeared to be a progression in the actions of the dream ego in terms of responses to threat.

For Flora, taking a stand and finding her voice were the key elements in her initial dreamwork experience. In her initial, replicative nightmare, she was being chased by a group of men who wanted to kill her because they believed she had incriminating information. In this recurring dream, she was frozen, and could not find a voice to respond to the men. In the new dream ending she was able to stand up to her attackers and find her voice. She was able to let go of her fear about the outcome of the encounter, to face the men and tell them she did not care what they did. This action was empowering, and in this new version of the dream, which was richly experienced, the men stopped pursuing her.

The nature of Flora's dreams changed after this. She immediately stopped having nightmares, and although they returned briefly about two months later, her actions within the dream had changed to incorporate her new dream ending. The series of four nightmares she had before the dreams stopped again began very much like her typical replicative trauma dream in which she was pursued by a group of men who wanted to kill her. However, help appeared within the dream in the form of a man who offered to lead her and the children with her to the safety of a house he designated. In the dream she took this action, took the children and went to the safe house. She took action on her own behalf and for others. Help came in three forms: help from outside, helping herself, and helping others.

Mitra experienced all three kinds of help in her series of dreams, although the progression was not as clear or linear. From the very first dream she brought, she attempted to help others in the dream, particularly family members. In the first dream she brought to therapy, she was in a ruined city where her brother was a threat to her, but her main concern was for the safety of

others in her family. She took her sister to a concrete building out of harms' way and then returned to the site of destruction to help her mother. She did not always feel able to help herself, however. "In my dream I was quiet the whole time and always observing… only sometimes do I see myself defending myself or smacking my brother. Because I wasn't used to escaping. If they beat me up, I just stood still." In the next session, she revised this notion of her own helplessness. She said, "I always stand against my brother. I always resist, like I'm trying to prevent him from doing something wrong." In a yet-later session, when she was asked to reflect on the entire FOD study process she said, "The way I dream is different now. Previously I was always oppressed, being oppressed, but now I stand against it. I am not defeated by the other person."

In her real-life trauma, one of the most difficult aspects for her was the lack of support she received from others. During the worst beating she received at the hands of her brother, her mother was just outside the room but did not intervene. So for Mitra, asking for and receiving help from others was a sign that she had regained some lost hope. In the new dream ending of Mitra's second nightmare, which was deeply disturbing to her, she was suddenly transported in her imagination to the house of the Imam Ali, the religious leader famous for crying into a well. She said, "I'm holding the Koran, I'm leaning my head to the wall, the Koran is in my hand. I'm asking for help from Imam Ali… I'm at a well. I ask him for help… right now I am asking him with my heart, and I'm not using any words. I'm asking him with the way I look at him and also with my heart." In this imaginal dream ending, Imam did help her. She felt he looked upon her with favor.

In the subsequent dream she brought, there was help within the dream, although it was transient. The dream was similar to her initial dream, which was set in a city with ruined houses, although now the houses were "half-built" and being constructed rather than destroyed. She

asked for refuge and shelter from a man in one of the houses and he gave it to her. Yet after few minutes, he became part of the group of men that was pursuing her, so the help did not last. She then went back to running away, helping both herself and her sister find safety.

The actions of the dream ego in the nightmares of Mitra and the other participants appeared to parallel the continuum of fight/flight or freeze responses the body will automatically make in response to a dangerous situation. The freeze, or immobility response is usually the last line of defense, when all hope of escape is lost. Mitra described how she used to freeze and do nothing when she was being beaten, and in her dreams late in the study process, she said she was always running and escaping, and sometimes taking a stand and fighting. This demonstrates a progression from freeze to flight, and fight.

For Gina, the sense of fighting and struggling against her oppressor was something she brought into the new dream ending. In her usual nightmare, the dream ended as her attacker took hold of her hair and she had a sense that she could do nothing. In the new dream, she engaged in a struggle that was more than a simple physical fight. She used the word *luca* to describe it; luca is a word in Spanish for taking a stand against something, a word used by activists. In this imagined dream ending, the fight was effective and the men did not hurt Gina.

Three of the dreamers specifically talked about not being able to find their voice in their initial trauma dreams. Flora described how the men were intending to kill her because of what she knew, she could not find the voice to confront them. In one of Mitra's nightmares, she said, "There is nobody to hear my voice and I can't make a noise… I want to scream but I can't."

In Katherine's initial dream, when they were trying to take her children, she said, "I'm crying, it's like I'm helpless. I want to do something, but it's like I can't move. I want to scream, but I can't scream." In the dream ending she imagined, she called cab and took herself and her

children away from the place of danger. In Katherine's subsequent dream, her daughter was being led away, and she was able to scream, calling her daughter's name. Although this was a progress of sorts, her daughter did not respond. In her imagined dream ending, she asked for her family's help and they effectively stopped the kidnapping. In the progression from initial dream, to subsequent dream and then new dream ending, like Mitra, Katherine had moved from freeze to flight to fight.

As Mitra and Katherine have shown, the FOD process can move the trauma response toward the more active and effectual end of the continuum of fight/flight or freeze, both in dreams and in waking life. This pattern was examined across participants to determine if it was generally true for them. Table 4 summarizes this analysis.

Table 4

Progression of threat response across dream series, by individual

Participant	Flora			Jose			Mitra			Gina			Katherine		
Dream type	ID	ND	SD	ID	ND	SD	ID	ND	SD	ID	ND	SD	ID	ND	SD
1. Freeze	Y	N	N	Y	N	N	Y	N	N	Y	N	Y	Y	N	N
2. Flight	N	Y	Y	Y	N	N	Y	Y	Y	N	Y	N	N	Y	N
3. Fight	N	N	Y	N	N	N	N	Y	Y	N	Y	N	N	N	Y
4. Progression		Y			Y			Y			N			Y	

This table tracks the progression of fear responses within the dreams of participants. Some of the participants worked with several dreams, and in these cases the first column refers to the first dream the participant recounted for the study, the second describes the first new dream ending, and the third column analyses the final representative dream.
1. Freeze responses were counted if the dreamer specifically recounted the inability to move, call out or help oneself.
2. Flight responses were counted if there was any form of running away or escape attempted within the dream or imagined new dream.
3. Fight responses were counted if there was any indication of resistance directed at the threatening character(s), verbal or physical, or any attempt to protect others from the threat. Where an indication of any of these states was unclear or ambiguous, the instance was not counted.
4. The final row shows whether or not the final dream indicated a progression from freeze toward fight in terms of change in the actions of the dream ego from the first to the last dream. The interim new dream actions were not counted as part of the trend because more empowered responses are expected as part of the dreamer's conscious intervention.

Another way to illustrate the progression of threat responses was to count the three types of responses in IDs, NDs and SDs (using the same criteria as above) for all participants. In this case, all dreams recounted as part of the study were included, and Table 5 illustrates the results.

Table 5

Progression of threat response across dream series, cumulative

	Initial dreams	New dreams	Subsequent dreams
Freeze	6	0	2
Flight	2	2	4
Fight	1	4	6

Valli and Revonsuo (2009) analyzed the content of nightmares of several major studies. They found a flight response in 39% of cases, fight in 34% and both in 5% of cases. In nightmares 58% of responses were fight or flight. The other responses were ineffectual (Zadra et al., 2006) and this may indicate some were actually a freeze response. Aggressive (fight) responses are common in content analyses of nightmares (Firemen, Levin, & Pope, 2014; Robert & Zadra, 2014). Yet in the sample for this study, freeze was the most common response in the initial dreams participants brought, suggesting that the content of those with recurrent replicative nightmares may differ in this respect from typical nightmares. Such a response might be reported by the dreamer in different ways. The dreamer might recall feeling literally unable to act, as reported by Gina, "I was trying to move but I couldn't." Alternatively this part of the dream might be fuzzy or forgotten as freeze is also linked to a dissociative response pattern, which is how Katherine reported her dreams. The dreamer may wake up and still be in a frozen state, as Mitra reported, "After I woke up I felt like it was dark in the room even though the light was on.

I was choking, I couldn't breathe." Valli and Revonsuo accounted for the lack of fight or flight response in these dreams in another way. They stated that 21% could not be coded because of missing information, and 15% could not take evasive or countering action in the dream because the threat had passed or was not accessible. Some of these unexplained responses may be better explained as an immobility response to the threat within the dream (Lanius, Bluhn, & Frewen, 2011). This freeze response changed to a more active flight or fight response after FOD. Mitra summarized her experience of the change in her dreaming as follows: "The way I dream is different now. Previously I was always oppressed, being oppressed, but now I stand against it. I am not defeated by the other person."

Transformations in Dream Time and Setting

Dream setting was a common area of change both within individual dream series and across participants. In those participants whose dreams transformed over time post-intervention, setting was one of the first things that changed, even as many of the other dream elements continued to be literal representations of the original trauma.

Interestingly, in the initial dreams brought by Jose and Mitra, the setting of the dream was already a departure from the literal experience of the trauma. Both of their dreams were set in a nameless city. For Jose, the city was explicitly unknown, although the rest of the action in the dream was a fairly close replication of his trauma experience. Mitra's dream began in a ruined city, the site of a major earthquake. Her dreams were frequently set in a ruined city, which she saw as symbolic of her mental state. Hartmann (2001) found that in dreams after trauma, the main emotion of the dreamer was often depicted as a natural disaster. Mitra's dream is the only example of this in our sample.

For both Mitra and Jose, the setting of the second dream, following their first FOD session, shifted forward to the current time and place. For example, Mitra's next dream took place in her current bedroom, and although the action within the dream was very frightening, the setting was a safe place, her current home. Jose's dream setting also moved from the unknown to the familiar, from the past to the present, and from underground to above it. A few years prior, he was raped in his native Ecuador and his recurring nightmares partially replicated this experience. They began in an unknown city where he was fleeing from pursuers. He ran into a building, into the basement, and when he realized there was no way to escape, he locked himself in a room. It was dark and in this room, he re-experienced the rape.

In dreaming the dream on, he imagined himself on a beach, not in the city at all. He imagined riding a bicycle, or flying, with a sense of freedom. Not immediately, but within a few weeks, Jose's dreams began to change. The representative dream he brought to the therapist in his second dreamwork session was set in Vancouver, his home during the study. He was also with someone he knew and liked. Later in the dream, he recognized the street he was on. From there, they went into a building and up to an apartment, not down to the basement. They had sex that was consensual and enjoyable rather than forced and terrifying.

The changes in Jose's dream (and also the way he changes it himself) were simple opposites. They seemed perhaps too easy, as though he was inventing rather than authentically dreaming into the dream. His language also indicated there was a low level of experiencing in the new dream ending. For example, he said, "I *would like* the scenario to change to being on a beach," rather than using present tense.

In Mitra's imagined new dream ending, there was much more direct experiencing. In allowing her second dream to continue, she simply found herself in the house of Imam Ali, and

felt the experience as deeply embodied. This was much closer to the type of dream experience the therapists were trying to engender. However, in spite of this difference, both participants' dreams began to change. That there was change was significant because one of the main features of the nightmares of participants was the recurring, unchanging nature of their dreams. The FOD process appeared to move the dream content forward in time, and to animate and change static aspects of the dreams. It may be that the simple act of paying attention to the dreams themselves with open curiosity made the difference. Asking participants to turn toward rather than away from the recurrent nightmares was new for them. There was also a suggestion inherent in this protocol that dreams could be entered into in an interactive and creative way, and that they could have meaning, and could shift. This had not occurred to many of the participants. To them, the idea seemed radical, and many asked for clarification or repetition of the instructions to imagine a new dream ending.

Where the dream took place was highly evocative for participants. Jose's unknown city was dark and a strong felt sense of "horror and sorrow" came with it. For Mitra, the ruined city was filled with texture, was busy and confusing and there was a pervasive sense of threat. Exploration of dream settings was the most efficient way to bring the dream back to life, especially if participants were asked to use as many senses as possible. However, this evocative process should be used with caution. Not surprisingly, the dreamers experienced a degree of discomfort and distress when revisiting their nightmares. Some activation of the trauma memory is needed before such a memory can shift (Foa et al., 2009; Long & Quevillon, 2009) but there is evidence to suggest that this activation must be managed (Siegel, 1999; Briere, 2002). If the fear becomes too great, the body becomes overly activated or dissociative. Either way, the process does not move forward. In the recurring nightmares of the study participants, the intensity of fear

was waking them up in the worst part of their dreams, and with no effective way to calm themselves or to work with the dream, they kept dreaming the same thing over and over.

In dreaming into a new version of their nightmares while remaining calm, both Mitra and Jose transported themselves to an entirely different place in their dream landscape. The peaceful, good feelings that followed were a direct result of where they went in their imagination. It took some time, and a few prompts for them to understand what was being asked. Yet even with the freedom to dream the dream onward from any point in the dream and in any way they wished, their imaginative responses were still quite limited. Mitra felt she had to follow the logical narrative of the dream, while Jose could only imagine something opposite and easy. In spite of this, the dreams themselves appeared to respond to process of change, to move out of their repetitive patterns.

Both Jose and Mitra's dreams after the treatment were located in their current home city. There was a sense when they began treatment that their dreaming world had been left behind in their country of origin, the place of unresolved trauma, and stuck in the past. After treatment, Mitra had a dream of transition in which she started in the same messy, ruined city, but by the end of the dream, she had boarded a long-distance bus headed for a new city. Of course all of the participants are immigrants who have literally and recently moved to a new city. Sense of place, of finding home would be far more important to these dreamers than for someone who has a secure sense of home. The refugees in the study also brought with them a sense of hope in movement, the idea that a new city would be the place where they can start a new and better life, free from trauma and persecution.

For the remaining participants, Flora, Katherine and Gina, their most recurrent nightmares all took place at the scene of the original trauma. For Flora this was at her step-

brother's family house. For Katherine, it was at her father-in-law's house, the scene of various rituals that traumatized her and her children. For both of these African women, there was a strong desire for the safety of home.

Katherine said the setting of the initial nightmare she brought to her session was the thing that stood out the most for her. "The rituals were in my ex's father's house. They had all those rituals in it and they were scarier when they were in his father's house. So much rituals. It was like they were going to do, like, human sacrifice." In her new dream ending, Katherine called a taxi, which arrived right away, and she took her children home with her before they were even spotted by her ex-husband's family.

Flora also felt a need to go home. Her second dream began in her own bedroom in Africa, but the scene shifted to a cemetery that contained a sense of threat. She was afraid and started to pray. In her imagination, she completed this dream by going home, but she had to work hard to get there. First she could only crawl, then gradually she could stand and walk, and finally, run. This was a less easy solution than Katherine's new dream ending, but more experientially real.

For Gina, the trauma event that most affected her took place at home so there was no safe place to run to. Her initial dream was set in this home, in the room closest to the front door where the attackers assaulted her and shot her partner. In imagining a new dream ending, she took her son and moved to a different part of the house, deeper inside. She was able to soothe her son, and in turn, she felt calmer. Yet her nightmares continued as before. Gina experienced the least progress as a result of the FOD sessions. It may be in part that a sense of having no safe place (because the threat for her was right in her own home) made it difficult for her to maintain an internal sense of safety. She could find a sense of safety through the process of clearing a space and imagining a new dream ending, but these calm feelings were transient and at the end of the

study, her nightmares were much the same as at the beginning. For the other four participants, there was movement both towards safety and to varying degrees towards the present time. In their later dreams, they all moved closer to the safety of home.

Discussion

Summary and Discussion of Dream Transformations

The process of analyzing the dream material (first by summarizing the experiences of individual participants, and then tracking the transformation of dream material within dreams and dream series of individuals, and finally across participants) brought forward a number of convergences within the data that shed light on the process of recovery from trauma-related nightmares. The FOD process was clearly a form of exposure, and all of the participants found it difficult to confront their trauma material. This is a key difference from IRT, where nightmares are specifically not chosen as the dreams to re-imagine. The latter appears to facilitate the process of forgetting, while FOD appears to be more useful for trauma memory integration. Due to the fact that the focusing-oriented approach tends to invite a deeper level of experiencing, and works best with those who achieve this (Gendlin, 1978/1981), the protocol is best suited for those who have a natural ability to engage in focusing, or have done some work in therapy to develop the ability to work deeply without excessive distress. Or, as Katherine demonstrated, the skill level for engaging in focusing can develop as the person follows the protocol, but the process can take time.

When the nightmares of participants began to change, they did so in specific ways, changing the identity of the dream villain and the nature of the dreamer's interaction with these characters, and weaving current time and place into the trauma memory. This could be seen as the beginning of a return to healthier dream functioning. As Jose's case illustrated, FOD may

facilitate a break in the fear/arousal cycle that perpetuates nightmares. The threat responses within the dreams changed as well, and all participants moved in the direction of more empowered responses.

Study Findings and Mastery

The findings in this study bear some relationship to the study conducted by Germain and colleagues (2004) on increased mastery elements with IRT for the nightmares of 44 female sexual assault survivors. The authors provided support for their hypothesis that mastery, and not exposure and abreaction, was a key process for nightmare reduction. Germain examined the content of imagined new dream endings using both the Hall and van de Castle dream content scoring system and a multidimensional mastery scale (MMS) developed by Germain and Zadra for the study. The authors found significant instances of increased mastery over distressing nightmare content and suggested this may generalize to increased mastery in waking life (i.e., for controlling flashbacks). However, a key limitation in the study was that the authors sought instances of mastery in the new dream endings imagined by participants, but did not examine subsequent dreams. In asking participants to change their nightmares, the specifics of creating a new dream ending were left open by Germain. Participants were not specifically asked to create a positive ending, however most did have significantly more positive and fewer negative elements in the new dream endings compared with the original dreams. This was the case in all five FOD study participants as well, and is hardly surprising. When asked to change a dream in any way, there would be a natural human tendency to solve, fix or improve upon the situation in some way. In their study of IRT outcomes for 48 combat veterans with PTSD, Harb and colleagues (2012) found that 98% of imagined new dreams ended on a positive note. A more powerful indication of change would come from subsequent dreams in which study participants

do not exercise conscious control. Germain (2004) concurred: "Examination of post-treatment dream reports are required to determine how the observed increase in mastery might be incorporated into subsequent dream scenarios or otherwise influence dream activity" (p. 204). In the FOD study, there were a number of instances of increased mastery reflected in the content of the dream reports of participants following the intervention, which is a stronger indication of actual change.

In developing the MMS, Germain and Zadra identified six subscales of mastery: behavioral, social, environmental, emotional, mythical and avoidance. Comparing initial dreams to imagined new dreams, they found that occurrences of social and environmental mastery were significantly greater in new dreams, avoidance decreased, emotional and mythical mastery were unchanged, and contrary to expectations, behavioral mastery decreased. Behavioral mastery was defined as action by the dreamer to alter the dream to their advantage by fighting back or seeking help. Social mastery involved changing aspects of the personality of dream characters, removing threatening characters, changing interactions between characters, adding a helpful new character or assistance by another character. Environmental mastery referred to change the dreamer made in the physical environment to make it less threatening. Germain (2004) suggested that the unexpected reduction in behavioral mastery might be due to the fact that the social and environmental mastery rendered fighting back or seeking help unnecessary. It is interesting in light of the current study because in the new dreams of the five participants, all but one fought back or sought help as part of their new dream ending. Seeking or receiving help emerged as one of the main themes in the subsequent dreams as well. This is possibly because the FOD protocol has a specific step for finding help in the original dream. Also noteworthy is that the themes that

emerged in analysis of dream changes parallel the MMS categories (setting = environmental; dream ego actions = behavioral; changes in the identity of the aggressor = social).

Quantitative Data and Analysis

Although the quantitative data for the initial study were incomplete in some cases, and derived from too small a sample for quantitative analysis, a summary of relevant data is included in Table 6.

Table 6

Summary of Quantitative Data

Participant	1. Flora		2. Jose		3. Mitra		4. Gina		5. Katherine	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
1.Replicative: ID/SD	31	11	38	13	35	28	42	42	42	34
2. PTSD	37	19	27	13	38	27	34	-	25	-
Delayed Onset?		N		N		N		Y		Y
3. ND: EXP/CAS	H	9	M	6	M	9	L	-	L	-
4. BDI	29		34		31		-		38	
5. TRNS data:										
a. Distress: ID vs. SD	5	1	3	1	4	1	3	3	3	3
b. NM freq./week pre/ post	2	0	3	0	5	0	4	4	7	-
c. Hours of sleep	5	-	7	7	4	2	8	8	3	3
d. Time to fall sleep post nm	15-60	0	15-60	<15	240	0	15-60	15-60	120	180
e. Fear of falling asleep	4	1	3	2	3	1	3	5	0	1
f. Yrs exp nms		3		1.5		8		2		20

Definitions

1. The degree to which the dreams were replicative of the original trauma was measured for the initial dream (ID) and subsequent dream (SD) using the dream imagery questionnaire (DIQ) which asked participants to rate degree of similarity in terms of setting, characters, dream ego actions, actions of other characters, and feelings or emotions.
2. PTSD scores pre and post-intervention as measured by the PDS Scale. This section also indicates whether or not the PTSD had a delayed onset.

3. New dreams (ND): The depth of experiencing was measured using the Hendricks scale which scores high (H), medium (M) and low (L). Clearing a space checklist provides a score out of 9 on the degree to which participants were able to engage in focusing steps.
4. Depression score at intake, as measured by the BDI-II.
5. TRNS data pre and post intervention.

a. Distress level of the initial dream versus subsequent dreams, self rated on a scale of 1-5
b. Nightmare frequency per week as indicated on the initial and final trauma-related nightmare survey (TRNS). (Interim scores were also recorded, but not consistently across participants.)
c. Average hours of sleep per night in the past week.
d. Time it takes participants to fall back asleep after a nightmare, in minutes. For those with no nightmares reported for the week, the score was recorded as 0.
e. Fear of falling asleep when first going to bed, pre and post-FOD, self-rated on a scale from 1-5, where 1=not at all and 5=extremely.
f. Number of years the participant has been experiencing nightmares.

Missing data is indicated by a dash.

The direction of PTSD levels showed a promising trend. All participants began with very high levels of PTSD, most in the severe range, and all three of the participants who completed the final outcome measures experienced a marked reduction in PTSD scores. The last two participants were not able to complete the study prior to the closure of VAST, and so they did not complete the PDS post-test.

The dream imagery questionnaire scores (DIQ) represent the scores of the first six questions that relate directly to the degree the dream brought by participants replicated their original trauma overall and in terms of character, setting, actions of self and other, and emotions. The highest score possible was 42, and two participants scored this high on their initial, typical nightmare. Also noteworthy is the fact that all but one of the subsequent DIQ scores (rated for the first dream post-intervention that the participants brought) were reduced. There is a potential correlation between degree of trauma replication in the dreams, and PTSD levels. This is supported by the research of Davis, Byrd, Rhudy, and Wright (2007) who found a positive correlation between degree to which dreams replicated trauma and degree of related distress in the experience of 94 trauma-exposed participants.

Also noted in the quantitative data are the extremely high depression scores among all the participants who completed the BDI-II. This instrument was not workable with this population (due to the fact that it was for English or Spanish speakers only), and was used as a screening tool. However it would be worthwhile to collect post-intervention data on the effect of the FOD intervention on depression levels, as this may have improved in conjunction with reduced PTSD.

Finally, the experiencing scores were based on the Hendricks simplified experiencing scale as applied to the intervention sessions of each of the participants. The scale is simple to follow and distinguishes between three levels of experiencing: high, medium and low based on how directly and personally participants describe their experience. The ratings were done by the author for this data set (however for a quantitative analysis independent raters would be preferable.)

In comparing and combining the dream content changes and quantitative data, two distinct categories of experience emerged among the five participants. The elements that differentiated participants 1-3 (group one) from participants 4-5 (group two) are summarized in Table 7

Table differentiating patterns of experience

Participant	Flora	Jose	Mitra	Gina	Katherine
1. ID differs from trauma event	Y	Y	Y	N	N
2. Change consistent					
a. Villain	Y	Y	Y	N	N
b. Dream ego	Y	Y	Y	N	N
c. Time/Place	Y	Y	Y	Y	Y
3. Med-high Exp.	Y	Y	Y	N	N
4. Less nm distress	Y	Y	Y	N	N
5. Fewer nms	Y	Y	Y	N	N
6. Reduced PTSD	Y	Y	Y	-	-
7. Less fear pre-sleep	Y	Y	Y	N	N
8. Less time to sleep	Y	Y	Y	N	N
9. No delayed onset	Y	Y	Y	N	N

Definitions

1. This indicates whether the initial dreams (ID) were already in some ways different from the original trauma event.
2. This section indicates whether the changes made to create the new dream (ND) were reflected in that particular content area in the subsequent dream (SD).
3. This indicates whether the participant had a medium-high experiencing level as indicated by the Hendricks simplified experiencing scale.
4. Indicates a reduction in nightmare distress.
5. Indicates a reduction in frequency of nightmares.
6. Indicates a reduction in PTSD symptoms as measures by the PDS scale.
7. Indicates reduced fear falling asleep, as measured by the TRNS self-report measure.
8. Indicates reduced time to fall asleep initially, as indicated on the TRNS survey.
9. Indicated no delayed onset: PTSD symptoms were experienced within three months of trauma

There are a few preliminary conclusions that could be drawn from this table. The first is that it appeared as though the FOD intervention was best suited for those whose initial dreams had begun to change from exact replication of the trauma event. This shift in dream content may have indicated the process of recovery from trauma had started, and that they were primed for the intervention. The delayed onset of PTSD differentiates the two groups and raises the question of whether delayed onset PTSD is more intractable. Overall, I am reluctant to conclude that group two were not good candidates for FOD, but rather that they may have been at an earlier stage in the recovery process, and could show evidence of further recovery given more time and treatment. Table 7 indicated that all of the participants' dreams showed some change in the time and/or setting. An optimistic reading would be that FOD is most helpful to those further along in their trauma recovery, but that the intervention may also help move those at an earlier stage forward to a place where change is possible. A more guarded interpretation might be that there is an optimum time to use a dream revision process because it works like a vaccine that is most effective the first time it is administered, with diminishing returns when used on an ongoing basis. If this is the case, it would be better for participants in group two to engage in regular trauma therapy prior to FOD to maximize potential benefits.

PTSD Symptom Relief

This section focuses on the clinically significant improvement in PTSD symptoms for group one participants. Table 8 summarizes symptom changes across the three symptom clusters.

Table 8

Group two change in PTSD scores pre and post FOD, including symptom clusters

Participant	Flora		Jose		Mitra	
Pre-post total	37	19	27	13	38	27
Re-experiencing	12	5	7	5	14	7
Avoidance	14	6	14	4	10	9
Arousal	11	8	6	4	14	11
Change: Total	14		14		11	
Re-experiencing	7		2		7	
Avoidance	8		10		1	
Arousal	3		2		3	

Using the PDS scale (Foa, 1995), PTSD symptoms were measured across three clusters: re-experiencing, avoidance and arousal. Participants experienced a reduction in symptoms across all of the three clusters, but arousal symptoms were generally reduced the least and avoidance was reduced the most. For the participants whose PDS data was complete, re-experiencing symptoms dropped an average of 36%, avoidance symptoms by 30% and arousal by 18%, with an average reduction in PTSD symptoms of 25%. Below are some excerpts in which participants specifically mentioned changes in their PTSD symptoms.

Re-experiencing. One of the obvious factors to account for the high reduction in re-experiencing symptoms was the reduction in nightmares. Flora, for example, experienced a complete cessation of her nightmares, and two of the other participants experienced a reduction in nightmare frequency. Participants also reported fewer daytime flashbacks, and less disturbing emotion.

Avoidance. Jose found the process of working with his nightmares to be a form of direct confrontation of his trauma material, and in particular, the emotions the trauma-related nightmares brought up for him. As a result of learning to calm himself down after a nightmare and to imagine a new dream ending, a practice he adopted on his own after the study, he noted less fear going to sleep, and a markedly increased ability to confront disturbing dream material. "I'm not that fearful to have the dream itself or like to have the nightmare…. since I wrote them down I think it's a way for me to fight against them." Of all the participants, Jose had the highest initial score on the avoidance cluster (14) and the most dramatic reduction (down to 4), a reduction of 48%. The exposure aspect of this intervention worked well for him and his particular distribution of symptoms.

Arousal. This symptom cluster changed least, and for at least one participant, Gina, it increased in the week following the FOD intervention, to return to pre-study levels and few weeks later. In tracking trauma-related nightmare symptoms throughout the study, this is a pattern that was observed to a lesser degree in other participants as well. There is a chance that working as directly with nightmare material as this protocol does can be likened to a homeopathic treatment where like cures like, and symptoms worsen before they get better.

Additional Themes and Outcomes

Below is a brief explication of each of the themes that came up in the initial thematic analysis that were not already covered in the dream transformation analysis, but are noteworthy for their impact on the participants. They were not included in the summary tables above because not all participants addressed these themes. However, they emerged often enough, or were striking enough to be worthy of mention.

Changes and Perception of Changes of Sleeping and Dreaming

One curious theme that emerged from the data is the lack of recognition of acknowledgement of the positive changes that took place in the participants' dream lives and in their PTSD symptoms during the course of the study. For most, acknowledgement of change required direct questioning or prompting. Even when the changes were quite dramatic and positive, the participants tended not to experience them as such. This could be a feature of those who have been traumatized for much of their lives. For them, it is difficult to acknowledge and enjoy good and positive events because in their challenging lives, there have always been more problems to attend to. Therefore, they are pragmatic and when one problem is solved, they turn their attention to other problems. Another possible explanation is found in a study (Walker, 2009) that demonstrated that retention of emotional memory, *particularly positive emotional memory* was disrupted with sleep deprivation (which was consistently experienced by most participants in this study).

Flora, who arguably had the most dramatically positive outcome in the study, provided an example of this. Over the course of the study, her relationship to her dreams was transformed. In her closing session she said she "very much" enjoyed her dreams and missed them. Yet her answers to the initial questions about her nightmares clearly indicated her dreams were unwelcome, and extremely disturbing. Somehow, over the course of the study, she seemed to have forgotten how bad her dreams were, and expressed the wish that she could remember them better.

Mitra had a similar, rather nonchalant reaction to the outcome of the FOD intervention. Although both her PTSD symptoms and her nightmares improved in a number of tangible ways over the period of the study, she was not effusive about the progress. In her recurring dream, her

brother who had abused her was always present, and always terrified her. In the dreams she reported at the close of the study, he was less of a presence and did not scare her at all. Yet because he was still a presence in her dreams, she said she thought the process had failed to work for her. Mitra's case also illustrated the way many of the participants failed to see change that was indeed happening in their dreams. For example, Mitra brought a third dream that was very similar in some ways to her first dream of a city in ruins. Yet in the first dream, the city was being further destroyed, while in the subsequent dream, the emphasis was on reconstruction. Mitra saw these dreams as essentially the same, and only noticed the positive change once prompted to look for it. Such prompting would be a useful addition to the FOD protocol.

FOD Works in a Cross-Cultural Context

Another theme to briefly mention here is the cross-cultural nature of the study, and the observation that the intervention appeared to function similarly regardless of race, culture, language or country of origin. This is not to say that everyone was adept at focusing, but that all had similar types of questions and none were jarred by the process or closed to what it asked of them. Participants were from Afghanistan, Honduras, Congo, Ecuador, and Nigeria, and whereas some had trouble understanding or answering some of the measures in the study, all were able to engage the focusing process (to varying degrees) and to take something of value from it. This suggests the FOD protocol could be useful in a wide variety of cultural settings.

Benefits Identified by Participants

Although the participants were not effusive about the change in their dream lives, they did mention some very specific benefits of the process. This seemed to differ across participants, and appeared to address the needs of their individual cases.

Restoration of identity. Flora said she felt empowered by the FOD process. In her first new dream ending, she took control within the dream situation and found a voice with which to stand up to her attackers. This gave her a new sense of identity, or more accurately, enabled her to reclaim the identity she had lost as a result of her trauma. At her exit interview, she said, "I know what I want, I know what I don't want. If I can't stand it, I have a voice to say no I don't like it. Before I was like being frightened, like no, I am not going to say anything. I am not like that anymore. Now I have a voice. I can say yes or I can say no." And later she added, "I found my real identity. The one that I had before experiencing these trauma. I found my real identity."

Self-regulation and control. Jose began to use the techniques of clearing a space and re-imagining to work with his suicidal thoughts as well as his nightmares. Jose said that he was learning to be calm, and that he learned this from working with his nightmares in the way the FOD therapist taught him. He could see the benefits of applying this to other areas of his life. He expressed feeling much more in control of his own dreaming process, and the emotional effect of his nightmares. He was no longer a passive victim of his dreams but felt he had gained some power over how they affected him. "I can have control on the dream, not the dream on me."

The ability to self-regulate by controlling the emotional impact of nightmares appeared to create a shift in the cycle of fear that appears to perpetuate PTSD symptoms. The fear was ever-present, even during sleep, and the state of arousal that in normal sleepers shuts down at night, does not do so for those with PTSD. Germain's (2014) unpublished brain research confirms this. When a person experiences recurrent nightmares and then wakes up in terror, they want to stay awake to avoid repeating the terrifying experience. If they have a means to calm themselves down upon awakening from the nightmare, they are less afraid to go to sleep, less afraid *as* they go to sleep, and possibly experience less fear *during* sleep as well. In this less frightened state, they may be less likely to have nightmares. This is the theory behind Levin and Neilsen's (2007)

cross-state continuity, and also compatible with the widely-supported continuity hypothesis. The suggestion here is that the clients treated by FOD who were able to develop a new ability to self-regulate were able to change the pattern of their PTSD dreaming, interrupting the cycle of fear. This appeared to be the case in all but one of the five participants.

However, all participants reported increased arousal first, in the direct encounter with their nightmare material. This is a painful step that may be necessary to achieve a sense of control over the fear. The ability to stand and face the trauma material in the dream may be the key to its transformation.

Bodily felt shifts. Another possible avenue for change as a result of the FOD process is in the body, and the felt sense of the body. This type of shift happened quite dramatically for one of the participants, and is a fairly common occurrence during a course of focusing-oriented therapy. The client who experienced this shift had been in focusing-oriented therapy for longer than any of the other participants. She also might be someone who naturally tapped into their bodily felt sense of a situation, an ability that comes naturally to a minority of people (Gendlin, 1978/1981). Mitra's experience of the stone in her chest was the most focusing-oriented of any passage in the session transcripts, so is presented here as an example of how such work might go with other clients given more time, and a more typical therapy setting.

Mitra first reported a sense of the stone in her chest in a nightmare of her brother suffocating her. She associated her brother with "something" on her chest. In the second dream of the series recorded in this study, a terrorist was sitting on her chest, brandishing a knife, with the intent to kill her. She was left with the sense of a stone in her chest that she (at times quite literally) wanted to cut out from inside her. "I want to open my chest. It's like a lump that has been torturing me all my life. I just want it out." Her new dream ending transported her to the

house of Imam Ali, and she felt lightness in her chest. At her final interview about two months later, Mitra said the sensation of the stone in her chest had not returned. This was a physical *felt shift,* and is a significant step in the process of focusing.

Adverse Reactions: Remembering Versus Forgetting

The main adverse reaction reported by most of the participants was the discomfort they experienced in telling their nightmares, which brought back clear memories of the trauma they experienced. Flora said, "The bad thing in this is recalling all the memories, all that happened. When I recalled all of those, to sleep at night is a problem. It's like I'm reliving again those things. That's a negative side. The positive side is now I have my feet to stand on again. But that bad thing is, I am trying to forget."

In Mitra's exit interview, encouraged by her new husband-to-be, she spoke of a strong desire to erase the past. "What I'm thinking is that if I gradually let it go, if I just go away… actually now I have no reminders of my brother, no pictures of him. My husband says don't even mention his name. Because even simply his name reminds you of the difficult past that you've experienced and I really try not to…" In this session, the therapist suggested that talking about the past can be helpful in the context of therapy, and is something worth paying attention to. Mitra continued to talk about her desire to forget: "It [the past] depresses me… I think that it's a lost piece that I will not be able to find again. The same as like this moment, once this moment is gone, it's gone. It won't come back again. The years that I could have lived happily were spent with sorrow and sadness. So I can't go back and recreate those childhood years, recreate them again, they're all gone. That's why I don't want to talk about them."

As discussed earlier, Lavie and Kaminer (1991) showed that in the very worst trauma situations, effectively forgetting can be an adaptive response. Clearly those who continue to

experience nightmares have not effectively forgotten their trauma. Even if they could, not everyone wants to file the memory away without coming to terms with their traumatic experiences. For many, working through their trauma history is the key to healing and can have benefits beyond recovering from the trauma (Tedeschi & Calhoun, 1996, 2004). Desire to avoid the trauma memory can be part of the symptom picture of PTSD, or it can be exactly what is needed. Specific ways to determine which the best approach is in a given case would be a valuable addition to the field of trauma therapy. The examination of the nature of the dream life of the trauma survivor could be an important factor in the decision-making process.

For some participants of the FOD process and for virtually all of those who benefitted from IRT (Barry Krakow, 2014, personal communication), the practice of imagining a new dream ending reduced not only nightmare frequency, but dream recall in general. It is possible that completing the nightmare puts it to bed, so to speak, and facilitates the process of forgetting. However, in cases of normal remembering, where PTSD is not present, trauma memories do not disappear but instead soften and lose their intense charge; only those with PTSD remember their traumatic experiences in perfect detail years later (Lee, 1995). In his review of the role of sleep, Walker (2009) found that REM sleep (and dreaming) separate the emotional charge from memories, but this does not happen for those with PTSD, and so the cycle of nightmares repeats. The FOD process is an attempt to induce a normal dream-like experience while awake, which may have the dream-like effect of reducing the emotional charge of the trauma event. This might also begin to reinstate a more normal dreaming process.

In Flora's case, her nightmares stopped, as did all dream recall, but a period of stress brought her nightmares back briefly. This may be the danger of sealing off a trauma memory and attempting to completely forget it. Triggers, stress, and the passage of time could all potentially

break the seal, and flood the trauma survivor with unprocessed trauma memories once again. Working through and integrating the trauma memories reduces this risk, and also offers protection against the development of PTSD symptoms in the future (Foa, Keane, Friedman, & Cohen, 2009; Moustafa, 2013). The FOD protocol, which includes the challenging exercise of working directly with the trauma-related nightmare material, was developed for those with PTSD for whom remembering is better than forgetting. I believe this is true for most trauma victims, provided the trauma material can be constructively integrated. Whether or not this is possible depends on the client's stage of trauma recovery, the intensity and duration of the original trauma experience, the stability of the current life situation, and personality factors such as degree of resilience, strength and ability to work with traumatic dream material in an embodied, experiential way. It is ultimately the client's decision, but for those who feel it is important to stand and face their nightmares directly, and to integrate their trauma experience, FOD offers a protocol for therapists to follow that was designed to be gentle and client-centered, in keeping with the philosophy of the focusing-oriented approach.

In the version of FOD developed for this study, (which is an enhancement of Gendlin's method particularly for working with trauma), there is controlled but direct exposure to the trauma material. Included is instruction in somatic regulation skills, such as distancing, pacing and development of an *observer-self* which gives the clients a greater sense of control over their process. All of these are tools the participants adopted to varying degrees, and none are present in the IRT protocol. In fact, other than creation of a new dream ending, FOD and IRT are very different approaches to working with nightmares.

Overall, what emerged from the data analysis is a clearer picture of how a focusing-oriented dreamwork intervention effects change in the dream lives of trauma survivors. There are

several possible mechanisms of action. The simplest may be that paying attention to dreams in a supportive environment, akin to Hartmann's (2001) idea of "making connections in a safe place" is what facilitates positive change. In addition, deeper levels of imaginal experiencing appear to enhance the process through finding a felt sense of dreaming the dream forward. Another possible change agent is the emerging power of the dreamers to take control of their nightmares and fear responses, both within the dream, and in response to it upon waking. When this process was possible, it seemed to increase resilience, and enable greater self-reflection which appeared to break the cycle of fear and arousal that perpetuates recurrent nightmares. The temporal and setting changes may reflect the beginnings of change in the way participants stored their trauma memories. They were beginning to differentiate between past trauma and current experience, which could explain the reduction in re-experiencing symptoms. Other benefits identified by individual participants included restoration of identity and greater control over fear response to nightmares. However, there was a curious lack of recognition or enthusiasm for the positive change engendered by the FOD protocol, which can be characteristic of those with complex trauma experiences. Trauma survivors may have a reduced ability to enjoy and appreciate positive change. For some, any engagement with trauma memories was disturbing and unwelcome, even if such encounters might facilitate integration. However, for those who were good candidates for the process, the FOD protocol appeared to facilitate change in their recurrent and repetitive nightmares, and these changes were reflected both in dreaming and waking life changes.

Chapter 5: Summary, Conclusions, and Recommendations.

Summary

The aim of this study was to use an interpretative phenomenological analysis (IPA) to examine the experience of five refugees who engaged in an aborted larger study testing effectiveness of focusing oriented dreamwork (FOD) for recurrent PTSD nightmares. In the analysis, I was interested in fine-tuning the FOD intervention itself, determining who might be good candidates for such an intervention, and what worked and what did not in their experience. I tracked several aspects of the dreams themselves including how closely the initial dreams matched the original trauma event, and if imagining a new dream ending could engender more dream-like elements in the participants' subsequent dreams. I was also interested in the effect of the intervention on PTSD symptoms, and what might be possible mechanisms of action, if in fact FOD did help alleviate PTSD.

Although the data were not sufficient to answer any of these questions definitively, they could begin to point in directions that seem promising and might warrant further inquiry. The review of the literature provided justification for the study of FOD. The modality falls into the category of imagery rescripting therapies for treatment of nightmares. IRT has received by far the most empirical support in this category, but there are two gaps that this study addresses. The first is that IRT does not work for everyone and is specifically not recommended for those with replicative nightmares. Second, the mechanisms of action are not well understood.

The FOD intervention was designed without prior knowledge of the IRT process, although in retrospect, it does fill in some missing pieces that would improve the treatment for some categories of nightmare sufferers. Focusing is a gentle, body-oriented form of therapy that was designed for one-on-one, client-centered exploration of the client's inner felt sense of a

situation. The FOD intervention was designed for treating nightmares, so it incorporated techniques to manage trauma responses, and allow for safe exposure to the trauma material.

The data were collected as part of an initially-planned quantitative study that included measures of various clinical symptoms (PTSD, depression, aspects of sleep and dreaming) as well as questions about the degree to which the dreams of participants were replicative or metaphorical. The data collection plan proved to be too ambitious for the participant group, so the data were not gathered fully or systematically for some participants. However, the sessions and dreams themselves were recorded, and the resulting transcripts provided adequate data for a qualitative analysis.

The IPA analysis began with a detailed examination of individual participants' dream material, including initial dreams, newly imagined dream endings, and subsequent dreams. Participants were also asked about their experience with FOD and the study, and major themes emerged from close reading of transcripts of the above material. Themes were grouped into two main categories: the changes in dreams themselves, and the participant experiences of the intervention/study. Data from these two main categories were examined separately.

The focus of the analysis of the dreams was on whether and how they changed from initial recurrent replicative dreams to dreams post-intervention, and the possible role the imagined new dreams played in these changes. Participant experiences, such as symptom changes and depth of experiencing, were noted as they related to dream changes. Within the dreams themselves, there were three major areas of change in the content of the dreams: the identity of the aggressor, the actions of the dream ego, and the time and place in which the dreams were set. Coinciding with the change in dream content, there were clinically-significant improvements in PTSD symptoms (particularly in the avoidance and re-experiencing clusters),

and changes in some aspects of the cycles of fear and sleep. A close reading of how the dreams and symptoms were changing suggested a theory about what was happening in those participants for whom the process appeared to work. There was an apparent interruption in the cycle of fear, specifically less fear falling asleep, during dreaming and in waking from nightmares. In listening closely to the accounts of how fear patterns related to their dreams, I noticed that the dreams contained representations of the three major threat responses (fight, flight, and freeze), and that these appeared to coincide with the dreamer's actions within the dream, and with their feelings and sensations upon waking. I investigated this further, finding instances of fight, flight, and freeze in the dreams, and some indication of a progression from a passive to active response in all participants. Analysis of the process of conducting the study and testing the FOD intervention yielded practical information about how to improve the protocol and study design. These findings are summarized in the section below on limitations and recommendations.

The data analysis took me far from where I started, but en route provided many valuable insights. It appeared that the FOD intervention worked for most participants as a treatment for PTSD and nightmares, and that the best candidates were those who had already begun the trauma recovery process or had dreams that were not strictly replicative of their trauma. It is possible that in order to benefit from FOD, participants must first reach a basic level of inner somatic and psychological resourcing. The data suggested that trauma recovery might be indicated by the beginning of a shift in the recurrent dreams from exact replication of trauma events toward more typical dreaming that included elements that were not part of the original trauma experience. Analysis of participant responses to the treatment garnered many insights into the ways in which a study on the use of FOD for PTSD nightmares could be improved upon.

Conclusions

The following conclusions briefly describe my understanding of what was happening in the FOD process that enabled change to occur for the study participants. These conclusions draw a theory. It would require much further study to determine whether the process is actually working as I envision it here.

According to Gendlin (2012a), all dreams are unfinished pieces of life-forward process, and he would include nightmares within this definition. However, the recurrent nightmares of trauma survivors may be an exception to this definition because the dreaming process is not only incomplete, but also is usually stopped in the most frightening place, before the dream can be said to move the dreamer forward in any constructive way. The fear engendered by the nightmare creates such an intense emotional response, it wakes up the dreamer and stops the dream part-way through. This could be viewed as a "stopped process" in Gendlin's (1997, p. 85) process model. In this model, a stopped process then becomes an iterative "implying" (p. 90) as it repeats and repeats until something new or different happens that can move the process forward as intended.

When the dreamer wakes up from a nightmare, it is often as a result of their intense physical/emotional response to the content of the dream. Given the high level of physical activation that participants reported upon waking from nightmares, I would suggest that the nightmare content in those moments is directly related to the currently-experienced feelings in the body of the dreamer. When the dreamer of a nightmare is having a fear response while dreaming, they appear to have a fight, flight, or freeze response in their body and the dream content reflects this. If they are in flight mode, they will have the classic fear dream of running away. If they are engaged in a battle of some kind, they are clearly in fight mode. The freeze

response, common in nightmares, is taking place when the dreamer feels immobilized, physically frozen, unable to fight back, call out or move. All of these fear response states are so uncomfortable that the dreamer wakes up from them, and when they wake up, the physiological state continues (as reported by the participants who noted increased heart rate and respiration, feelings of panic and many other physiological responses upon waking from nightmares).

Does the fear cause the dream (fear of going to sleep, habitual hyper-arousal) or does the dream cause the fear, or is it a cycle of both/and? If the dreamer could somehow break the cycle of fear response, if they were not as afraid while dreaming, they could stay asleep and keep dreaming, and the dream would be able to complete its process. The natural dreaming process could continue in a more normal fashion if, within the dreaming process itself or upon waking, those who experience nightmares were able to calm the fear, or change the dream so it was less frightening. For example, during the dream or in imagining it after, they could change the nature of their attacker, change the time and place of the dream, or change their actions within the dream to something more constructive.

The focusing oriented process is one way of interrupting the fear cycle. In working directly with their trauma nightmare, the dreamer confronts their trauma memory head-on. This can be more challenging than the IRT protocol where nightmares are not worked with directly, but there is evidence that direct confrontation of trauma material (exposure) has benefits for many, including post-traumatic growth (Tedeschi & Calhoun, 1996, 2004) and protection against PTSD in the future (Foa, Keane, Friedman, & Cohen, 2009). Whether it is better to remember or forget one's trauma experiences depends upon each individual situation; it depends upon the intensity of the trauma experience, and the ability of the dreamer to work with the memory in a way that does not undo them. I have a bias here that, where possible, it is better to work toward

conscious integration of trauma memory, but that it is the client's, not the clinician's place to decide this.

Stopping the cycle of fear inherent in the PTSD symptom picture appears to reduce all symptoms. A relevant question is whether it matters where the cycle is changed. Would working with daytime symptoms such as flashbacks or arousal work the same way? In fact, most therapy for trauma symptoms does work with the daytime symptoms, teaching PTSD sufferers to calm themselves, and to try to recognize the threat response as a reaction to a danger from the past. It seems that this process is slow, and tends not to reduce nightmares (Spoormaker & Montgomery, 2008). Working directly with nightmares appears to act more quickly and powerfully, often making a difference in just one intervention. I would suggest one thing that gives work with the dream such power is that the recurrent nightmare represents the essence of the trauma memory, or the aspects of the memory that continue to be the most disturbing and unresolved for the dreamer. Therefore, working with this material takes the dreamer to the heart of the problem. In addition, it moves a stopped process forward, and this can have a "startling power [because when what was missing occurs] all of that process which was stopped by the absence will occur" (Gendlin, 1997, p. 12). It is as though the stopped process formed a dam that when broken, allowed for many processes that were not possible before. For those with dreams stuck on repeat, moving them forward allows the dreams to again resume their proper functioning. If, as much evidence suggests, these dream functions include emotional regulation and memory consolidation, then this can make an enormous difference in the lives of those with PTSD. I picture the process like a skipping record (for those old enough to remember record players). The dreamwork simply nudges the needle forward to the next track and the song (or the dream) can then resume playing.

In picking up the thread of how the FOD process might affect metaphorical thinking capabilities, this study did not provide much evidence of increased metaphorical content or richness in the dream changes of participants. There were some small moves in this direction, and one may expect more of such change further along in the recovery process. When the brain is in a heightened trauma response state, as it was for all participants, its normal resting state, the *default mode network*, is not active (Daniels, Bluhm, & Lanius, 2013). There is evidence that the brain's default mode, which is activated (or more accurately, not de-activated) when a person is not directing their attention to a particular goal or task, is the state that generates creativity (Takeuchi et al., 2011), social and emotional processes, and internal reflection (Binder et al., 1999). Given this, I would suggest that the resting state, where the mind is free to wander, is the state in which metaphorical thinking is possible. Domhoff (2011) has made a strong case that this same default network is "likely the neural substrate that supports dreaming" (p. 1163).

One of the mechanisms that might be at work in FOD process, when successful, is the activation of a dream-like state that makes it possible to experience the completion of the dream itself. The protocol asked clients to dream their dream onward as if they were actually still having the dream. Participants were guided to find the felt sense of the dream (or of the cleared space if the dream itself was too frightening) and then allow the natural forward-moving tendency of the felt sense to complete the dream. This is different from inventing just any new ending because it invites the dreamer back into an experience that is closer to the dreaming state itself. If a person is able to authentically re-enter their dreaming process, they will be completing, while awake, the unfinished business of the dream. Once this is done, the dream does not repeat. Or, if the completion is partial, the dream might come back in a different form, but not quite the same as before (like Mitra's second dream of the ruined city). In allowing the dream to complete

naturally by staying as close as possible to the dreaming body's intention, not only does the dream no longer need to repeat, but it has moved the dreamer forward in the way it was intended by the dreaming process itself. Early progress might be indicated when elements of the current setting or time are woven into the concrete, realistic replay of a trauma memory. Also, the dream characters, particularly the villain and the dream ego, might begin to change. The appearance and increased richness of metaphors would indicate a further progression, but not one that was yet much in evidence in this participant sample.

The FOD process may be exercising the imagination, allowing the dreamer to experience more open-ended, imaginative processes while awake that may then translate into dreaming. IRT does this as well, but with an increased level of conscious ego-directed attention. The FOD process encourages more of a stream of consciousness that invites the dreamer to tap into the intention of their dreaming body, ideally engendering an authentic, and deeply experienced completion of their dream. The more deeply experienced an event, the more difficult it is to forget and the more likely to be integrated into ongoing experience.

In both FOD and IRT, the creation of a new dream ending teaches people to use and manipulate their internal imagery system. Subsequently, in their actual dreaming, it might occur to them to do the same thing, to seize the same kind of power. For example, when they are being attacked, rather than wake up, they might dream that they run to a safe place, or face up to their attacker and stand their ground. The more empowered the response is, the less frightening and the more healing the dream is likely to be, and the less likely it is to recur. Possibly FOD could be thought of as dream calisthenics, or dream training similar to the way lucid dreamers develop dreaming skills to cultivate consciousness awareness and/or control of dreaming. The difference is that FOD is trying to engender the process of dreaming while awake. There is potentially more

control over the dreaming process in the waking state, which can be a good or a bad thing. Conscious control can either allow or prevent the process of dreaming to complete, and could depend on the degree of avoidance present in the dreamer.

Increased control and empowerment while dreaming can stop the cycle of fear for PTSD sufferers. If a person can remain calm enough to complete the dream while awake, this may translate into the ability to remain calm enough in the dreaming state itself so that they are not startled awake, and their dream can finish. The dreamer could also take the ability to calm themselves from their dreaming into their waking life either working with the nightmares that do still occur or working with other difficult daytime situations (such as Jose's suicidal thoughts). They will sleep better, be less afraid to fall asleep, and more able to calm themselves, if needed, upon wakening. These are exactly the types of changes that occurred, to varying degrees, with the participants in this study.

The degree of success of the FOD process may depend upon which strategy the dreamer uses to work with their nightmare. Do they avert the trauma event, move it forward or change its pattern? In Katherine's response, she changed the dream at the beginning, avoiding entering the ritual house altogether. This pre-emptive strike was calming and averted the memory, but could also be seen as a form of avoidance, which is itself a symptom of PTSD. It would likely be better to have the ability to return to the memory at one's choosing, along with the ability to regulate the emotions that arise in response to the memory. Focusing teaches such emotional regulation skills, encouraging clients to find the right distance from difficult memories or feelings.

In light of the findings, I might add to the FOD protocol by encouraging the dreamer in the direction of changes identified in this analysis. When asking into the dream, I might ask what the dreamer notices about the dream aggressor because this appears to be a possible place of

change. I would watch for shifts in time and place, especially those that move toward the current time and place because this could indicate the beginning of the weaving of present and past that is present in healthy dreaming. Another area to consider is the action of the dream ego, but here I would exercise caution against being too directive. It is tempting to encourage someone, when dreaming the dream on, to take control, to stand up and fight, but there is some evidence that the process works better when the new dream direction is left open, rather than changed to something positive. Krakow and Zadra (2006) speculated that the open-ended instruction "leaves open a psychological window through which the patient may intuitively glimpse multilayered solutions to other emotional conflicts" (p. 61). I think the new dream ending must feel authentic to be deeply experienced, and to move the business of the dream forward in the direction it was intended to go.

The final option for changing the dream, and where this study's participants most often wanted to be when their imagined dream ended, was safely home. This sense of a safe home is different for each person, and for some, does not exist either internally or externally. For those in the latter category, trauma work begins with establishing a sense of safety because this is an important first step in trauma recovery. It was also a challenging part of working with the participants in this study. Their lives in their countries of origin were very difficult and challenges often continued in Canada. Although their lives in Vancouver were generally free from trauma (though not universally), they all experienced loss of family, community, economic stability, and many other issues that made it more challenging for them to heal. On the positive side, they were resilient, resourceful people who had the wherewithal to leave their desperate situations and travel to Canada, which was, in their minds, a place of safety and refuge. It saddens me to say that for some of the participants, and many other refugees, Canada did not

provide the safe home they were seeking. However, the participants in this study did develop a greater internal sense of safety and ability to calm themselves when needed, and this they can take with them anywhere.

Limitations and Recommendations

This section will focus on the FOD protocol and study design, including limitations, how the protocol worked for this population, and what elements of the study might be added to or improved upon.

Sample

The data was originally intended for use in a quantitative analysis, but with just five participants, and an incomplete data set from two of those, the analysis had to be changed to a qualitative one. There were many complications in the data collection process, and these are addressed below. The issue of sample size is more fully addressed in the methods sections and those arguments will not be repeated here.

Screening

Screening was a challenging aspect of the study. There was a concern about working with participants who were too traumatized, depressed or suicidal to work directly with their trauma material. However if VAST had screened out all severe reactions to trauma and ensuing challenges, there would have been no participants. For example, the initial cut-off for depression was set at 29, and at this level, all but one of the participants would not have qualified for participation. Severe depression levels appeared to be a standard feature of this population. What was more practical was to monitor for suicide risk. The ultimate decision about whether or not to include participants was made on a case-by-case basis based on the judgment and knowledge of the therapist and clinical supervisor who had ongoing contact with participants. Such a provision

may not be practical in larger-scale studies. However, the inclusion criteria must be broader than originally set, especially for depression.

Participant Factors in the Data Collection Process

The study was designed with a fairly strict and tight time frame, with three weekly sessions and a one-month follow-up. This schedule was not strictly followed by any of the participants, and was, in retrospect, impractical. The data collection schedule must be flexible for this population and take into consideration the participants' many physical and mental health issues, their limited resources and highly complicated lives. Many were in the process of applying for refugee status, and immigration hearings and meetings clearly took precedence over the study. Many were working several jobs and unpredictable shifts, which is typical in a new immigrant population. As well, all participants suffered from moderate to severe PTSD and depression, so did not always feel energized or resourced enough to process their nightmares on a strict schedule. Future study design for research with a refugee/new immigrant population would need to include greater flexibility in terms of timing of data collection.

In addition, the time to complete the data collection sessions was highly variable but often more than twice as long as expected (or indicated on the documentation for the questionnaires). This was due in part to the need for a translator in one case, and in other cases because the questions were not always immediately understood, and were taken very seriously by participants. Participants rarely gave fast answers, even when specifically instructed not to over-think or take too much time with each question.

Also, although the data collections sessions were designed to be non-taxing for participants, and the number of questions and questionnaires was carefully limited (and reduced again once the study was under way), the overall experience was difficult and tiring for most of

the participants. Some had to break sessions into two segments to complete them, and most found the process time-consuming and challenging. There is a balance to be struck in conducting a study of this nature between acquiring enough data for the result to be meaningful, and avoiding over-taxing study participants. For this population, questions should be pared down to acquire only information that is considered essential.

Measures

The Beck depression inventory did not work as a clinician-administered measure and should always be used in the self-report manner in which it was designed. The different choices of answers in each question are qualitative and nuanced, not set on a simple scale, so those completing the questionnaire needed to have the choices in front to them to reflect and compare. We tried administering this measure orally because of the variety of first languages spoken by participants, and variable ability to read English. The task was time-consuming and difficult for participants and so was dropped. The simpler suicidal behaviors questionnaire was used on an ongoing basis through the study to screen and monitor for dangerous levels of depression.

The posttraumatic distress diagnostic scale (PDS) was useful for obtaining a diagnosis of PTSD and assessing severity of symptoms. It was also fairly quick to administer and did not require much exposure to trauma memory. However, it was not designed for the population in this study, and for this reason, some parts did not fit the experience of participants. For example, the PDS asked that respondents choose a single trauma incident that bothered them the most and answer subsequent questions with respect to that single trauma only. This approach is acceptable for those with primarily single-incident trauma, but for those with complex and multiple trauma experiences, key aspects of their trauma symptom picture can be missed. A recommendation

would be to use the Harvard trauma questionnaire for immigrants either alone or in conjunction with the PDS.

Another area of interest was the depth of experiencing achieved by participants of this process, and its impact on subsequent dreaming and on metaphorical thinking capability. Instruments for these constructs were either not readily available (for metaphorical thinking) or very complex to administer (experiencing scale). However, more simple measures for experiencing levels have been developed that were more practical for the purposes of this study (such as the Hendricks scale). There was no adequate existing measure for tracking change in metaphorical thinking, so the dream imagery questionnaire was developed for this purpose, but it had not yet been tested or validated.

Analysis

The analysis tracked changes in dream life and waking life symptoms that were presumed to be a result of the FOD process. However, given the timing of the interventions, and for some, the gaps between sessions, it would not be possible to confidently attribute changes to the FOD intervention. However, to counter this, it is important to note that the nightmares of participants had been unchanged through many major events in their lives, so it might be reasonable to suggest that dream changes were, at least in part, a result of working on the dream. Analysis was hampered by gaps and sparseness in the data. The study would have been strengthened if measures of nightmare content and frequency, PTSD symptoms and other variables were gathered more fully and frequently, and over a longer term.

FOD protocol

In addition to sample size and analysis issues, there were many ways the protocol itself might have been improved upon, and the following section discusses how the FOD process worked and how it might be improved.

Clearing a space. Clearing a space (CAS) was the first step of the research protocol, and it was used as both an introduction to focusing practice, a gentle way to begin sensing inside, and also as a self-regulation tool for calming participants when the process became challenging. For the most part, CAS worked as intended, and in fact, three of the participants specifically mentioned that they started using CAS on their own to calm themselves down. There were varying degrees of comfort and skill with the process: some participants, particularly those who had already been working in a focusing-oriented way in their therapy, found the process easy and were able to engage fully in the process, as indicated by high scores on the CAS checklist. For others it was a learning process, as it was intended to be, a gentle introduction to the more complex skill of focusing, and as such, it appeared to work as intended. It is clear that having some focusing skill and practice prior to engaging in the FOD protocol was beneficial.

In addition, although CAS worked well, it might have even been more effective and helpful with self-regulation had the version used included elements of distancing and scaling to enable the client to find a comfortable distance from their felt sense. This would enable a focusing process that does not re-traumatize or overwhelm the person such that they cannot access inner resources and discover new meaning. This step would be important to add to a revised FOD protocol.

Finding help. As expected, finding help in the recurrent nightmares of PTSD sufferers proved to be a challenge, especially for those with purely replicative dreams. Gendlin (2012a)

has stated that finding help is the key to unlocking the life-forward potential found in every dream. However, purely replicative trauma dreams might be an exception to this rule because they lack many of the characteristics of normal dreams.

In the study, the questions used to find help in the nightmares were carefully worded to avoid a simplistic searching for the positive, if such elements could actually be found in the nightmare. The first suggested query was into dream elements such as "people, animals, life, light or anything that seems like help," but there was often nothing in the trauma dreams like this. Other areas of inquiry included "any striking or incongruous details," the setting of the dream, and anything surprising. However, these inquiries most often led to an elaboration of the most frightening elements of the dream, the opposite of what was being sought. In an effort to avoid forcing a positive association, often this step failed to work as intended.

It was acknowledged within the protocol itself that finding help may not be possible with purely replicative nightmares, and rather than searching in vain, therapists were directed to ask participants to return to the cleared space they had found earlier in the process before moving to the next stage of the intervention. This was a useful instruction and did help calm participants who needed inner resourcing after exploring the dream as above. However, the purpose of the step of finding help was often lost.

Finding help in a nightmare was often not possible, and when it was, it was an artful process. This is an area where more explicit training of the therapists was warranted. In many of the trauma dreams, there were helpful elements: loved ones, positive action, elements of the setting that might have brought a felt sense of forward motion had they been explored more deeply. This can be an alternative or additional way to help participants self-regulate as they explore their nightmares, and can ease their discomfort and concerns about the process.

However, for the most part, this step did not work as intended; this can be addressed through clearer instructions within the protocol itself, and more explicit training for this complex process.

Dreaming the dream on. This was the key step in the FOD process, and for the most part, it worked well. Participants often did not understand the instruction at first, but that was expected. The idea of altering their dream, creating a new segment or ending, was something none had ever thought about doing, and at first there was a sense of hesitation, a questioning: "Am I really allowed to do this with my dream?"

Once the participants understood the instructions, all were able to imagine a new ending to their nightmares, although the level of experiential depth and creativity varied considerably. Some participants needed a lot of prompting to keep dreaming their dream on. This was expected as one of the effects of trauma is to limit imaginative and metaphorical thinking processes. Some participants were able to re-enter the dream and had an authentic experience of completing their dreaming process while awake. Others came up with simpler, more invented solutions to the problems brought up in their nightmares.

For the IRT protocol, Krakow (2014) suggested that it does not matter what kind of dream patients work with, nor the type of ending they come up with. However, in this study, details of this imaginative process were a focus of the intervention. The therapists were operating under the assumption that the type of process participants engaged in while imagining a new dream ending might impact subsequent dreams and have an effect on the outcomes that were measured. This process could be examined in greater detail with a larger sample of imagined dreams, more accurate instruments, and a sample that begins with less compromised imaginal capacities.

Recommendations for future study

Although the conclusions drawn from this study remained speculative, the close examination of the how the nightmares of participants changed after FOD process raised many interesting questions. The data pointed to a relationship between the degree of replication of trauma in the nightmares and degree of PTSD severity that would make an interesting quantitative study. The relationship between nightmare content and threat responses is another area of interest. Mechanism of action, including experiencing levels and interruption of the cycle of fear response might also warrant further investigation. Finally, the question of whether FOD increases metaphorical thinking capacity is still of interest. Although there was not much evidence of this progression in the current study, this may be because metaphorical thinking is a capacity that develops later in the trauma recovery process. It seems plausible that only when the trouble has passed does the dreaming mind regain its normal capacity to play.

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Appendices

Appendix A

Informed Consent Form for Study: *Effects of Focusing-Oriented Dream Imagery Therapy for Trauma Survivors with PTSD Nightmares*

Date: _____ Principal Investigator: Mariana Martinez Vieyra

Participant's name: _____ Study ID #: _____

Thank you for considering participation in this research study. This informed consent form is designed to provide you with the information required to make an informed decision about your participation. If there are any further questions, please ask. (See contact information below.)

Nature of the study
This study will test the effect of a brief intervention of focusing-oriented dream imagery therapy for those with PTSD who experience repetitive, trauma-related nightmares. The intervention is a modified version of imagery rehearsal, a therapy method that has been tested in many controlled clinical trials and found to be safe and effective for relieving symptoms related to the repetitive nightmares and to PTSD in general. This study's intervention has been modified to increase safety in several ways: it will be delivered in an individual versus group format, exposure level will be moderate, the treatment will be delivered as an adjunctive treatment to trauma therapy, and it will incorporate current findings about best practices for PTSD treatment. In addition, your current therapist at VAST will be your therapist for this study.

Participants' role
You have been given this consent form because you have met the requirements to participate in the study. Your participation will consist of 3 weekly sessions, and a one-month follow-up session. Session 1 will be a collection of baseline data, will take about 1.5 hours, and will include questions about your dreams, trauma history, trauma symptoms, sleep habits, demographic and contact information. You will also be asked to keep a brief dream log over this period, and the form will be provided and explained. The following two sessions will consist of the intervention. In session 2 (about 1.5 hours), you will be guided through a process that includes learning to sense inside, create safety for yourself, and you will be asked to recount and revise a typical nightmare in a way that is designed to create a new experience of the dream. In session 3 (about 1.5 hours), the dream revision process will be repeated as appropriate and there will be a shorter re-assessment immediately after. At one month post-treatment, there will be an additional assessment session (about 1 hour) to measure effects of the process

Length of time of commitment
Participants will be involved in the study for a maximum of two months. Participation will be terminated if at any time the researcher feels that the safety of the participant is compromised. Participants are free to withdraw from the study at any time, for any reason without consequence. If you decide to withdraw, it would be helpful for the researchers to know the reason.
Potential risks

The assessment process will include questions about trauma history that you may find distressing. In addition the therapy sessions may cause anxiety, although these effects are usually very brief and often ultimately beneficial. Controlled, manageable exposure to trauma has been shown to improve resilience and ultimately reduce anxiety and trauma symptoms. Steps have been taken to both minimize risk to participants and to assess for risk throughout the duration of the study. Support is provided in session and additional support is available if needed. As well, participants will be included only if they have a professional support system in place and are deemed appropriate for the study.

Potential benefits

Treatments using imagery rehearsal are considered best practice by the American Academy of Sleep Medicine for therapy-based treatment of trauma-related nightmares. Imagery rehearsal methods have been found to reduce nightmares, improve sleep quality and reduce overall PTSD symptoms. Other potential benefits of this particular version of imagery rehearsal include an improved relationship to your dreams and a positive shift in the nature of your dreams.

Treatment is provided free of charge and has been recommended by several recent studies as an effective adjunctive therapy for PTSD. The results of this study will add to the knowledge base of treatment for PTSD and related nightmares.

Confidentiality and participant rights

Only the principal researchers will have access to the data collected, and data gathered will be identified by number, with no identifying information included for the purposes of analysis. The data will be destroyed within five years. During the duration of the study, data will be kept in a secure location. Participants have the right to withdraw from the study at any time.

Any questions about this project or about participation in the study can be directed to Mariana Martinez Vieyra at (604) 299-3539 or mariana.martinezvieyra@vast.vancouver.ca
Please check the following options:

____ I request a summary of the results of this study when it is completed. I may be contacted at the following address, email or phone number to receive results:

_____

____ I have read this form and understand its contents. I am 18 years or older and voluntarily agree to participate in this research project.

____ I understand that sessions will be recorded (audio only) for data collection and quality control purposes. I give my permission for recording of the sessions.

_____ _____

Participant's signature Date

_____ _____

Researcher's signature Date

Appendix B

Intake Screening Protocol

(For VAST clients who are pre-screened and deemed to be potential candidates. Clinicians can fill in all known information from the VAST intake process and ask only necessary questions.)

Client ID # _____ Assessed by: _____ Date: _____

Are you interested in being a part of a study on the use of a new treatment for repetitive trauma-related nightmares? (End here if no. Make it clear that this in no way affects their relationship with VAST or their ability to continue in therapy with you.)

First, I will tell you a little bit about the study, and then I will ask you a few questions to see if you are eligible to be a participant.

The study is for adults who have experienced trauma and suffer from repetitive nightmares related to the trauma. We are defining nightmares as disturbing dreams *that wake you up*. If you qualify to be part of the study, you will be given more details about the study and can consent to continue or not. If you choose to continue, you will be asked to go through a more in-depth screening process that will take about one-and-a-half hours. It will include brief questions about your trauma history and your nightmares. You will then be scheduled to receive two weekly treatments followed by two assessments, a brief one at the end of the second session, and another a month later. Each session will take between 1 and 2 hours.

Are you still interested in participating? (If no end here). Do you have any questions at all?
Is it all right to ask you a few questions now?

1. Are you 18 years or older? _____ (End here if no.)
2. Do you experience nightmares that wake you up at least 3 times a month? (End here if no.)

    Have you had a least three nightmares in the past month? (End here if no.)

    How long have you been having nightmares?_____

    How often do you have nightmares? _____

    When was your most recent nightmare? _____

    Are your nightmares repetitive? _____

    Do they replay aspects of your trauma experience? _____
3. Are you currently using drugs or alcohol? _____

    If so, do you consider your drug or alcohol use to be a problem? _____
4. Have you ever been diagnosed with any form of mental illness? _____

    If so, what was the diagnosis? _____

_____

(End here if there is a substance use problem of if there is a clear diagnosis of schizophrenia or bipolar disorder.)

5. Can you tell me very briefly about your trauma experiences?

_____

_____

_____

For assessor: Does the trauma qualify for potential PTSD diagnosis? Must involve actual/threatened death/serious injury or threat to physical integrity to self/other.

_____ (If no, end here.)

6. Did you experience severe long-term trauma before the age of 18?

(If yes, end here.)

7. How long ago did your most recent trauma happen? _____

Have you experienced a trauma episode in the past 3 months? _____

(End here if trauma experience was within past 3 months)

8. Have you received past therapy for your traumatic experiences? _____

For how long? _____

9. Are you on medication? _____ Is the medication regime stable?_____

If on no medication or a stable regime, criteria is met. If not, end here.)

If they meet the criteria:

It appears that you may meet the criteria to participate in the study. We will have to do a longer assessment to be sure. I would like to set up a time for the pretreatment assessment. (Make the appointment for the following week if possible. Ask that they bring a list of current medications, and dosages.)
Thank you very much for your time.

If they don't meet the criteria:

Thank you very much for your time. It appears that you don't meet the criteria for the study but I appreciate you taking the time to answer these questions. Our therapy relationship will continue just as before.

Appendix C

Demographic Questionnaire

Gender: o Male o Female
Age: In what year were you born? _____
Marital Status: o Now married
o Widowed
o Divorced
o Separated
o Never married

Education: (mark the highest level achieved)
o No schooling
o Elementary school
o Some high school (G10-12)
o High school graduate
o Some post-secondary or college
o Bachelor's degree
o Master's degree
o Professional degree (ie MD, LLB, JD) or PhD.

Employment status:
o Employed – full time
o Employed – part time
o Seeking employment
o Homemaker
o Student
o Retired
o Unable to work
Income level:
o Less than $10,000
o $10,000 to $40,000
o $40,000 to $80,000
o $80,000 or higher

Country of origin:
o Canada
o Other _____
o Length of time in Canada _____

Race/Ethnicity: (mixed - check all that apply)
o First Nations
o Asian
o Black or African
o Hispanic or Latino
o Pacific Islander
o White
First language o English
o Other _____

Appendix D

Measures

Suicidal Behaviors Questionnaire-Revised (SBQ-R)

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

q 1 Never
q 2 It was just a brief passing thought.
q 3a I have had a plan at least once to kill myself but did not try to do it.
q 3b I have had a plan at least once to kill myself and really wanted to die.
q 4a I have attempted to kill myself, but did not want to die.
q 4b I have attempted to kill myself and really hoped to die.

2. How often have you thought about killing yourself in the past year? (check one only)

q 1 Never
q 2 Rarely (1 time)
q 3 Sometimes (2 times)
q 4 Often (3-4 times)
q 5 Very often (5 or more times)

2. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

q 1 No
q 2a Yes, at one time, but did not really want to die.
q 2b Yes, at one time, and really wanted to die.
q 3a Yes, more than once, but did not want to do it.
q 3b Yes, more than once, and really wanted to do it.

2. How likely is it that you will attempt suicide one day? (check one only)

q 0 Never
q 1 No chance at all
q 2 Rather unlikely
q 3 Unlikely
q 4 Likely
q 5 Rather likely
q 6 Very likely

Osman et al., (2001) Revised.

Beck Depression Inventory II (BDI-II)

1. **Sadness**
   0 I do not feel sad.
   1 I feel sad much of the time.
   2 I am sad all the time.
   3 I am so sad and unhappy that I can't stand it.

2. **Pessimism**
   0 I am not discouraged about my future.
   1 I feel discouraged more discouraged about my future than I used to be.
   2 I do not expect things to work out for me.
   3 I feel my future is hopeless and will only get worse.

3. **Past Failure**
   0 I do not feel like a failure.
   1 I have failed more than I should have.
   2 As I look back, I see a lot of failures.
   3 I feel I am a total failure as a person.

4. **Loss of Pleasure**
   0 I get as much pleasure as I ever did from the things I enjoy.
   1 I don't enjoy things as much as I used to.
   2 I get very little pleasure from the things I used to enjoy.
   3 I can’t get any pleasure from the things I used to enjoy.

5. **Guilty Feelings**
   0 I don't feel particularly guilty
   1 I feel guilty over many things I have done or should have done.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. **Punishment Feelings**
   0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. **Self-Dislike**
   0 I feel the same about myself as ever.
   1 I have lost confidence in myself.
   2 I am disappointed in myself.
   3 I dislike myself.

8. **Self-Criticalness**
   0 I don't criticize or blame myself more than usual.
   1 I am more critical of myself that I used to be.

2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. **Suicidal Thoughts or Wishes**
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. **Crying**
0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. **Agitation**
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I feel so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. **Loss of interest**
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. **Indecisiveness**
0 I make decisions about as well ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions more than I used to.
3 I have trouble making any decisions.

14. **Worthlessness**
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. **Loss of Energy**
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. **Changes in Sleeping Pattern**

0 I have not experienced any change in my sleeping pattern.
1a I sleep somewhat more than usual
1b I sleep somewhat less than usual
2a I sleep a lot more than usual
2b I sleep a lot less than usual.
3a I sleep most of the day
3b I wake up 1-2 hours early and can't get back to sleep.

17. **Irritability**
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. **Changes in Appetite**
0 I have not experienced any change in my appetite.
1a My appetite is somewhat less than usual.
1b My appetite is somewhat more than usual.
2a My appetite is much less than before
2b My appetite is much greater than usual.
3a I have no appetite at all.
3b I crave food all the time.

19. **Concentration Difficulty**
0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. **Tiredness or Fatigue**
0 I am no more fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. **Loss of Interest in Sex**
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Posttraumatic Stress Diagnostic Scale (PDS)

Part 1.
Many people have *lived through or witnessed* a very stressful and traumatic event at some point in their lives. Indicate whether or not you have *experienced or witnessed* each traumatic event listed below by circling Y for yes or N for no for each item below.

Y N: 1. Serious accident, fire, or explosion (for example, being in an industrial, farm, car, plane or boating accident)
Y N: 2. Natural disaster (for example tornado, hurricane, flood, or major earthquake)
Y N: 3. Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed or held at gunpoint)
Y N: 4. Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed or held at gunpoint)
Y N: 5. Sexual assault by a family member or someone you know (for example, rape or attempted rape)
Y N: 6. Sexual assault by a stranger (for example, rape or attempted rape)
Y N: 7. Military combat or a war zone
Y N: 8. Sexual contact when you were younger than 18 with someone who was 5 or more years older than you (for example, contact with genitals, breasts)
Y N: 9. Imprisonment (for example prison inmate, prisoner of war, hostage)
Y N: 10. Torture
Y N: 11. Life-threatening illness
Y N: 12. Other traumatic event. Specify: _____

If you marked yes to any of the items above, continue. If not, stop here.

Part 2.
If you marked yes for more than one traumatic event in Part1, indicate *which one bothers you the most*. If you marked Yes for only one traumatic event in part one, mark the same answer below.

1. Accident
2. Disaster
3. Non-sexual assault/someone you know
4. Non-sexual assault/stranger
5. Sexual assault/someone you know
6. Sexual assault/stranger
7. Combat
8. Sexual contact under 18 with someone 5 or more yeas older
9. Imprisonment
10. Torture
11. Life-threatening illness
12. Other traumatic event

Below are several questions about the traumatic event you marked in item 14.

15. How long ago did the traumatic event happen? (mark ONE)

__ 1. Less than 1 month
__ 2. 1 to 3 months
__ 3. 3 to 6 months
__ 4. 6 months to 3 years
__ 5. 3 to 5 years
__ 6. More than 5 years

16. During this traumatic event:

Y N 16. Were you physically injured?
Y N 17. Was someone else physically injured?
Y N 18. Did you think that your life was in danger?
Y N 19. Did you think that someone else's life was in danger?
Y N 20. Did you feel helpless?
Y N 21. Did you feel terrified?

Part 3
Below is a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and choose the answer (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you marked in item 14. (Circle the number that corresponds best to your experience.)

0 – Not at all or only one time
1 – Once a week
2 – 2 to 4 times a week/half the time
3 – 5 or more times a week/almost always

0 1 2 3 22. Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to.
0 1 2 3 23. Having bad dreams or nightmares about the event
0 1 2 3 24. Reliving the traumatic event, acting or feeling as if it was happening again.
0 1 2 3 25. Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)
0 1 2 3 26. Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)
0 1 2 3 27. Trying not to think about, talk about, or have feelings about the traumatic event
0 1 2 3 28. Trying to avoid activities, people or places that remind you of the traumatic event
0 1 2 3 29. Not being able to remember an important part of the traumatic event
0 1 2 3 30. Having much less interest or participating much less often in important activities
0 1 2 3 31. Feeling distant or cut off from people around you

0 1 2 3 32. Feeling emotionally numb (for example being unable to cry or unable to have loving feelings)
0 1 2 3 33. Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children or a long life)
0 1 2 3 34. Having trouble falling or staying asleep.
0 1 2 3 35. Feeling irritable or having fits of anger
0 1 2 3 36. Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on tv, forgetting what you read)
0 1 2 3 37. Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)
0 1 2 3 38. Being jumpy or easily startled (for example, when someone walks up behind you

---

39. How long have you experienced the problems that you reported above? (Mark only ONE)

___ 1. Less than one month
___ 2. 1 to 3 months
___ 3. More than 3 months

40. How long after the traumatic event did these problems begin? (Mark only ONE)

___ 1. Less than 6 months
___ 2. 6 or more months

Part 4
Indicate if the problems you rated in part 3 have interfered with any of the following areas of your life DURING THE PAST MONTH.

Y N 41. Work
Y N 42. Household chores and duties
Y N 43. Relationships with friends
Y N 44. Fun and leisure activities
Y N 45. Schoolwork
Y N 46. Relationships with your family
Y N 47. Sex life
Y N 48. General satisfaction with life
Y N 49. Overall level of functioning in all areas of your life.

Trauma-Related Nightmare Survey (TRNS) – adapted

Instructions: The following questions relate to your experience of nightmares in the past month/week. Nightmares are dreams with **negative emotions** that **wake you up**. Please read each question and answer to the best of your ability. If you need more room, feel free to use the back of the page.

1. Approximately how many hours do you sleep per night? _____

2. Approximately how long does it usually take for you to fall asleep?
   ___Less than 15 minutes
   ___15 minutes to 1 hour
   ___1 hour to 2 hours
   ___More than 2 hours
   if more, how many? ___ hours

3. In general, how fearful are you to go to sleep?

   __ Not at all __ Slightly __ Moderately __ Very much __ Extremely

4. In general, how depressed do you feel when you wake up?

   __ Not at all __ Slightly __ Moderately __ Very much __ Extremely

5. In general, how rested do you feel when you wake up?

   __Not at all __ Slightly __ Moderately __ Very much __ Extremely

6. How long have you experienced nightmares? ___ months OR ___ years

7. Did your nightmares begin after a traumatic event, such as sexual assault, combat, fire or any other stressful event? ___ Yes ___ No

   7a. If yes, how old were you when the trauma occurred? _____

   7b. What was the trauma or stressful event?
   _____

8. Approximately how many nightmares have you experienced in the past month?
   ____ in the past week
   ____ in the past month (if less than one per week)
   ____ less than one per month

9. On how many nights in the past week have you experienced a nightmare? _____

10. On how many nights in the past week have you experienced **more than one** nightmare per night? _____

11. In general, how disturbing have the nightmares been?

__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

12. How many different nightmares do you generally experience? _____

13. If you have experienced a trauma (serious car accident, natural disaster, sexual assault, etc.), please indicate how similar your nightmare is to the trauma you experienced. If you have more than one nightmare, please answer for the most frequent nightmare. My most frequent nightmare is:

___ Exactly or almost exactly like the trauma

___ Similar to trauma, but not exact; Please explain:

_____
_____
_____
_____

___ Unrelated to traumatic event(s); Please explain:

_____
_____
_____
_____

14a. How long does it typically take you to return to sleep after a nightmare?

___less than 15 minutes
___15 minutes to 1 hour
___1 hour to 2 hours
___ more than 2 hours
___ typically do not return to sleep

14b. What do you do to help you get back to sleep? (e.g. nothing, read, watch TV, consume alcohol or drugs, etc…)

_____
_____
_____

14c. After waking from the nightmare, do you experience any of the following symptoms? (check all that apply)

___ Palpitations, pounding heart, or accelerated heart rate ___ Sweating
___ Feeling dizzy, unsteady, lightheaded, or faint ___ Trembling or shaking

___ Sensations of shortness of breath or smothering
___ Chest pain or discomfort
___ Numbness or tingling sensations
___ Derealization (feelings of unreality)
___ Depersonalization (being detached from oneself)
___ Feeling of choking
___ Nausea or abdominal distress
___ Fear of losing control
___ Chills or hot flashes
___ Fear of dying

14d. What time do you generally wake up from a nightmare? [if you experience more than one nightmare per night, please indicate the time you wake from the first nightmare].

_____ 0-2 hours after sleep onset

_____ 3-5 hours after sleep onset

_____ 6-8 hours after sleep onset

_____ 9+ hours after sleep onset

15. In general, my nightmares are related to themes of

Powerlessness
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

Trust
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

Intimacy
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

Safety
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

Esteem
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

16. In general, I have the same nightmare[s] over and over
__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

Dream Imagery Questionnaire (DIQ)

In the space below, describe the most recent dream you remember (preferably from last night).

How long ago did this dream occur? (circle one)

Last night Night before last Two nights ago Three or more nights ago

WAS THIS DREAM A RECURRING DREAM?	YES___ NO___

A RECURRING DREAM IS ONE DREAM IN A SEQUENCE OF TWO OR MORE DREAMS WITH THE SAME (OR A SIMILAR) THEME BUT WITH SLIGHTLY DIFFERENT CHARACTERS, PLACES, OR ACTIONS. (RECURRING DREAMS ARE SOMETIMES NIGHTMARES, BUT THEY ARE NOT NECESSARILY NIGHTMARES.)

WAS THIS DREAM A NIGHTMARE?	YES___ NO___

A NIGHTMARE IS A DISTURBING DREAM (USUALLY IN THE SECOND HALF OF THE NIGHT) THAT AWAKENS YOU FROM SLEEP AND THAT IS CLEARLY RECALLED.

WAS THIS DREAM A SLEEP TERROR?	YES___ NO___

A SLEEP TERROR IS AN EPISODE (USUALLY IN THE FIRST HALF OF THE NIGHT) ACCOMPANIED BY INTENSE PANIC AND SOMETIMES BY RECALL OF ONLY A BRIEF DREAM.

WAS THIS DREAM A SLEEP PARALYSIS EPISODE?	YES___ NO___

SLEEP PARALYSIS EPISODES USUALLY OCCUR DURING THE TRANSITION BETWEEN SLEEPING AND WAKING DURING WHICH YOU FEEL A TEMPORARY INABILITY TO MOVE OR SPEAK AND YOU SOMETIMES VIVIDLY EXPERIENCE THE PRESENCE OF SOMEONE OR SOMETHING NEARBY.

Brief Survey of Dream Type

1. How often have you remembered **any kind of dream** during the **last 30 days?**

Total (estimate) _____ (0 - 21 or more)

2. How often have you experienced **bad dreams** during the **last 30 days**?
Bad dreams are very disturbing dreams (usually in the second half of the night) that do not wake you up, but are clearly remembered.

Total (estimate) _____

3. How often have you experienced **recurring dreams** during the **last 30 days**?
Recurring dreams are two or more dreams with the same (or a similar) theme but with slightly different characters, places and actions. (They can be bad dreams or nightmares but there can also be ordinary recurring dreams.)

Total (estimate) _____

4. How often have you experienced **nightmares** during the **last 30 days**?
Nightmares are very disturbing dreams, usually in the second half of the night, that wake you up and are clearly recalled later.

Total (estimate) _____

5. How often have you experienced **night terrors** during the **last 30 days**?
Night terrors are awakenings, usually in the first half of the night accompanied by intense panic and sometimes recall of only a brief dream.

Total (estimate) _____

6. How often have you experienced **sleep paralysis** during the **last 30 days**?
These are dreams that usually occur during the transition between sleeping and waking accompanied by a temporary inability to move or speak and sometimes the vividly experienced presence of someone or something nearby.

Total (estimate) _____

Dream Imagery Questionnaire

Please answer the following questions about your dream:

Where there are choices of words (ie replicate/match/reproduce or metaphor/symbol) use the word that makes most sense to the participant. There is no need to repeat all synonyms each time you ask the questions.

The following questions address how literally and directly this dream replicates reproduces or imitates your original traumatic event. That is, how fully and concretely does your dream reproduce or imitate your original trauma?

1. Overall (considering the dream as a whole), to what extent does your dream replicate/literally and directly replicate the actions, events, and feelings of match your original traumatic event? *(How closely does it match the original traumatic event?)*

1 2 3 4 5 6 7
not at all almost exactly

1a. To what extent does the setting of your dream literally and directly replicate the setting in which your original traumatic event occurred?

1 2 3 4 5 6 7
not at all almost exactly

1b. To what extent do the characters in your dream literally and directly, replicate the characters present during your original traumatic event?

1 2 3 4 5 6 7
not at all almost exactly

1c. To what extent do your actions in the dream literally and directly replicate your actions in the original traumatic event?

1 2 3 4 5 6 7
not at all almost exactly

1d. To what extent do the actions of other characters in the dream literally and directly replicate the actions of other characters in the original traumatic event?

1 2 3 4 5 6 7
not at all almost exactly

1e. To what extent do your feelings or emotions in the dream literally and directly replicate your feelings or emotions in the original traumatic event?

1 2 3 4 5 6 7
not at all almost exactly

The following questions address how literally and directly your dream replicates other events in your personal life. That is, how fully and concretely does your dream reproduce or imitate an event other than—and separate from—your original trauma?

2. Overall (considering the dream as a whole), to what extent does your dream literally and directly replicate/reproduce the actions, events, and feelings of some event other than—and separate from—your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

2a. To what extent does the setting of your dream literally and directly replicate the setting in which some event other than your original trauma occurred?

1 2 3 4 5 6 7
not at all almost exactly

2b. To what extent do the characters in your dream literally and directly replicate the characters present during some event other than your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

2c. To what extent do your actions in the dream literally and directly replicate your actions in some event other than your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

2d. To what extent do the actions of other characters in the dream literally and directly replicate the actions of other characters in some event other than your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

2e. To what extent do your feelings or emotions in the dream literally and directly replicate your feelings or emotions in some event other than your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

In addition to literal and direct replication of life events, dreams often indirectly (metaphorically, symbolically) reflect life events. The following questions address whether your dream indirectly (metaphorically, symbolically) reflects events in your personal life.

(Note to therapist: choose one word -- indirectly/metaphorically/symbolically -- that makes most sense to the participant. No need to repeat them all after this.)

Note: your answers to questions 3 and 4 are not mutually exclusive, i.e., your dream may metaphorically (symbolically) reflect either (a) your original traumatic event, (b) an event other than—and separate from—your original trauma, (c) both a and b; or (d) neither a nor b.

An example might be: Your family had a big fight the night before. You dream of a huge storm sweeping through your house. The storm could be a metaphor or symbol for the fight in your household. Or the storm could be settake place in the same settingplace as your original trauma; then it might be a metaphor for the trauma you experienced. Let your own sense of what feels like a fit guide you.

3. Overall (considering the dream as a whole), to what extent do the actions, events, and feelings in your dream metaphorically (symbolically) reflect the actions, events, and feelings of your original traumatic event?

1 2 3 4 5 6 7
not at all almost exactly

4. Overall (considering the dream as a whole), to what extent do the actions, events, and feelings in your dream metaphorically (symbolically) reflect the actions, events, and feelings of some event other than—and separate from—your original trauma?

1 2 3 4 5 6 7
not at all almost exactly

If your rating in response to either of the preceding two questions was 2 or more, please answer the following question about how your dream metaphorically (symbolically) reflects personal events in your life.

5. Sometimes dreams are common metaphors for personal events, e.g., climbing a ladder reflects a personal effort to get ahead (climb to the top), and, at other times dreams are novel metaphors for personal events, e.g., a wood chip floating down a stream reflects purposeless drifting (lost agency).

Another example of a common metaphor is: life is a journey. The end of the road can be a typical metaphor for the end of a certain phase in life such as retirement, divorce, or death. Unusual or novel metaphors for death might be to disappear, or to sail off the edge of the horizon. Death images themselves can be common metaphors for the end of something – for example, a person dying may mean they are no longer in relationship to the dreamer.

Overall (considering the dream as a whole), to what extent is your dream a common or a novel metaphor (symbol) for personal events in your life?

1 2 3 4 5 6 7
extremely common extremely novel

6. Sometimes dreams are conventional metaphors for personal events, i.e., they express what could be said literally or directly (e.g., "Time flies" can be restated as "Time passes quickly"). At other times dreams are unconventional metaphors for personal events, i.e., they express something that cannot be said literally or directly (e.g., "As time passes, it leaves a trail of debris").

Overall (considering the dream as a whole), to what extent is your dream a conventional or an unconventional metaphor (symbol) for personal events in your life?

1 2 3 4 5 6 7
extremely conventional extremely unconventional

75. Sometimes dreams facilitate the dreamer's understanding of personal events. Take a moment to consider how your dream as a whole is a metaphor for a personal event in your life.

For example if something in your life is changing, you might dream of a change of season, such as leaves falling from the trees or summer flowers dying. If the change is sudden, you might see a strong wind stripping the tree of its leaves.

5a. Overall (considering the dream as a whole), to what extent is your dream a metaphor (symbol) that helps you understand personal events in your life?

1 2 3 4 5 6 7
not at all helpful extremely helpful

5b. By considering the dream metaphorically, I became sensitive to (or aware of) aspects of my life that I usually ignore

1 2 3 4 5 6 7
not at all true extremely true

5. Sometimes dreams are common metaphors for personal events, e.g., climbing a ladder reflects a personal effort to get ahead (climb to the top), and, at other times dreams are novel metaphors for personal events, e.g., a wood chip floating down a stream reflects purposeless drifting (lost agency).

Another example of a common metaphor is: life is a journey. The end of the road can be a typical metaphor for the end of a certain phase in life such as retirement, divorce, or death. Unusual or novel metaphors for death might be to disappear, or to sail off the edge of the horizon. Death images themselves can be common metaphors for the end of something – for example, a person dying may mean they are no longer in relationship to the dreamer.

Overall (considering the dream as a whole), to what extent is your dream a common or a novel metaphor (symbol) for personal events in your life?

1 2 3 4 5 6 7
extremely common extremely novel

6. Sometimes dreams are conventional metaphors for personal events, i.e., they express what could be said literally or directly (e.g., "Time flies" can be restated as "Time passes quickly"). At other times dreams are unconventional metaphors for personal events, i.e., they express something that cannot be said literally or directly (e.g., "As time passes, it leaves a trail of debris").

Overall (considering the dream as a whole), to what extent is your dream a conventional or an unconventional metaphor (symbol) for personal events in your life?

1 2 3 4 5 6 7
extremely conventional extremely unconventional

76. Sometimes elements of a dream seem particularly meaningful. Is there an element (character, object, event, setting) that stands out for you or somehow feels important. Take a minute to identify an important dream element. Briefly describe it:

6a. To what extent does the dream element help you understand personal events in your life?

1 2 3 4 5 6 7
not at all helpful extremely helpful

6b. By considering the dream element metaphorically, I become sensitive to (or aware of) an aspect of my life that I usually ignore

1 2 3 4 5 6 7
not at all true extremely true

'Clearing A Space' Check List

____ NO FELT SENSE

1. I am sure that the person did not locate a felt level of experiencing.
2. The subject's description was basically a description of body sensations.
3. The felt sense can only be located in the extremities of the body.
4. I am unsure as to whether or not the person located a felt level of experiencing
5. Other

____ FELT SENSE - the location of a bodily felt level of a problem or experience

1. A description of a vague and unclear something which is felt.
2. Silence and then an acknowledgement of a concern (distinct from the list of problems in the head).
3. When asked to check to see if it is there or 'right', there is a time lapse, there is a 'yes'.
4. The person 'knows' it is there, but cannot say what the content of the felt sense is.
5. There is a physiological change such as head nodding, sighing, voice sounds calmer or slower.
6. The identified felt sense is definitely felt in the torso area.
7. Other

____ NO HANDLE

1. I am certain that the subject did not discover a handle for any felt sense.
2. I am uncertain as to whether or not the person discovered a handle for any felt sense.

____ FELT SENSE WITH A HANDLE OR A CLEAR SENSE OF WHAT IT IS ABOUT - a word, phrase, image that exactly describes the felt sense after resonating.

1. A time lapse occurred before the naming (as distinct from something that came right away).
2. The person discarded some things before settling on one.
3. After resonating, the person acknowledges the fit.
4. The person did a self-check and says something like, 'Yes, that's right.'
5. The trainer just repeated the phrase, there was no disagreement, and the subject showed a physiological indicator of release.
6. There was a physiological confirmation of the 'fit' - head nodding, sighing, fingers moving, muscle twitch.
7. The subject expressed the same phrase repeatedly, indicating its handle quality.

____ DOES NOT SIT WITH ANY FELT SENSE

1. I am certain that the person did not silently attend in a 'being with' way (keeping it company, digesting what is there, receiving what is there) to any felt sense with a handle or to a felt sense after something came.
2. The person did not sit with a felt sense because of their strong negative reactions to it, such as, 'I can't stand this place' or 'I want to get rid of this place'.
3. I am uncertain as to whether or not the person silently attended in a 'being with' way to any felt sense with a handle or after something new came.

____ SITS WITH FELT SENSE AFTER the STEP OF GETTING A HANDLE

1. The person is in touch with a particular felt sense - either a problem, a felt sense that develops after putting something out, or a felt sense of a cleared space - and then in a gentle, friendly way silently attends to the felt sense without doing anything else (like fighting it or wanting to get rid of it).
2. I have observed indications such as eyes turned inwards literal silence, or reluctance to move on.
3. I observed physiological changes such as a softer, calmer voice.
4. The person describes their experience by saying things like, 'It's easier now' 'It's just there'.
5. The person has some negative reactions to the sense but can still just attend to it. An indication of this would be the person saying, "It's hard to do."

DOES NOT MOVE OUT A FELT SENSE

1. I am certain that the person did not move out or make a place for the concern in such a way that

included the felt sense.
2. I am uncertain as to whether or not the person made a place for a concern because the imagery is used more directly and literally thus possibly becoming disengaged from the felt sense.
3. The person reports that the felt sense 'is gone', an indication that they may have just lost it.
4. I am otherwise uncertain.

____ **MOVES OUT ONE FELT SENSE**

1. The person creates or places same metaphorical space between oneself and the felt sense of the problem.
2. The felt sense is 'out there' because the subject describes himself as now feeling different inside (more calm, lighter, laughter).
3. The felt sense is described as being 'half-way out'.

____ **DOES NOT MOVE OUT MORE THAN ONE FELT SENSE**

1. I am certain that the person did not move out or make a place for more than one concern in such a way that included the felt sense.
2. I am uncertain as to whether or not the person made a place for more than one concern because the imagery is used more directly and literally thus possibly becoming disengaged from the felt sense.
3. The person reports that the felt sense 'is gone', an indication that they may just have lost it.
4. I am otherwise uncertain that the person moved out more than one felt sense.

____ **MOVES OUT MORE THAN ONE FELT SENSE**

1. The person creates or places some metaphorical space between himself and more than one felt sense of a problem.
2. More than one felt sense is 'out there' because the subject describes himself as feeling different inside each time.
3. One or more felt sense is described as being 'half-way out'.

____ **DOES NOT DISCOVER A BACKGROUND FEELING**

1. The instruction was not given.
2. I am certain that the person did not find a background feeling.
3. The person did not understand the instruction.
4. The person went directly to a cleared space.
5. I am uncertain because the person used the term outside the context of the guided instructions.
6. I am otherwise uncertain.

____ **DISCOVERS A BACKGROUND FEELING - a subliminal feeling that is always there in the background and is in the way of a 'cleared space'.**

1. Adjectives such as 'always anxious', 'always rushing', 'the sick person' are used.
2. It has the quality of 'this is just the way I am'.
3. The words of description are positive but they have a sense of forcedness or restriction, a superego expectation, or a script quality.
4. This is a general felt sense, not one that refers to a specific problem.
5. A sense of relief is expressed as it is located.

____ **DOES NOT EXPERIENCE A CLEARED SPACE**

1. The instruction was not given.
2. I am certain that the person did not discover a cleared space.
3. I am uncertain because this person describes herself as 'having no problems' or 'always fine'.
4. I am otherwise uncertain.

____ **EXPERIENCES A CLEARED SPACE**

1. I heard a description of a felt sense that reflects an experience of well-being, calmness, peace, vitality, energy, creativity, goodness, release, or an empty place free from problems.
2. There is a solidness to the description meaning that the person was able to remain in this place for several (20) seconds.
3. The person reached this place after putting down problems.
4. The person touched a cleared space and then got in touch with a problem.
5. The person got to a cleared space via another route than following the focusing steps, and the

cleared space is a felt sense.

____ EXPERIENCES A CLEARED SPACE WITH NO HANDLE

1. There is no indication that the person worked to find a handle to describe the cleared space.
2. I am uncertain as to whether or not the person found a handle for the cleared space, because although words were used there was no indication of resonating or checking.
3. I am otherwise uncertain.

____ EXPERIENCES A CLEARED SPACE WITH A HANDLE

1. The person found the exact words or image to describe the felt sense of the cleared space because they resonated and then confirmed that there was an exact fit.
2. Because the handle was discovered the cleared space opened further and was experienced as more solid.

____ DID NOT EXPERIENCE A SHIFT - an overall change in the understanding of a problem or concern that changes the bodily felt sense and the cognitive awareness.

1. I am certain that the person did not experience a shift any time during their process.
2. I am uncertain that the person experienced a shift because the words used were too vague, such as 'this is different.'
3. The person had more vague "action steps" which repeat the focusing steps, such as "I guess I need to sit with it more" that are NOT indicators of a shift.
4. I am otherwise uncertain.

____ EXPERIENCES A SHIFT

1. The person articulates a change in a problem description that includes an aspect of surprise or discovery such as 'I never knew that I could be without that feeling of always Rushing', or 'I have this sense now that I can take care of myself.'
2. The person experiences new material or articulates a new relationship with the problem. For example: "Oh, I didn't realize how alone I feel with this problem." (NOTE: Just relief at putting something out is not in itself a shift.)
3. The emergence of small action steps are expressed. For example: "Now, I really want to share my feelings about the divorce with others. It feels like this would help." The action steps discussed have to be more unique and specific to the issues and the person.
4. The experience of a shift can occur at any point in the process.

TOTAL SCORE: _____

Appendix E

Dream Log Instructions

To be completed each morning as soon after waking as possible:

1. Do you recall dreaming last night? _____ How many dreams do you recall?_____

2. Was it a nightmare: _____bad dream: _____ or non-distressing dream: _____
(If more than one dream, add additional checkmarks where appropriate. A nightmare is a distressing dream that wakes you up.)

3. How disturbing was the dream(s)?

__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

4. Did you have a dream that is recurring? _____

Was it: ___ Exactly or almost exactly like the trauma

___ Similar to trauma, but not exact; Please explain:

_____
_____
_____
_____
_____

___ Unrelated to traumatic event(s); Please explain:

_____
_____
_____
_____

3. Was the dream(s) realistic?

__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

4. Did the dream have elements that were fantastic or surreal?

__ Not at all __ Slightly __ Moderately __ Very much __ Extremely

5. Please write down your dream(s) from the night, and please include detail. If this is a recurring dream, make a special note of new or changed elements, if any. (Use reverse side or a dream journal if you like.)

Appendix F

Semi-Structured Exit Interview

With all of the questions below, ask the main open-ended question first and encourage the participant to elaborate. Use the bullet points *only as needed* to prompt for more detail about areas of interest they may not have covered in their initial answer.

The questions are generally aimed at understanding *change* in participants' dreams, determining which elements of the intervention sessions appear to facilitate change, and how the participants experience the change process within their dream life.

1. What has your *experience of working with your nightmares* been like for you?
- Comment on the clearing a space process
- What was it like for you to recount your nightmares?
- Comment on the exploration of the dreams (finding 'help')
- Comment on the process of imagining a new dream ending?
- What did you find most helpful/facilitative within the session?
- What was least helpful/facilitative?

2. Can you identify any *pivotal moments* in the dreamwork process that stood out for you? Please describe these in as much detail as you can.
Explore each instance completely before inquiring about the next one. For each impactful moment, ask the following:

- What about this moment was so impactful?
- How did the experience impact you (emotionally, mentally, physically, spiritually)?
- What may have been different/possible for you after this moment?

3. Have your *dreams* changed as a result of this process? If so, how would you describe these changes? What changes stand out for you?
- Prompts:
- Degree to which they are scary or disturbing.
- Changes in your role/perspective within the dream.
- Changes in characters, settings, story line
- Changes in degree of realism vs. fantasy
- Changes in relationship to your trauma

4. Has your *experience* of your dreams changed, and if so how?
- Level of comfort/distress with your dreams?
- Ability to derive meaning from your dreams?
- Ability to see/interpret the dreams symbolic or metaphorical?

Appendix G

Dream Log Sample from "Jose"

Data includes a scale from 1-5 on the level of distress the dream caused, as well the participant's sense of its similarity to the trauma event.

Nov. 14 : 3 nms. Distress levels: 1: 4/5, 2: 3/5, 3: 4/5 All similar to trauma.

#1 *This dream was at work, I was doing a repetitive task, folding t-shirts. My boss got angry at me, made me work faster. So co-workers laughed at me, called me faggot. I started screaming to them and lost control. The scenario changed and I am in front of a church and I wished to me normal, I wished to be like other guys. My family was there but suddenly they just vanished.*

#2 (repetitive) *I am in school; it was exam day. I haven't studied for the test. This is a classmate who I secretly loved him. He explained to me the questions in matter to be tested – it was a math test. I kissed him and everyone in the classroom booed to me. I run away, I missed the exam. I got angry, I wished I could escape. I was still at school. I found myself talking to the social worker: Dr. B. She was counseling me, gave me Christian doctrine about my behavior. I didn't want to listen to her. She kept talking. The room was getting bigger each time. I wish to die. I woke up.* 3:50

#3 (repetitive) *This dream took place in hell. Satan was not there, nor his demons. For some reason in my dream, I realized that this was a dream and that I didn't want to be there. My body levitated and started flying; I was in outer space. I could see the planet earth, I came down to a new place. It is an unknown place, I felt peace, calm, tranquility, serenity. I saw dead animals that were sacrificed in the name of Satan. I kept saying in my dream that this is just a dream, Satan did not exist. I run away; and woke up.* 6:00

Nov. 17. 1 nm, 1 bad dream, 5/5 distress level, recurring themes

#1 This dream used to come to me every couple of months, and I've been having it since high school. *The scenario is at the ocean. There was a beach, a hotel, tourists. I was a tourist. I jump in the ocean and I got all wet and sank deeply. My respiration got lost – I ask for help – seashells, fish and other marine species were close to me. A book which looked to me like the Bible was somehow floating over me. I tried to reach it. I wake up*. 2:30 am

#2 (repetitive) *In Canada. Someone was touching my body in my dreams. I didn't want to be touched. Someone is putting his fingers in my anus. Someone raped me in my dreams. Someone took away my life. My funeral took place in my house. Everyone was crying. I could see this, I was crying too. I woke up desperately.* 5:30

I also dreamt this Oct. 17 and Nov. 22. This dream used to be extremely intense. I could not stop sobbing and shedding tears. On Oct. 17, 2012 I attempted to commit suicide due to this kind of dream, in Ecuador. I used to have this dream before, but Satan was the one who used to rape me. Now, Satan is no longer in this dream. Satan used to drag me to hell after he got sexually satisfied. Now nobody drags me to hell.

On July 5, 2013 I attempted to commit suicide due to this dream, in Canada. This dream and other facts pushed me to lose control over myself. At the Vancouver Mental Hospital I realized that Satan is not here in Canada. I am safe.

Appendix H

FOD Instructions from the Manual for Participating Therapists

Main intervention session

1. Clearing a space
2. Telling of the dream
3. Administer dream questionnaire
3. Finding 'help'
4. Imagining a new version or ending.

This session is the main intervention session. However, there is a brief questionnaire to administer in-session. The questions are aimed at determining how literally (or metaphorically) participants view their initial dream.

SESSION INSTRUCTIONS

1. Preamble. Take a few minutes to allow the participant to settle into the session, and check with your client to see if they have any questions or concerns about being part of the study. Begin with a very brief check-in about dream frequency and impact over the past week and check to make sure they have brought a dream to work with.

2. Safety check. Ask for any significant changes/adverse reactions since last week's screening. If they had an initial score above 3 on the SBQ, repeat the SBQ. Do not continue if the SBQ score has increased. Follow crisis intervention protocol if the score reaches 7 or more.

3. Clearing a Space. Use the script provided. (on the previous pages).

At the end of the Clearing a Space step, ask the client to check in and see how they feel after the exercise. At the end of the CAS protocol, participants are asked to mark the felt sense of the experience so they can come back to it. Check that they can feel/access that felt sense. Say:

See if you can keep that felt sense with you as you tell me about your dream.

4. Telling the Dream. Ask the participant to recount his/her recurrent nightmare, or most frequent or impactful dream from the previous week. Ask them to tell you all the details and write it down in point form as you go. (This will help if you need to refer to details of the dream later in the session.)

As the client tells the nightmare, watch for signs of activation, such as:

- speaking very quickly
- signs of nervous energy, fidgeting, excess movement
- physiological signs: flushed face, heat, faster heart rate, shaking, etc.

Also watch for signs of dissociation (these can be harder to see):

- a sense that they are disconnected from what they are saying

- vagueness, dreaminess, loss of train of thought
- flatness, speech and manner devoid of emotion
- any sense you get that they are 'not there'

In either case (and throughout the session), ask the client to stop where they are, slow down and connect with the felt sense of the cleared space, pause, take some deep breaths if that helps. After this, check in with them to see how they are feeling, and ask them if it feels okay to proceed. Wait until they agree. If they need time, you can ask them to look around the room for something they find comforting, talk about something from their life that makes them feel good or again find the felt sense of the cleared space from earlier. Do this as often as necessary as they re-tell their nightmare so that they stay in the 'window of tolerance' throughout this part of the session.

Once they have told the dream in its entirety, thank them and here also, if it seems needed, suggest that they pause and connect with the sense of cleared space, or to you or the room – whichever option seems to calm them the most. They will likely engage in some self-soothing behaviors quite naturally as needed, so observe and reinforce what they do to calm themselves.

5. Dream Imagery Questionnaire. Ask the 6-question dream questionnaire here. Write the responses on the form, but allow the client to elaborate at any point if they wish to.

6. Finding 'help.' From here on, it is not possible to standardize the script because the intervention depends on the dream content, and on how the session unfolds, and this will be different for each client.

Before you suggest that the client dream the dream onward, try to collaboratively find the 'life-forward energy' Gendlin suggests all dreams bring. In the case of trauma dreams, this may be more challenging. Guiding steps are listed below (and elaborated upon, with examples, in the training session accompanying this manual).

Dreams are often melodramatic. Experiment with the client in ways you might not take them too literally. Do not shy away from content that appears scary. Instead, find a phrase that captures it and see if that can also be symbolic. Encourage this same attitude of curiosity and exploration in the dreamer.

Try any of the following options that feel right in the session – do not ask them all. With each query, if the client does not naturally do this, ask them to take the question down inside themselves and take time to reflect on it from there before answering:

- If there are people, animals, life, light or anything that seems like 'help' ask about them and invite the dreamer to get a felt sense of them
- Are there any striking or incongruous details? If so, you might ask about these.
- Ask if there is anything about the dream that the dreamer finds curious.
- Ask about the setting of the dream, what the surroundings are like
- Ask if there is anything about the dream that is surprising or different from the trauma

- Ask, of all the trauma-related events or details you could be dreaming about, what is it about this one that seems important?

- If there are people, animals, life, light or anything that seems like 'help' ask about them and invite the dreamer to get a felt sense of them
- If there is no sign of help, but there is a central sick or wounded character, ask what a healthy version would be like.

Watch the body language of the client for signs of life: posture that lifts them taller, signs of engagement with you: eye contact, excitement, interest. When you see this, spend time with what brings this. Then ask if they can find a felt sense of that image or dream element you are exploring. Give them time to find it and sense it in their bodies.

We are looking for 'help' by which we mean signs of life, but do not insist that it have a positive valence. The dream exploration may enable the processing of distressing thoughts and feelings that may lead to new-found meaning, but the material may not lend itself to good or happy feelings. Don't expect too much or force things. Watch for any kind of shift in the way the client thinks/feels/processes the dream; encourage them to acknowledge and sense into that shift.

7. Imagining a new ending or version of the dream.

a. If at this point, they have a felt sense of the 'life-forward' energy in the dream, ask them to dream the dream onward from that place. First be sure they are in the dream space by suggesting they 'enter' the dream as if they are actually dreaming it right now, feeling it with as many senses as they can. Then say: (phrase in italics below)

b. If they do not have a sense of forward motion or 'help' from the dream, ask them to contact the felt sense of cleared space they found earlier, keep that good feeling with them. Then let the dream unfold from where it ended. Ask them to 'enter' the dream as if they are in the dream ending again, feeling themselves back in it with as many senses as they can. Then say:

Both a and b:
From that felt sense, and also sensing into the whole of the dream, allow the dream to continue from any point in the dream – either the end or from any point you would like to change. Allow the dream to change in any way that feels right to you. Do not ***think too much about*** *the change, but allow it come up from inside* ***as though the dream itself is continuing forward****.* (Long pause).

If the client is silent for more than a few minutes, you might ask them what is going on for them, or if they need more time. Often, they will recount the new dream ending without prompting. Listen to (and write down) their new version and reflect back what they say. Ask them if it feels complete or if there is more. Keep going until this process feels complete.

Ask into the felt sense of the new dream. Ask them to check inside and see if they can find a felt sense of the new dream. Spend some time with this, and if it's a good feeling, ask them if there is a way they can mark and keep keep this feeling. Can they anchor it their body?

Can they return to it if they want to. What are the cues that will help them remember/keep this feeling?

8. Closing. In closing the session, check in with the client to see if they feel complete or if there is anything they need to do for themselves to close the session. Ensure they leave with a good feeling – if needed, bring them back to the cleared space. Ask if they are feeling okay and if they have any questions about next steps.

Remind them to keep their dream logs and to write down any significant dreams they have in the following week. Confirm the next appointment for the following week.